Moorfields Eye Hospital NHS
NHS Foundation Trust

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Annual Report and Accounts 2014/15

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

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1 Chairman's foreword

On behalf of the board of directors, I am pleased to introduce the annual report and accounts for 2014/15.

There is no doubt that this has been a challenging year for Moorfields, but one in which we made some striking achievements. Once again, more patients than ever chose to receive their care from Moorfields, and our A&E team continued to perform exceptionally well, despite the ever-growing demand for the service. Our clinical outcomes remain strong, with many of our sub-specialty services achieving results well above standard.

Our relationship with our partners at the UCL Institute of Ophthalmology continued to grow as we began to implement our joint strategy for research, and we introduced new qualifications for nurses to enhance the skills of this increasingly important group of professionals.

We expanded the footprint of our network model of care, opening in new locations in Croydon in south London, Stratford to the east and Dartford in Kent. This means that we now provide eye care in 22 locations in and around the capital, bringing our expertise closer to where people live and work across a wider area than previously.

Internally, we launched the Moorfields Way, a three-year programme of cultural change to address some of the apparently conflicting views presented by our staff survey. Over the course of the year, this project has generated more than 1,400 contributions from staff and patients. We have distilled these into a set of simple and straightforward commitments to each other, through which we can create the consistency to ensure that everyone – staff and patients alike – experiences Moorfields at its absolute best.

We were also delighted to be listed as one of the 10 best places to work in healthcare by the *Health Service Journal* during the year – one of only two hospital trusts to make it into the top 10.

On the national stage, our innovative network model of care was cited as a good example of how specialist care can be provided more effectively and efficiently in future in both the NHS Five-Year Forward View published in October 2014 and the Dalton review of new options for providers of NHS care published in December 2014.

One of our main challenges during the year was to restore our previously strong performance against the national referral-to-treatment targets. Our performance started to fall at the end of the previous financial year, and continued to consume a good deal of time and effort throughout 2014/15, although I am pleased to report that we are now back on track and meeting the targets once again.

In early 2015, the board of directors took the difficult decision to close the manufacturing unit of Moorfields Pharmaceuticals. This followed a period of non-production while we sought to address issues raised during a routine inspection by the Medicines and Healthcare Products Regulatory

Agency at the end of 2013. Ultimately, we concluded that to reinstate manufacturing would be too costly and complex after such a long period of suspension, especially given the increasingly competitive market in which the unit was operating.

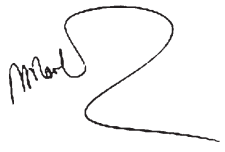
Together with the continued straitened financial picture nationally, these two issues meant that we delivered a smaller surplus (before impairments) than we had originally planned, which we need to take account of in prioritising our investments in new services or locations in the future. That said, delivering a surplus at all in the current climate is no mean feat, and puts us in a much stronger position than many other NHS organisations.

Two board-level colleagues who have been instrumental in many of Moorfields' achievements in recent years left us during 2014/15. Rob Elek, our director of strategy and business development departed for a new role at St George's University Hospitals NHS Foundation Trust, while Sir Roger Jackling, one of our non-executive directors, decided to take a well-earned retirement. On behalf of the board, I would like to thank them both for their sterling work over the years. In their places, I am delighted to welcome Johanna Moss and Dr Ros Given-Wilson. Jo, who is currently the deputy director of strategy at University College London Hospitals NHS Foundation Trust, will start as our new director of strategy and business development in July 2015, while Ros is the former medical director at St George's, and joined us as a non-executive director on 1 May 2015. Both Jo and Ros bring with them a wealth of knowledge and experience that will be invaluable to us.

The elected governors on our membership council remain crucial in maintaining links between the trust and its patients, and I was pleased to see so many of them returned to their seats in this year's elections. Having an established and experienced set of governors will be especially important given the enhanced role that they are now expected to fulfil, and I look forward to continuing to work closely with them in the future.

Despite this year's challenges, Moorfields remains in a strong position for the future and has much to look forward to in the next year, including securing a new site for our central London hospital and reapplying for National Institute for Health Research biomedical research centre status.

Finally, our staff remain fundamental to our continued ability to deliver high-quality specialist eye care. They are truly what makes Moorfields and, on behalf of the board, I would like to thank them all for their continued support and commitment.



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 2,000 staff are committed to sustaining and building on our pioneering history 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. We are one of only 11 sites nationally that have National Institute of Health Research (NIHR) biomedical research centre (BRC) status, which provides us with the infrastructure to support major innovative research initiatives and enables us to fast-track projects to benefit patients more quickly.

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

In 2014 we expanded on these values with the introduction of the Moorfields Way – a patient and staff engagement initiative which outlines a set of commitments and behaviours to support the realisation of our vision. Further information is included in section 2.3.9.

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 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
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
Ocular oncology	Treats cancers of the eye – this service was managed by Barts Health NHS Trust during 2014/15, with outpatient clinics provided by Moorfields; the management of the service is expected to transfer to Moorfields in the second quarter of 2015/16
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
- Ocular 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 UAE. Commercial developments are overseen by MEH Ventures, an entity established during 2013/14 specifically for this purpose.

2.1.3 Where we work

We treat people in 22 locations in and around London, which enables us to provide expert treatment closer to patients' homes. These services are organised into five main categories as set out below:

Moorfields Eye Hospital, City Road

This is our central London base. The hospital provides comprehensive general and specialist outpatient, diagnostic and surgical services, emergency surgery, and a 24-hour A&E. Our research and teaching activities are also predominantly based here at present.

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
- 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
- Darent Valley Hospital, Dartford (from September 2014)

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)
- Loxford Polyclinic, Redbridge
- The Nelson Health Centre, Merton (from April 2015)
- Purley War Memorial Hospital
- Teddington Memorial Hospital
- Sir Ludwig Guttmann Health and Wellbeing Centre, Stratford (from July 2014)

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:

- Homerton University Hospital NHS Foundation Trust, based in Homerton Hospital in Hackney
- 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 Intu Watford shopping centre in Hertfordshire

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.

2.1.4 How we are organised

Our patient services are sub-divided into several clinical directorates, as follows:

Moorfields at Bedford

Focused around our district hub at Bedford Hospital, this directorate is also responsible for activity in our community clinic at Bedford Enhanced Services Centre, known locally as Bedford Hospital North Wing.

Moorfields at Croydon

This is our newest clinical directorate. It includes our district hub at Croydon University Hospital and our community clinic at Purley War Memorial Hospital.

Moorfields at Ealing

This clinical directorate works closely with colleagues in our Northwick Park directorate to provide services for patients in north-west London. Its work centres on our district hub at Ealing Hospital.

Moorfields East

Moorfields East is responsible for the provision of eye care in the eastern part of London, a rapidly expanding area of the capital. The directorate comprises our local surgical centres at Mile End Hospital in Whitechapel, St Ann's Hospital in Tottenham and Darent Valley Hospital in Dartford, Kent. It also includes our community clinics at Barking Community Hospital, Loxford Polyclinic and the Sir Ludwig Guttmann Health and Wellbeing Centre in the former Olympic Village in Stratford, and our partnership based at the Homerton Hospital in Hackney.

Moorfields at Northwick Park

Together with the clinical directorate for Ealing, our Northwick Park directorate provides eye care for residents in north-west London. It covers activity undertaken at our district hub at Northwick Park Hospital in Harrow, local surgical centre at Potters Bar Community Hospital and in three of our partnerships: two in Watford and one in Wealdstone.

Moorfields at St George's

This directorate centres on our district hub at St George's Hospital in Tooting and encompasses responsibility for the management of four other locations in south-west London: our surgical centre at Queen Mary's Hospital, Roehampton and our community clinics at Teddington Memorial Hospital and, since 1 April 2015, at the new Nelson Health Centre in Merton.

Outpatient and diagnostic services, City Road

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, 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, City Road

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.

These directorates are supported by a range of corporate services covering quality and safety, human resources, governance, strategy and business development and finance.

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 what 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 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 change
  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 specialist 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 Strategic plan 2014/19

In line with national guidance, we submitted a five-year strategic plan for 2014/19 to our regulators in May 2014. This plan concluded that *Our Vision of Excellence* remained robust and relevant, and that our 2014/16 operational plan (see section 2.2.3) was an appropriate mechanism by which to implement the strategy and to monitor progress.

The plan used a prioritisation framework to provide a simple approach to identifying which strategic options should be given priority, with the following identified as immediate actions:

- To progress the expansion of our eye centre at St George's Hospital, Tooting
- To start providing services at the Sir Ludwig Guttmann Health and Wellbeing Centre in Stratford as a precursor to the implementation of our Moorfields East strategy
- To conclude the acquisition (or not) of a further location in north-west London
- To develop a new service in Dartford that will enable us to provide care closer to home for patients in the south east

2.2.3 Priorities for the year

We refreshed our approach to setting annual corporate priorities for 2014/15 to ensure that we were able to concentrate on key issues and speed up the implementation of critical workstreams. To this end, our operational plan for 2014/16 identified five objectives as set out below. In tandem, we continued to deliver many other workstreams as "business as usual".

Our priorities for 2014/16 were 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 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 proactive leader in this field

While significant progress has been made in some areas, we have not made as much progress as we would have liked in others. This was partly due to external factors outside of our control and partly due to significant operational factors, notably management time and effort invested in our programme for recovering the national 18-week referral-to-treatment target.

This annual report, including the quality report at appendix 1, contains many examples of where we have made progress, both against our corporate priorities and the immediate actions identified in our five-year strategic plan. It also provides information about those issues that prevented us from achieving as much as we would have liked in some areas.

2.2.4 Responding to the NHS Five-Year Forward View and the Dalton Review

Two important strategic documents were published during 2014/15, which will have an impact on all NHS organisations: the *NHS Five-Year Forward View* published in October 2014 and the *Dalton Review* published in December 2014.

We have assessed the implications of both publications and believe that our overall strategy is broadly consistent with them and that we are ahead of the game in some key areas. For example, we are already recognised as an innovative provider organisation which is taking the lead in using its networked model of care to provide care closer to patients' homes, out of hospital and within local communities.

This assertion was supported at the launch of the *Forward View* which took place at the Sir Ludwig Guttmann Health and Wellbeing Centre in Stratford, east London, on the site of the former Olympic Village. Since July 2014, Moorfields has been providing outpatient ophthalmology services for adults and children at this centre, and as part of his address on the day of the launch, Simon Stevens, the chief executive of NHS England, acknowledged us as an exemplar of a specialist provider working in a new and innovative way to deliver local services to residents outside of the acute hospital environment.

Sir David Dalton's review builds on the *Five-Year Forward View* by seeking to address the significant variations in the standards of service provided by healthcare organisations. He agrees with the view that new models of care are needed to support and care for people, and advocates the development of new and innovative organisational forms to underpin new clinical models and ways of working.

Both UCL Partners (of which Moorfields is a founder member) and Moorfields itself are cited in the review as examples of existing organisational forms to be considered by others; UCLP as a "federation" within which more than 40 higher education and NHS members have agreed to implement improvements in healthcare at a greater scale and pace by sharing resources and working together; and Moorfields as a "service-level-chain" operating a networked model of care across 22 locations in and around London.

In addition to these two organisational forms, the review gives five other examples of structures that in the appropriate context could be used to deliver the greatest benefit to patients. Again, we will review our overall strategy during 2015/16 in light of these options to ensure that our current organisational form remains fit for purpose.

2.3 Performance and business review

2.3.1 Patient activity

We experienced significant growth in our NHS patient activity in 2014/15, partly due to increasing demand for our services and partly due to the fact that we opened new sites during the year (see section 2.3.2). We recorded well over half a million attendances in our outpatient services, and 96,000 attendances at our A&E department, and we carried out almost 40,000 surgical procedures.

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. In addition, several of our staff provide support to ophthalmology services run by other organisations, where we charge the relevant organisation for the work our staff undertake.

The total NHS care provided by Moorfields grew across all settings in 2014/15 as shown in the table overleaf.

Activity	2014/15	2013/14	% change
Total outpatient attendances	532,674	479,969	11.7%*
A&E attendances	95,941	88,208	8.8%
Total inpatient and day-case admissions	39,686	33,405	18.8%

*This percentage increase includes an adjustment for the full year recording of optometry and orthoptic attendences, which were only recorded for half of the 2013/14 financial year.

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 25,709 intravitreal injections and 9,026 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.

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 for admitted patients for the year. Details of our performance against these standards can be found in our quality report at appendix 1.

2.3.2 New services and investments

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 2014/15.

More care closer to home

We 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. During 2014/15, we recorded 37,000 outpatient appointments at Croydon, and undertook some 3,000 surgical procedures.

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 NHS Trust, which runs the hospitals, and Croydon Clinical Commissioning Group, a decision was made 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 routine and more complex eye surgery. Purley is one of our community-based outpatient clinics, focusing predominantly on outpatient and diagnostic services.

Work continued to implement our strategy for Moorfields East. Moorfields East comprises our satellite locations in St Ann's, Mile End, Loxford, Barking and Homerton, and has been augmented this year by the start of new services in Stratford and Dartford. Each of the older sites 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 set out a coherent approach for the future in this important and growing part of London.

The start of services at the Sir Ludwig Guttmann Health and Wellbeing Centre in Stratford in July 2014 and at Darent Valley Hospital in Dartford, Kent, in September 2014 represented an important achievement in implementing the strategy.

The Sir Ludwig Guttmann Health and Wellbeing Centre is located on the former London 2012 Olympic and Paralympic Park, and our presence there forms part of the legacy benefit to London from the Games. Our five-day-a-week service includes general ophthalmology, paediatrics (children's vision clinics), diabetic retinopathy and age-related macular degeneration (AMD). A stable monitoring service for Newham glaucoma patients, who were previously seen at other Moorfields sites in London, is also being provided. Between July 2014 and the end of the financial year, we recorded some 700 outpatient attendances in this location.

Our service at Darent Valley is our first site to serve south-east London and Kent. Patients referred by their local GPs to the four-day-a-week service are able to receive treatment for medical and surgical retina conditions, cataract, and children's eye conditions, and there is also an AMD injection service. We recorded 1,100 outpatient attendances and undertook around 300 surgical procedures during our first nine months of operation, and continue to work with colleagues from Dartford and Gravesham NHS Trust to expand the services we run at Darent Valley Hospital.

We are also exploring further the option of creating a new surgical hub for Moorfields East so that we can expand the range of services we 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.

Throughout the year, we have been working to strengthen our presence in south London. In partnership with lead provider St George's University Hospitals NHS Foundation Trust, we have been developing an ophthalmology service as part of a new state-of-the-art health centre in Merton, which provides an integrated range of services to the local community. The centre officially opened at the end of March 2015.

During 2014/15, we ceased to provide services in the Princess Alexandra Hospital in Harlow following a decision by the trust that manages that hospital to bring eye care completely in-house, rather than buying in consultant support from Moorfields. Our pilot project at Bridge Lane Health Centre in Battersea in south London also came to an end.

The opening of these new sites and the cessation of services in others means that we are now providing care in 22 locations in and around London, ensuring that more people have access to high-quality eye care closer to where they live and work. A full list of all our current locations is included in section 2.1.3.

Developing our portfolio

Since December 2014, we have been involved in an NHS England (London) tender for the restructuring and consolidation of diabetic retinopathy screening (DRS) services in the London area. We have a strong interest in supporting patients with diabetic eye disease and have been involved in the national DRS programme since its inception in 2002, providing some elements of the pathway, including clinical leadership, programme management and hospital eye services. Work on the tender and our future involvement in these services is ongoing.

Throughout 2014/15 we have also been working towards the transfer of ocular oncology services from Barts Health NHS Trust. We already host two outpatient clinic sessions for the ocular oncology service and a further three transferred to us from Barts in April 2015. It is intended that NHS England will contract directly with Moorfields for the provision of the full service from July 2015; from that point all ocular oncology investigations and outpatient clinics will be managed by Moorfields, with the inpatient service sub-contracted to Barts.

We began providing a limited outpatient medical retina (MR) and intravitreal injection service at our Potters Bar site towards the end of 2015, and plan to start a full service in July, once all the staffing and equipment needs have been secured. The new service aims to fill a gap in our provision in this

part of outer north London, following the end of our partnership with Princess Alexandra Hospital in Harlow during 2014/15.

It also reflects the significant expansion of MR as a sub-speciality in eye care over the last five years and predicted growing demand, driven by demographic changes linked to an ageing population, an increased prevalence of systemic disorders associated with retinal disease (diabetes, hypertension and raised cholesterol) and the availability of new treatments, in particular intravitreal injections. The new service at Potters Bar will additionally provide care closer to home for many patients, enabling some of them to be relocated from City Road, and free up capacity there.

Screening and stable monitoring service

Our glaucoma service has experienced an unprecedented rise in activity over the past five years, with outpatient visits increasing by more than 30,000. As part of our response to this growth, we introduced a new screening and stable monitoring service at our City Road hospital at the end of 2014. The new model of service delivery – in which tests are carried out by technicians and reviewed by a consultant later – was introduced following a pilot study by three glaucoma consultants to check whether there are any differences in the quality of clinical management. None was identified.

Visual field and imaging machines are in one contained unit in the clinic, and specially-trained ophthalmic technicians manage all tests. Patients suitable for the clinic are new low-risk glaucoma suspect patients or stable glaucoma patients.

For the future, we envisage that further investment in a consultant-led service – with specialists providing leadership and clinical expertise at all stages in the patient pathway – will be required to ensure effective links between hospital and community services, and to enable us to maintain the highest standards of care, regardless of location. We will continue to adapt to the increasingly challenging landscape, identifying the best ways to maintain and strengthen the quality of our service, with the aim of ensuring we remain a world leader in this important area of eye care.

Expansion of independent prescribing

Independent prescribing continued to expand throughout the year across a range of extended roles, including in glaucoma, medical retina, cataract, external diseases, A&E and general ophthalmology. There are now 30 specialist optometrists who are qualified independent prescribers at Moorfields, with more to come over the next few years. In each service, specialist optometrists work within a protocol and those with independent prescribing rights have the autonomy, where appropriate, to treat and manage patients. This initiative has enabled clinics to work more efficiently and provide a better service as patient numbers continue to rise.

Additional consultant resource

We expanded our consultant capacity during 2014/15, creating new posts or enhancing existing roles to support and provide additional capacity in our glaucoma, anaesthetics, adnexal, A&E, paediatrics, medical retina, and corneal services. Eleven new consultants started during the year and we appointed one consultant in 2014/15 with a confirmed start date in 2015/16.

A&E – exploring different ways of managing A&E

Attendances at A&E have doubled over the past 10 years, and we anticipate that we will soon be looking after 100,000 patients a year in this way. Although the A&E team are successful in ensuring that more than 99% of patients are seen and treated within four hours – and that more than 80% are dealt with in under three hours – we will not be able to continue to provide such a responsive service if the number of patients attending continues to grow at the rate that it has historically done.

In light of this, the A&E team completed a review of the service during 2014/15 to consider how we should organise and resource our urgent care services in the years ahead, both in the A&E department at City Road and at some of our other larger locations. Several options have been developed and will be the subject of further discussion during 2015/16.

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 on clinical audit and effectiveness, patient safety and patient experience.

Much of our work this year has been focused on driving improvements in quality and safety across the organisation by implementing the key objectives set out in our quality plan. The plan is designed to improve the patient experience, and the safety and effectiveness of clinical care across all of Moorfields' sites and services, using a patient journey as its framework.

Although further work will be required during 2015/16 to make the delivery of the quality plan feel like a cohesive piece of work with an overarching implementation strategy, some good progress has been made in the last year in delivering some of its key objectives, as follows.

Better information for our patients

We opened a new health information hub in our City Road hospital in May 2014, providing written and electronic information about eye conditions and other public health information. The hub is also being used as a platform for patients to engage with such organisations as Diabetes UK, the Macular Society and Blood Pressure UK. We are working with charity Action for Blind People to grow the hub to become a focal point for patients to drop by on the way into and out of the hospital, and to receive specialist advice.

Live clinic information screens are present in most of the main clinical areas across City Road and other locations. These display patient-centred information about clinics and waiting times, application of eye drops and general health. Patient information leaflets on a broad range of eye conditions are available in clinics and floor walkers are also present to keep clinics flowing and to provide information to patients as necessary, including about waiting times.

Several improvements were made following the introduction of a new telephone system at our City Road hospital. These included the installation of additional lines to the main switchboard, enabling external calls to be answered in a more timely manner, and extra line capacity to booking appointment lines, making it easier for patients to contact the correct extension and speak to the most appropriate person to deal with their query. This initiative was supported by a training programme for frontline staff, focusing particularly on customer care skills. We also introduced extended operational hours for the nurse-led advice line at City Road, which has improved access for patient callers by extending the service into the evening and at weekends. Three additional nursing staff to cover the service have also been recruited. Call handling in the booking centre and optometry department has also improved as a result of the new telephone system.

The system allows activity to be monitored and identifies call volumes, waiting time and duration, as well as abandoned calls. It can also identify problems with waiting times as they occur so they can be dealt with promptly. The impact on patient experience has been positive; there is already a reduction in the number of adverse patient advice and liaison service (PALS) enquiries associated with telephone problems.

Improving safety

Throughout 2014/15, we continued our programme of patient safety walkabouts and site/service reviews. This included a Care Quality Commission-style unannounced visit to the medical retina and glaucoma clinics at City Road, which involved extensive interaction with staff and patients. Although no major issues of concern were identified, several improvements have subsequently been made, including improved signage and painting supporting pillars in a different colour to improve visibility for visually-impaired users.

We also continued to drive and embed improvements in safety and compassionate care in response to the Francis Report, failings at Winterbourne View, Berwick Review and other government reports commissioned to support their consideration of the outcomes of the Francis inquiry.

Key actions taken in this regard during 2014/15 included updates to our Being Open policy, which ensures that open, honest and transparent communication takes place with patients, their families and carers following a patient safety event. We also improved the information published on our day-care wards so that patients are clear about the named consultant responsible for their care, ward staffing levels, and infection rates. We appointed a senior social worker to a safeguarding post with responsibility for all patients including those with dementia and learning disabilities, and introduced a "This is me" document for patients with learning disabilities and/or dementia. A pocket prompt for all clinicians involved in taking consent from patients was introduced to help them assess whether a patient has the mental capacity to give informed consent and to inform them of what they should do if this is not the case.

In addition, from April 2014, the resuscitation service worked to upgrade existing automated external defibrillators (AEDs), which we need in case anyone has a heart attack on our premises. The resuscitation team also ran familiarisation sessions in clinical areas, as well as drop-in sessions to provide information and guidance for staff on using the new equipment.

A medical gas project at City Road was completed and delivered a new liquid oxygen compound. The previous oxygen supply for the hospital was provided from bottles which now operate as a standby unit. This project has mitigated a significant health and safety risk as the oxygen bottles required frequent changing by porters.

Clinical outcome measures

All services continue to report on at least three key clinical outcome indicators, which are generated through a combination of electronic data capture, prospective data collection and retrospective analysis of case notes. Standards for comparison are based on analysis of national and international scientific literature, and benchmarks for other major international ophthalmic units through our links with the World Association of Eye Hospitals (WAEH). On the whole, Moorfields' performance against these standards demonstrates excellent clinical care, with many services achieving results well above standard.

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

- Results for the predictability of biometry
- Very low rates of failure in drainage surgery for glaucoma
- Excellent results of all lid surgery
- Very low rates of serious complications of squint (strabismus) surgery
- Low rates of serious infection (endophthalmitis) after procedures
- Excellent safety and accuracy for refractive laser procedures

During the year, work has been underway to produce an automated audit function for cataract outcomes, which will enable clinicians to obtain real-time audit results. This will make the process of collecting outcome data less time and labour intensive, and will enable reporting for up-to-date and personalised surgeon outcomes. It will also allow us to submit data to the national cataract audit which is currently being established by the Royal College of Ophthalmologists.

Surveys in relation to achieving better outcomes were completed in all clinical services, with input received from patients and other stakeholders, including GPs, optometrists and commissioners.

In addition, the Federation of Specialist Hospitals (FSH), of which Moorfields is a member, released a report in May 2014 which highlighted impressive clinical outcomes achieved by England's specialist hospitals. Moorfields contributed to this report and was cited in press materials surrounding the publication for our success rates on drainage tube surgery for intractable glaucoma.

Moorfields carries out around 330 of these operations every year and has a success rate of 98%, compared to 80% achieved by other hospitals. The occurrence of complications is also significantly reduced to 3.4% at Moorfields, in comparison to 20% at some other centres.

Moorfields' service director for glaucoma was also interviewed about the publication for the *Health Service Journal.* The FSH released its report as a contribution to the debate on hospital configuration in the NHS, following NHS England's announcement that it plans to reduce the number of providers of specialised services from 270 to 30 or fewer.

Improved facilities

Several projects were completed during 2014/15 to improve the environment in which we see and treat our patients.

Moorfields' facilities at Ealing Hospital, where we provide the entire ophthalmology service, were extended in 2014 to provide additional capacity, and refurbished to provide a much improved environment for patients. The extension has allowed for additional clinic and injection space in front of the existing unit, enabling us to improve the patient experience, accommodate additional equipment and capacity, and provide a better working environment for our staff who were providing high levels of service within very cramped conditions.

We also completed the first phase of works in our new eye centre at Croydon University Hospital, which has improved patient flows in the outpatient entrance as well as facilities for staff.

The expansion of the children's ocular prosthetics department in the Richard Desmond Children's Eye Centre was completed in July 2014, while work to the adult ocular prosthetics area was completed in December 2014.

Organised by Moorfields art committee, the medical retina and medical imaging clinic at our City Road hospital was refurbished in July 2014 with a range of donated art, photography and sculpture.

In addition, work got underway to upgrade the theatre complex at our City Road hospital in March 2015. This work is necessary to ensure that the theatres are compliant with technical standards on air changes, but we are also taking the opportunity to complete other important maintenance work to ensure that they remain fit for purpose until we move to our new hospital.

For the longer term, we acquired Kemp House, the office building adjacent to our City Road hospital, in October 2014. This purchase will help us to address the space pressures resulting from our increasing clinical activity, which comes in the face of higher demand for our services. Planning is underway to agree what functions could and should move into the new building in order to free up space to expand our clinical services on the City Road hospital.

At St George's, development work planned for 2014/15 to create a stand-alone, purpose-built facility at the hospital was put on hold to allow us time to do further work to assure ourselves of the clinical safety of our plans. The reprovision of our service at St George's is now a corporate priority for 2015/16.

External review of environment

The annual Patient-Led Assessment of the Care Environment (PLACE) visit took place in March 2014 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, A&E and wards.

Our scores were as follows:

- Cleanliness of wards, including bathrooms, furniture, fixtures and fittings: 99.62% against a national average of 97.25%
- Condition, appearance and maintenance of sites, including decoration, signage, linen and car park access: 99.10% against a national average of 91.97%
- Privacy, dignity and wellbeing, including changing and waiting facilities, appropriate separation of single-sex facilities, telephone access and appropriate patient clothing: 88.31% against a national average of 87.73%
- Patient food and hydration, including assessment of choice, taste, temperature and availability over 24 hours: 100% against a national average of 88.79%

As City Road is an ambulatory care hospital, the score for food and hydration, although internally recognised as receiving a percentage score, was not published to a wider audience.

The PLACE process obtained very positive feedback from both employee and patient representatives alike. Areas of possible improvement that were raised on the day of inspection have been addressed and will continue to be monitored. The 2015 PLACE will take place in forthcoming months.

2.3.4 A new central London facility

Work continued throughout the year to produce a business case in partnership with our research colleagues at the UCL Institute of Ophthalmology to build a new centre for eye care, research and education away from our existing central London location in City Road.

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.

Identifying and relocating to a new site is considered the best option for our joint aspiration to create a fully integrated and flexible modern facility, bringing together eye research, education and healthcare in a patient-friendly environment, and allowing us to attract the best ophthalmic scientists, educators and clinicians. The work completed to date suggests that this will not be feasible or affordable on the existing City Road site, where we would also need to keep all services fully functional at the same time as building a new hospital.

During 2014/15, we completed the design brief for the new building, which 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.

Although we were unable to reach any final agreement about a site during the year, we continued discussions with site owners over a range of options, with a preferred site in the King's Cross/Euston area, which is subject to negotiations with its present owners.

Wherever our new facility is built, we will continue to provide expert eye services for the residents of all local boroughs. We will also be exploring options to retain a local presence in Islington, as happens through our satellite network across other parts of London.

2.3.5 IT improvements

Over the past two years, considerable effort and resource has been invested in refreshing and updating the underlying IT infrastructure across our various locations. This has been delivered successfully, enabling work on information systems and their interaction to begin, and supporting the drive for better knowledge management and greater operational efficiencies. It has also been instrumental in facilitating improved service delivery.

Despite a significant impact on resources, IT has been continually improving and redesigning its service in line with industry standards and Information Technology Infrastructure Library (ITIL) good practice. This has resulted in a consistent level of service to end users, supported by robust, resilient back-end services.

In addition, an out-of-hours on-call service has been introduced, ensuring business-critical systems are supported 24 hours a day, seven days a week. A key benefit of this programme of change has been the delivery of a robust and consistent IT service, with user experience being equal, irrespective of location. Moorfields also now has a significantly improved understanding of its infrastructure, which will enable a quicker return to operation in the event of a failure.

An integration engine has been developed and is in the early stages of adoption. Its growing use throughout the hospital will result in reduced data entry, increased data accuracy, and will mean a significant contribution to operational efficiencies. The introduction of medical grade wireless technology at our City Road hospital has been particularly beneficial to mobile working and has promoted the efficient use of space. This is also expected to facilitate systems for tracking and locating equipment and patients in future.

This programme of IT and operational change has transformed IT into a much more customer-focused, trusted service provider, at the same time as maintaining strong service delivery. These improvements to the underlying infrastructure during the past year mean that we can now focus on other priorities, which will be led by a new chief information officer – a new role – due to take up post in the early part of 2015/16.

2.3.6 Research and development

Along with our academic partners at the UCL Institute of Ophthalmology (IoO), Moorfields Eye Hospital 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 and the USA. We publish more scientific papers than any other eye and vision research site, and have an extensive joint research portfolio. During 2014/15, Moorfields supported more than 230 active projects and follow-up studies, and the IoO had 280 active research grants.

Our joint strategy for research and development was published in 2013 and 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. We are implementing this strategy 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 key areas of expertise, such as rare genetic diseases, and essential scientific platforms, such as stem cell and gene therapy, that will underpin this activity and require further development.

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.

The BRC provides the infrastructure support to major programmes of innovative research such as gene therapy, stem cell therapy, novel surgical devices, visual assessment, genotyping and inflammation. It supports research from the point of conceptual proof to studies that assess safety and potential efficacy for patients, as well as activities and networks that involve patients in working with researchers to determine the drivers and priorities of specific research projects. Examples of such work include events where informal discussions and presentations take place for large numbers of people, and small focus group discussions (between patients, researchers and facilitators) to consider very detailed information about research projects. The information we obtain from these events is informing the way in which we conduct new research at Moorfields.

Our BRC supports 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 provides specialist support for clinical research studies and clinical trials being undertaken at Moorfields. The CRF 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.

Several significant developments were supported by the CRF during 2014/15, including:

- **Ocular surface failure and corneal disease**
  We successfully recruited patients to a study to test whether recombinant (a DNA technology) human nerve growth factor could be effective in treating neurotrophic keratitis – a condition which results in decreased corneal sensitivity and poor corneal healing following neurosurgery, shingles or a tumour. Moorfields is the leading research centre for this pioneering, industry-sponsored phase I first-in-human trial, and the research infrastructure provided by the CRF has been instrumental in its successful delivery.

- **Novel therapies for retinal diseases**
  Several projects are underway to investigate the potential of stem cell transplantation. There is also a phase 1 trial sponsored by Roche to look at whether a bispecific monoclonal antibody (a type of artificial protein) could be effective in treating wet age-related macular degeneration (AMD). Our CRF has successfully recruited patients to this trial during the year.

- **Novel therapies for thyroid eye disease (TED)**
  We are successfully recruiting to the innovative TED River project. This is an industry-sponsored randomised, efficacy and safety study of RV 001 administered by intravenous infusion in patients suffering from active thyroid eye disease. RV 001 is an insulin-like growth factor 1 receptor (a protein found on the surface of human cells), which defends a cell by inhibiting or neutralising the biological effect of antigens or infectious bodies. Moorfields is the leading centre for recruitment to the trial globally.

- **Gene therapy for inherited retinal disorders**
  Achromatopsia is a rare cone photoreceptor disorder for which we have been evaluating patient phenotypes (a person's observable characteristics or traits) with new imaging technology with a view to commencing a gene therapy trial in 2015/16. Phenotyping work for this study has been ongoing throughout 2014/15, supported by the CRF.

We appointed our first head of research nursing at the CRF during 2014/15. The role involves working closely with the research and development team and clinicians in all directorates to ensure the efficient delivery of high-quality research. It also involves supporting the development of the nurse/allied health professional researcher role, developing collaborative relationships with the corporate nursing team and contributing to the delivery of our nursing strategy within the research arena. The head of research nursing is also responsible for raising the profile of ophthalmic research nursing by speaking at local and international conferences, attending teaching commitments, and contributing to various national and international committees and collaborations.

In May 2014, our CRF held an open day for the public, providing an insight into the science and research behind future eye treatments. This annual event marked NIHR clinical trials day and included presentations of groundbreaking research, a session exploring the structure of the eye using state-of-the-art imaging equipment, and interactive workshops demonstrating clinical skills and discussing the importance of eyes and vision research.

UCL Partners

We are a founding member of UCL Partners (UCLP), which is one of 15 academic health science networks (AHSN) in England, as well as an academic health science centre (AHSC). The UCLP network brings together 40 organisations and spans 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 region, 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 AHSC eyes and vision programme, which will drive forward translational research programmes, targeting the blinding diseases that pose the greatest burden to patients and society, and increase our capacity and support for high-quality research programmes.

In December 2014, Moorfields became one of six hospitals to form a partnership to create the North Thames Genomics Medicine Centre, led by UCLP. This partnership is supporting the delivery of the 100,000 Genome Project – a government initiative. The pioneering study will support the delivery of more personalised diagnosis and targeted therapy for patients with cancer and rare diseases.

Throughout 2014, Moorfields was involved in a pilot for the project, which involved providing blood samples to Genomics England for detailed analysis.

Research activity in 2014/15

Publication of paper on nurse-led intravitreal injections

A paper by members of Moorfields' medical retina (MR) team was published in April 2014 in *Eye*, the official journal of the Royal College of Ophthalmologists. The paper discussed a study which aimed to introduce nurse-delivered intravitreal injections to increase MR treatment capacity by measuring outcomes related to patient safety, patient experience and clinic capacity.

Moorfields has pioneered the introduction of nurse-led intravitreal injections, and the publication of this paper represents an important change in ophthalmology practice in the UK, where there was initially significant resistance to nurses undertaking injections.

The study found that no serious vision-threatening complications were recorded in a consecutive series of 4,000 nurse-delivered intravitreal injections and that there was a significant increase in the number of injections offered after the introduction of the service. The majority of patients accepted, and were satisfied with, a nurse-delivered intravitreal injection.

Nurse-led corneal collagen cross-linking service

Results from the first six months of Moorfields' nurse-led corneal collagen cross-linking (CXL) service were presented at the Royal College of Ophthalmologists' annual congress in May 2014. Results demonstrated the practice to be as safe and effective as CXL performed by an ophthalmologist.

CXL is used to treat keratoconus and aims to prevent further loss of vision by halting progressive and irregular changes in corneal shape. Moorfields was the first London hospital to offer this treatment to NHS patients, and the service has been running since 2012. In March 2015, our team administered their thousandth corneal collagen cross-linking treatment.

Additional nurses are currently undergoing training, which will enable us to expand capacity in our CXL service and meet the growing demand for keratoconus intervention.

Glaucoma research

Led by Moorfields in conjunction with a group of international scientists, research into the causes of glaucoma – the leading cause of irreversible blindness – was published in September 2014 in the journal *Nature Genetics*. The study – which examined almost 36,000 people and analysed their genomes to discover genetic markers for intraocular pressure (IOP) – identified four new genetic variants linked to the risk of disease. Raised IOP is a major risk factor for the development and worsening of glaucoma, and is the only treatable element of it.

In December 2014, Moorfields' groundbreaking research into open-angle glaucoma (OAG) was published in *The Lancet*. Findings showed that prostaglandin eye drops, the most commonly prescribed treatment for glaucoma, can reduce the risk of vision loss by more than 50% over two years. Medication to lower raised eye pressure has been used for decades as the main treatment for OAG, the most common form of glaucoma, to delay progressive vision loss. However, until this point, the extent to which the most frequently prescribed class of pressure-lowering drugs (prostaglandin analogues) have a protective effect on vision was not known. The results provide solid proof to patients and practitioners that visual deterioration caused by glaucoma can be reduced using this treatment.

The research also showed that with more frequent testing, data can be collected using shorter observation periods – in this case, two years instead of the usual five. This has the potential to

bring considerable benefits, including speeding up novel drug development, reducing costs, and increasing the likelihood of bringing new drugs to patients.

Patient counselling research

In October 2014, the *International Journal of Ophthalmic Practice* published research into our counselling service for patients – part of our integrated patient support service – in its first year. The research analysed quantitative and qualitative data, and explored reasons that patients were referred to the service. Visual impairment is associated with a higher than normal rate of depression, and this vital research reinforced the importance of psychological and emotional support for visually impaired people, and for those attending an eye hospital.

3D facial imaging research for thyroid eye disease

A research grant co-funded by Fight for Sight and the British Thyroid Foundation was awarded to researchers at our National Institute for Health Research biomedical research centre in January 2015. The research will investigate whether a new 3D facial imaging tool can help to improve the management of thyroid eye disease (TED), a distressing cause of sight loss which can also lead to significant facial disfigurement.

Current treatments for the disease mean that it is hard to predict what result an operation will have, which makes it difficult to provide appropriate counselling to the patient on the potential benefits of surgery in reversing disfigurement caused by the disease.

In three pilot studies, researchers are testing the imaging system, which captures images of patients and uses software to analyse changes in volume, contour and shape, or to simulate the change in appearance that could be achieved by having surgery.

Research into retinoblastoma

Moorfields is pioneering research into retinoblastoma using next-generation sequencing technology. Accounting for around 11% of all cancers developing in the first year of life, the disease is the most common inherited cancer among children and can be fatal if left untreated. With this targeted therapy, we hope to develop more effective and less invasive treatments, and enable earlier diagnosis.

Current treatments for retinoblastoma are limited and the main method involves removing the affected eye completely, so identifying alternative treatments is important to improve quality of life for children with the disease.

Annual alumni meeting 2015

Moorfields' annual alumni meeting was held in February and delivered a programme focusing on clinical and research developments at Moorfields and the UCL Institute of Ophthalmology. The event included a range of presentations on developments in eye care, a keynote address on childhood retinal dystrophies, as well as updates from Moorfields' medical director and director of research and development. This year's research medal was awarded for research into nonsense suppression drugs for the treatment of inherited eye disease.

External recognition for research

Several clinical staff received external recognition for research achievements during 2014/15. They included Moorfields fellow Pearse Keane who became the first ophthalmologist to receive the National Institute for Health Research clinician scientist award in recognition of his pioneering work using binocular optical coherence tomography (OCT) to "reinvent" the eye exam.

Dr Hari Jayaram, a fellow in our glaucoma service, received a Fight for Sight Fulbright research award, which supports pioneering research into the prevention of sight loss and the treatment of

eye disease at an accredited institution in the USA, while academic clinical lecturer Mariya Moosajee was awarded the Foulds Trophy for a second time. Considered the most prestigious research prize an ophthalmology trainee can win in the UK and awarded by the Royal College of Ophthalmologists at their annual congress, the Foulds Trophy recognises the best scientific paper presented at the event. Mariya received the award for her talk on her research into a potential treatment to halt the progression of choroideremia.

The 2014 George Giles postgraduate research prize from the College of Optometrists went to optometrist Padraig Mulholland. One of four research excellence awards given by the institution annually, the prize celebrates outstanding contributions to research in the fields of optometry, optics and vision science. Padraig's research findings have significant implications for improving visual fields tests and, potentially, for understanding the relationship between the structure of the retina and visual function.

Finally, the Spanish Vitreo-Retinal Society award for clinical research was given to clinical fellow Julio González-López in March 2015. Focused on developing and validating a computerised algorithm to help clinicians diagnose uveitis, and tested on 200 patients with the condition, his research was carried out from June 2013 to August 2014 in the medical retina department at Moorfields.

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 2014/15.

A new education strategy

Our education strategy, approved in April 2014, sets out the current education landscape in ophthalmology and how we plan to realise our vision of excellent education as a key component of our overall strategy, *Our Vision of Excellence*, ensuring that Moorfields remains a leader in this field.

The four strategic themes for our education strategy are as follows:

- 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

During 2014/15, our focus has been predominantly on putting the building blocks in place in preparation for the implementation of the strategy itself. Progress has included the introduction of a new learning management system and the completion of a trust-wide training needs analysis to underpin an annual education operating plan.

Medical education

Moorfields provides ophthalmic training and education for doctors at all levels, including undergraduate medical students, postgraduate specialty registrars and fellows, academic clinical fellows and lecturers, nurses, and allied ophthalmic health professionals. Regular courses in various specialist areas are run at our City Road hospital, 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 more than 1,200 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 postgraduates in medical education. We received positive feedback from the three medical schools again this year, with a combined feedback average of 90.07 on a scale of 0–100.

Despite financial pressures, Moorfields continues to support trainees who work flexibly and those in shared academic/clinical training posts; combined, these two groups comprised 11% of our specialist trainees in 2014/15.

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 steps to empower trainees by ensuring that they are represented on the majority of trust committees. In addition, most trainees now undertake trainee-led multidisciplinary team quality improvement projects, which have generated numerous and significant benefits for patient care and service efficiency.

At the end of 2014, Moorfields received a positive write-up in Health Education North Central and East London's guidance on supporting quality and safety improvement learning for doctors in postgraduate training. We were recognised for providing high levels of support and guidance from our postgraduate medical education centre, Darzi fellows and the clinical governance team, and "unrivalled opportunities to develop clinical leadership and management skills".

Medical students from Moorfields' undergraduate education department performed highly in the 2014 Duke Elder undergraduate prize examination. The examination saw 550 students from 36 medical schools in the UK and Ireland compete for the prize. Six of the top 20 slots – including first place – went to our medical students from Barts, UCL and St George's.

Academic courses on the following subjects are planned for 2015/16, and will be attended by national and international delegates: macular (a five-day comprehensive course), ophthalmic A&E, clinical electrophysiology of vision, femto-phako cataract surgery, and orbital cadaver dissection (being held at the Royal College of Surgeons).

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

During 2014/15, we continued to support enhanced roles for our nursing staff, enabling them to develop their expertise, at the same time as freeing up medical staff to concentrate on more complex cases. To this end, we now have 50 nurses who are qualified to deliver our intravitreal injection service, and others who can perform corneal collagen cross-linking (CXL) for keratoconus (see section 2.3.6) or who have been trained to review stable glaucoma patients and post-operative cataract patients.

We also appointed our first nurse consultant for the medical retina (MR) service. The role involves running nurse-led clinics within the service, taking responsibility for the complete assessment, management and discharge of patients seen in the clinics. Providing education and support for staff in the MR service and initiating audit and research projects relevant to it is also part of the role, as well as speaking at conferences and raising the profile of ophthalmic nursing – also an aim of the nursing strategy. The role has also involved overseeing the introduction of a "remote" clinic for patients with stable age-related macular disease.

During December 2014 and January 2015, 28 European Union nurses were recruited due to the continuing shortage of appropriately trained nurses in the UK. To ensure safe and effective transition, the EU nurses received an intensive induction programme to acquaint them with nursing in the UK and the field of ophthalmology. The programme comprised a two-week clinical induction covering the anatomy and physiology of the eye, common eye conditions and clinical examination of the eye. This was followed by a series of 10 clinical training and development days to further enhance the ophthalmic knowledge of the nurses and to introduce them to the roles of the specialist nurses at Moorfields.

In December, we also ran the UK's first course on establishing a nurse-delivered intravitreal injection service. The course draws on our experience of implementing a nurse-delivered service of this kind, and on the expertise in clinical care, education and research of the consultants, senior nurses and management staff who were involved in establishing the facility – initially as a pilot project and subsequently as a fully-operational service. The one-day programme bridges the gap between theory and practical skills for experienced ophthalmic nursing professionals working in a medical

retina setting, focusing on the treatment of age-related macular degeneration, retinal vein occlusion and diabetic oedema either in the UK or overseas.

We held our annual nursing conference in February 2015. On the theme "Embracing the Future", this year's event was led by our director of nursing and allied health professions, and included several talks focusing on our nursing strategy, supporting our aim of remaining a centre of excellence in the training and development of ophthalmic nurses, and ensuring that patient care is at the heart of everything we do. Nurses involved in the leadership programme – set up to enhance leadership capability and enable productive working – were recognised at the event for their involvement in the initiative.

A range of study days is available for nurses to attend throughout the year. Study days cover emergency eye care, glaucoma, medical retina, ophthalmic pharmacology, ocular plastics and biometry. In addition we run a development day for healthcare assistants and technicians, a writing for publications and presentation skills course and regular half-day slit lamp workshops. The revenue generated by fee-paying external delegates is reinvested to support future educational activity.

Allied health professionals education

In April 2014, several members of staff shared their expertise with other healthcare professionals at two education events for GPs. The events – which included presentations on common eye conditions, glaucoma and red eye – were accredited by the Royal College of Ophthalmologists and supported by Moorfields Private, our private patient division.

We welcomed our first intake of 25 students for our new postgraduate certificate in clinical ophthalmic practice in September. A joint initiative with UCL Institute of Ophthalmology (IoO), the course provides nurses and allied health professionals – such as optometrists or radiographers – with the theory underpinning advanced ophthalmic practice, and encourages students to become autonomous practitioners. The aim is that students will undertake further training in areas such as YAG laser treatment, corneal collagen cross-linking and intravitreal injections for age-related macular degeneration. We also equip students with the skills necessary to prepare and present research projects independently.

Also in partnership with the UCL IoO, we are offering higher qualifications from the College of Optometrists, with the first students enrolled to start the professional higher certificate in glaucoma in September 2015. This qualification will contribute towards a UCL postgraduate certificate in advanced clinical optometry, 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 including contact lens practice and medical retina as well as glaucoma.

Sharing our expertise

Our staff have a deeply embedded culture for sharing research, knowledge and specialist clinical expertise. Reflecting the teaching and training aspect of Moorfields' mission statement, several clinical staff are involved in efforts to raise the standard of eye care across West Africa through the development of sub-speciality surgical training. This will extend the range of eye care available locally, and increase the number and quality of surgeries performed, helping to reduce the overall burden of blindness in line with Vision 2020 objectives.

To enable us to deliver training in the proper environment, we are working in partnership with the Lions Clubs International to develop a new eye unit and surgical training facility at Korle Bu Teaching Hospital, Ghana's largest teaching hospital and primary tertiary referral centre. To date, more than £2.95 million has been raised towards the construction and equipping of the new centre, which

is close to completion, and more than £500,000 has been secured to support the piloting and development of the training programme in partnership with the West African College of Surgeons.

As part of the project, four Ghanaian nurses visited Moorfields for a two-week training programme in June 2014. The focus of the visit was to provide a complete understanding of the patient pathway, from admission to discharge. This incorporated explanation of the sterilisation of instruments, ordering of equipment and patient flow in theatres, and visits to a day-care ward, pre-assessment unit, A&E, minor operations and ocular prosthetics, as well as theatres at other Moorfields locations. The week concluded with the nurses attending the annual conference of the International Ophthalmic Nurses Association, held at the Royal College of Nursing, at which Moorfields staff were giving presentations.

Throughout 2014/15 we had the opportunity to share our expertise with other visiting parties from across the world – some of whom had a general interest in Moorfields, and others who were keen to learn about specialist areas of our work. These included Vietnamese government officials, representatives from the Association of Optometrists and from a private eye clinic in Moscow, the President of Malta, a diabetic retinopathy screening team from Singapore, and delegates from Ghana, Botswana and Kenya who attended the Queen's Diamond Jubilee Trust diabetes meeting. We also hosted representatives from Singapore's National University Health System and from the Fondation Asile des aveugles and Hôpital Ophtalmique Jules-Gonin, as well as students from Denmark's largest university of applied sciences, VIA University College.

Clinicians from all disciplines, and non-clinical experts, are also engaged in speaking at conferences and professional fora worldwide. They also work in and with some of the best universities in the UK and abroad.

Several members of our medical team and colleagues from the UCL Institute of Ophthalmology (IoO) attended the annual meeting of the Association of Research in Vision and Ophthalmology (ARVO) at the beginning of May 2014. As the world's leading site for eye and vision research, our two institutions were very well represented at the meeting, giving various presentations and demonstrating our prominence in the field.

At the event, Professor David Garway-Heath, our clinical research lead for glaucoma and a consultant ophthalmologist, received a prestigious Alcon Research Institute award (the seventh awarded to Moorfields/IoO to date), which are given to doctors for outstanding research contributions in the field of ophthalmology and vision science. Our lead for immunology at the National Institute of Health Research (NIHR) biomedical research centre (BRC) was also voted onto the ARVO board of trustees.

Several of our consultants gave presentations at the second annual 100% Optical event held at London's Excel centre in February 2015. The three-day event – the largest for eye care professionals in the UK – attracted an international field of more than 6,000 optometrists, dispensing opticians, contact lens practitioners and ophthalmologists. Moorfields provided many of the keynote speakers.

Our lead nurse for education and the theatre manager at our Bedford site attended an ophthalmic conference in Luoyang, China, at the end of 2014, at which 200 delegates were present. They shared expertise and experiences, including a presentation on how we ensure the competence of nurses at Moorfields and information on the World Health Organisation surgical safety checklist.

In October, the World Association of Eye Hospitals (WAEH) visited several healthcare institutions at Dubai Healthcare City, including Moorfields Dubai. A WAEH convention was held there as part of World Sight Day, which provided a forum for delegates to exchange ideas about the future of eyecare, including how new technologies, changing behaviours and new competitors will have an impact internationally.

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, via traditional publications or digital media. 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.

Supportive partnerships

Our partnership with the Royal National Institute of Blind People (RNIB) has been strengthened over the past year with the creation of a new joint working group. This group, which includes representatives from both organisations, is looking at areas of common interest where we could work more closely together for the greater good of people with visual impairments.

We also welcomed the London Health Commission's (LHC) roadshow, Imagine Healthy London, to our City Road hospital in July 2014 to hear what patients, the public and staff think about health and well-being, their services and what improvements can be made to healthcare in London. The feedback is used to help the LHC understand what matters most to people when it comes to their own health, and to inform the recommendations it makes to the Mayor of London.

Raising our profile

We featured on two high-profile BBC television programmes during 2014/15. The work of our eye bank and the importance of eye tissue donation in sight-saving surgery were featured on BBC1's *Inside Out* in September. The programme explored the work of the corneal service, theatre staff and transplant surgical team, and patients who had undergone surgery at Moorfields talked about their conditions and the impact treatment has had on their lives.

In February 2015, a film focusing on ocular prosthetics was broadcast on BBC1's *The One Show.* The piece included a synopsis of the work carried out by this highly specialist team as well as a live studio discussion with a Moorfields patient. With regular viewing figures of up to five million, this sort of exposure is important in continuing to raise our profile with patients and other stakeholders, and ensuring their ongoing support.

We also ran our first public health campaign using our new website and social media channels in the autumn of 2014. The campaign focused on good contact lens care to raise awareness of the risk to healthy eyes of severe bacterial infections such as acanthamoeba keratitis, corneal infection and fungal keratitis.

For the campaign, we engaged with opticians via their professional trade publications and, timed to coincide with freshers' weeks across the country, targeted student health centres and student unions to reinforce the steps of good lens wear hygiene and habits to would-be, new and established wearers. The campaign comprised video case studies, a filmed demonstration of safe contact lens insertion, social media campaigns and interviews with the trade press.

Listening to our patients

We use a range of ways to find out what our patients think of our services and to make improvements in response. Our patient experience committee meets quarterly and oversees the patient experience agenda at Moorfields. This includes feedback posted on our website, NHS Choices and other patient feedback websites, or via social media sites such as Twitter or Facebook.

The national friends and family test, a standardised measure of patient satisfaction, is now used at 42 sites or departments across the trust. Moorfields has performed well since its introduction and, from June 2015, all of our results will be published on the NHS England website along with the A&E

and overnight admission results currently posted. In 2014/15, just over 84,500 of our patients completed the test, with 97% saying they would be likely or extremely likely to recommend Moorfields.

Accompanying comments stress the friendliness, professionalism and caring attitudes of our staff, with around 1,000 staff being identified by name for their excellent work. Good organisation and clinical outcomes are also frequently mentioned as the main reasons for recommending Moorfields. Waiting times in clinics were cited as the main area where patients felt we could improve.

Several patient focus groups were held across Moorfields throughout the year with the aim of improving patient experience. As part of our broader Moorfields Way initiative (see section 2.3.9), we ran "In Your Shoes" events in June and July 2014, providing an opportunity for patients to talk to staff about what they think of the care we provide, what we do well and how we can continue to improve the patient experience. These sessions were extremely successful with more than 140 people volunteering their time to help shape the future of our organisation.

The results of the Care Quality Commission's NHS A&E patient survey were released in 2014. Picker Institute was commissioned to carry out the survey and conducted an 80-question survey of around 850 patients who have visited our A&E department. Overall the results were very good and Moorfields was the highest scoring hospital in England for five of the questions. The A&E team have created an action plan which addresses those areas identified for improvement such as pain relief, waiting times and medication information.

The formal complaints process remains vital in identifying trends and areas for improvement. In 2014/15, we received a total of 174 complaints. The main causes of complaints were around clinical issues regarding treatment or outcome. Staff attitude made up the second most common cause of patient concerns, followed by administrative and appointment issues.

We also receive around 400 patient advice and liaison service (PALS) enquiries each quarter. These are dealt with in a timely manner and a weekly summary is also sent to management teams so that themes can be identified and addressed. Complaints activity is provided to the trust board on a quarterly basis, along with information about other activity undertaken by PALS, and a more detailed report is submitted on an annual basis.

From April 2015, we introduced a new system under which any service changes identified in the responses to patient complaints are sent to the areas concerned to ensure that they are addressed, and to monitor change to patient care where appropriate. A questionnaire is also being sent to all complainants to assess how their issue was handled and whether they felt that the response addressed their concerns.

Patient days

During 2014/15, our National Institute for Health Research biomedical research centre held or supported three patient days covering low vision, age-related macular degeneration and glaucoma. These days provide an opportunity for patients, their relatives and friends, and healthcare professionals to learn about conditions, share experiences and find out about ongoing and future research.

Our infection control team marked hand hygiene day in May 2014. Considered by the World Health Organisation (WHO) as the single most important way of preventing the spread of healthcare-associated infections, a series of activities was held across various Moorfields locations to reinforce the message to staff and patients. A "hand hygiene star" campaign was initiated in clinical areas, whereby staff could demonstrate their commitment to good hand hygiene.

In June 2014, children visiting the Richard Desmond Children's Eye Centre were invited to a "patch party" to mark World Orthoptics Day and to discover more about the work of orthoptists. Our team of orthoptists set up an information stall and display to promote their role and orthoptic therapy to patients and their parents. The initiative aims to heighten awareness of the profession, and promote the activities of orthoptists locally, nationally, and internationally.

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 who applies for a vacancy with us, is employed by us, provides a service to us, or receives 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

Our policies make a firm commitment to eradicating workplace discrimination across all of the nine protected characteristics. We are also accredited with the Two Ticks status which demonstrates our dedication to guaranteeing disabled people an interview if they meet the minimum criteria and making reasonable adjustments if they are successful.

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

New apprenticeship scheme

We are committed to developing a diverse, talented and motivated workforce that is supported to deliver great care to our patients. To further this aim, we created an apprenticeship programme in 2014/15 to encourage young people to consider careers at Moorfields, and offer a structured development programme to attract and develop capable individuals. The scheme is also part of Moorfields' response to the efforts of the NHS to reduce youth unemployment across London and create a brighter future for the health service.

In early 2015, we welcomed the first cohort of business administration apprentices who will spend 12 months learning practical, work-based skills while completing a formal training programme designed to build their confidence for a successful career within the NHS. Apprentices were employed following a rigorous selection process, which included a two-week work experience and pre-employment programme where they had the opportunity to shadow members of staff in their prospective departments, and learn key skills including teamwork, communication and problem solving.

This is the first time that Moorfields has taken on apprentices and we are committed to increasing our future intake to help young people gain a clear route into employment. We hope that the scheme will act as a positive educational experience and that apprentices will seek permanent positions with us at the end of the programme to continue developing their skills.

Voluntary activities

Many of our consultants, nurses and other clinical staff regularly volunteer in their own time to work for charitable organisations in other countries to provide specialist treatment not widely available to people from their own health service. Some work on specially converted vehicles which act as travelling hospitals, while others visit developing countries to provide treatment and training to establish new services.

In May 2014, one of our locum consultants who was undertaking volunteer work in Armenia saved the sight of a four-month-old baby born with a retinal detachment. It was the first time an operation of this kind had been performed in the country.

Supporting national and international awareness events

In October, we participated in World Sight Day 2014. On the theme of "avoidable sight loss", we provided visitors and patients with a wealth of information and advice on maintaining good eye health, alongside various sight-related charities. As well as celebrating 10 years of raising the profile of diabetic screening, the event provided information on new treatments and research, and how to get involved in research trials.

For World AIDS Day in December, we encouraged all staff to support a campaign for "no HIV stigma" in the NHS in order to eradicate discrimination for those living with the condition, and to help reduce transmissions and late diagnosis in the UK.

In February 2015, the National Institute for Health Research biomedical research centre and the UCL Institute of Ophthalmology lent their support to international Rare Disease Day. An annual initiative, the event aims to raise awareness among the general public and key decision-makers about rare diseases and their impact on patients' lives. We support programmes researching detailed phenotyping (or characterisation) of these conditions with the ultimate aim of applying that research to help patients.

In June 2014, we marked National Glaucoma Week with a range of sessions at our City Road hospital and our district hub at St George's Hospital, Tooting. Nursing staff and representatives from the International Glaucoma Association (IGA) were on hand to answer patients' queries at stands throughout the week at City Road. At St George's, an afternoon was dedicated to presentations involving consultants, nursing staff and IGA representatives on various aspects of the disease.

World Glaucoma Week followed in February 2015. A joint global initiative of the World Glaucoma Association and World Glaucoma Patient Association, the event followed a similar agenda with the aim of raising awareness of the condition and how it can affect people.

Environmental responsibility

Moorfields recognises the importance of improving sustainability as part of national initiatives to support the green agenda. Our primary focus at present is to reduce energy consumption, improve asset efficiency and meet all statutory requirements. Further detail about progress this year is included in our sustainability report at appendix 3.

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 2014/15

A range of projects was supported during the year including:

- A randomised controlled trial to reduce retinal displacement and symptoms of distortion following surgery to treat retinal detachment
- Several projects focused on retinitis pigmentosa (RP), including research into how mutations in genes found in many tissues in the body can cause such specific defects in the retina, and a study looking at how using skin cells from RP patients can be used to "make" retinal cells to serve as a model to test potential treatments
- Purchase of a new optical coherence tomography machine at our facility in Bedford to support and enhance the services provided there
- Support of a national survey of childhood uveitis (inflammation of the middle layer of the eye), looking at incidence, initial management and one-year outcomes
- Identification and characterisation of novel genes that influence progression and malignancy of retinoblastoma (cancer of the retina)
- A study looking at strabismic amblyopia (or "lazy eye")
- Support of research expenses for a UK Fulbright Fellowship awarded to a Moorfields clinician researcher to visit a leading laboratory in the University of Oregon to investigate ways nerve cells are damaged in glaucoma with the potential to define novel therapeutic targets
- CD players and a range of accompanying audio books for use by patients attending Moorfields for treatment who are often required to remain in a stationary position or limit the use of their vision as part of post-operative/treatment care regime
- Using state-of-the-art imaging of the retina, patients with Stargardt disease – the second most common cause of childhood blindness – will be followed over time to visualise how the retina changes and to help inform at what point in the disease progression potential therapies would be most effective
- Support for three medical device PhD studentships, including co-funding of ophthalmic imaging projects with the UCL Centre for Medical Image Computing
- A study to understand how increased pressure, swelling and inflammation influences disease progression of thyroid eye disease

- Underpinning key research posts, including a clinical fellow who will support a range of glaucoma research studies and clinical trials, and a clinician scientist working on projects on inherited retinal disease
- Purchase of several pieces of equipment to enhance the clinical services provided including replacement and upgrade of Humphrey visual fields machines and a femtosecond laser used for cataract surgery

2.3.9 Working with our staff

Moorfields employs around 2,000 staff across a variety of professional disciplines in 22 locations in and around London. Of these, 79% have been in post for more than a year, an indicator of high workforce stability. Our annual rolling staff turnover rate was 8.6%. Recorded sickness absence across the year was 3.6%. 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 around 1,300 women (65%) and 700 men (35%). 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 learning and development management system in 2014, a significant investment to replace several outdated legacy systems with a one-stop shop for staff through which to access learning and development opportunities, keep track of their mandatory training requirements, and provide a platform through which to offer learning and development to the wider NHS and beyond, in line with our ambitious education strategy.

Staff engagement – the Moorfields Way

We continue to develop ways of engaging with our staff, and our annual staff survey (see appendix 2) shows that people are positive about working for us.

In 2014, we launched the Moorfields Way, a three-year programme of cultural change, supported by a successful bid for external funding from the Local Education and Training Board (LETB). We had been concerned for some time about the apparently conflicting views presented by our staff survey. While the overall measures of staff engagement placed us consistently among the best trusts, we have stubbornly remained significantly worse than our peer group when it comes to staff experiencing bullying and harassment, discrimination, or reporting incidents, errors or near misses they have witnessed.

The areas of work the Moorfields Way either directly tackles or contributes to include:

- Building staff engagement through increasingly visible leadership
- Giving managers greater confidence to handle difficult issues, including bullying
- Refreshing our statement of values, expressing them in a simple way that is accessible and owned at every level of the organisation

- Setting and maintaining standards of behaviour based on these simple values, and holding each other to account
- Finding innovative ways to make it easier for staff to speak out if they have concerns, including the creation of a team of staff volunteer contact officers
- Encouraging individuals to report incidents, errors and near misses

Over the course of the year, we received more than 1,400 contributions from staff and patients to this work, and have distilled the messages into a set of simple and straightforward commitments to each other, through which we can create the consistency that means everyone experiences Moorfields at its absolute best.

The commitments are to be caring, organised, excellent and inclusive. A set of behaviours has been developed to underpin these, and an action plan has been put in place to bring them to life. In parallel, we have developed a range of tools to help staff, including a values-based recruitment process, an updated appraisal process, guidance on developing a coaching style, and help for those difficult conversations with people who need to be performance managed.

We have continued with our regular and well-established communications with staff. Many teams and departments hold local departmental meetings to enable two-way communication between staff and line managers. The chief executive hosts open meetings at City Road hospital every other month, to which all staff are invited, and the chief executive and other directors visit our other locations on a regular basis to ensure that staff based away from the central London 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 fortnights, 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. 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.

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 trade unions whose members work in the trust.

Mutuals in Health – pathfinder programme

Between January and March 2015, Moorfields participated in this programme, along with six other NHS organisations. Jointly funded by the Department of Health and the Cabinet Office, the programme was set up to explore the potential benefits of increased staff engagement in, as well as control of, NHS services. As a participant in the programme, Moorfields was provided with business and legal support to explore alternative organisational forms, and whether becoming a mutual could benefit the trust, its staff and its patients.

Mutuals take many different forms, and examples exist of services that have "spun-out" of the NHS, but have kept the NHS brand, continue to deliver NHS services and still contract with NHS commissioners.

We took part to research the various options, and participating did not bind us to following any particular path. The conclusion of our work is that a change in organisational form to a mutual could be an attractive option for Moorfields' patients and staff, but that three major barriers

stand in the way of any further work in this area: tax, because as a mutual Moorfields would pay corporation tax, stamp duty and land tax; borrowing, because we would lose the ability to access the low-cost borrowing available to foundation trusts; and legal barriers, because at the moment the law does not allow hospitals to spin out of the NHS. The Cabinet Office will present an overall report to the new government, and we will wait to see if they are persuaded to take action in relation to these barriers.

Supporting staff

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 City Road hospital three days a week and can be accessed at other times via telephone or at The Royal London Hospital in Whitechapel.

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.

The benefits we provide to our staff range from sabbatical leave opportunities to free contact lens and VDU eye examination clinics, discounted gym and swimming pool membership, and a salary sacrifice scheme for childcare.

Our sixth annual Moorfields' Stars ceremony took place in March 2015. The stars awards recognise and reward a wide cross-section of Moorfields staff who have achieved academic success, long service or external recognition from other organisations throughout 2014, as well as those who have won employee of the month awards 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.

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 both by 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.

In December 2014, Insight was launched across Moorfields as a direct replacement for My Learning Centre, Intrepid LMS and the other manual training systems that we have previously used. Designed to simplify the way staff can access learning at Moorfields, Insight enables staff to manage e-learning, training bookings, mandatory compliance and record all training completed at Moorfields.

Insight is a one-stop shop for all learning needs and in time will be used to access the entire Moorfields learning catalogue. It also enables managers to track their team's training history and receive regular email updates on their compliance. It offers automatic email alerts when people are due for renewal, which have had a dramatic effect in prompting staff to book for training, alerts to managers when staff book on training courses, and alerts to staff and their managers when they cancel or fail to turn up for training.

Many staff have taken advantage of the wide access we offer 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 UAE. 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.

MEH Ventures LLP is the partnership vehicle established in 2013/14 to develop our commercial business activities. It operates on a small scale, having no full-time staff, so its results are not shown separately in the accounts. During the year it has focused on our plans to expand our activities in the United Arab Emirates; on the future development of OpenEyes, our bespoke electronic medical record system; and on Moorfields' share in a promising bio-technology spin-out from within UCL's Institute of Opthalmology.

Moorfields Pharmaceuticals

It has been a challenging year for Moorfields Pharmaceuticals, which previously manufactured a range of niche ophthalmic medicines (known as specials), as well as managing a portfolio of branded licensed ophthalmic products made by third parties.

In January 2015, the board of Moorfields Eye Hospital NHS Foundation Trust agreed to close Moorfields Pharmaceuticals' central London production facility. Manufacturing at the unit had been suspended for more than a year following a routine inspection by the Medicines and Healthcare Products Regulatory Agency (MHRA), which identified concerns with some of the facility's practices and processes, although there was never any evidence of any potential harm to patients.

The board's decision was taken after a thorough review of the prospects for the business, supported by expert external input, and took account of the costs and complexity of achieving and maintaining the more rigorous standards now required for specials manufacturers, as well as the more challenging commercial environment in which such units operate.

Moorfields Pharmaceuticals has subsequently revised its business strategy to focus on its range of licensed medicines as well as the smaller range of outsourced ophthalmic specials, some of which are not available from other suppliers.

Although the revised activities are a profitable continuing business, the one-off non-cash write-offs associated with the closure of the manufacturing unit, and the losses incurred while production was suspended, were met from current and accumulated commercial profits.

Moorfields Private

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

In 2014/15, Moorfields Private made a net contribution to the business of £4.3 million, slightly below its target of £5 million. This slightly reduced contribution was the result of steady numbers of patients compared to the previous year, which had seen significant growth.

The division completed several important pieces of work during the year to ensure its continued success. These included the commissioning of a third laser room to trial a new laser technology and the introduction of a private patient service at our eye centre in Bedford. The division also put in place a call handling system for its new patient enquiry team to help manage calls more effectively, and undertook feasibility plans for the expansion and consolidation of private patient outpatient and diagnostic services.

Close working with the independent consultant practitioners who provide care under the umbrella of Moorfields Private is crucial, and a lot of work took place during 2014/15 to explore opportunities for their closer engagement in the provision of services and facilities.

The division also strengthened its management arrangements, restructuring the team to improve the alignment of services to consultants and patients, and appointing a full-time head of marketing and business development, and a substantive head of finance and business administration.

Moorfields Private's focus during 2015/16 will be on growth, supported by the rollout of a comprehensive marketing strategy, and an expansion in services.

Moorfields Eye Hospital UAE

Income remained broadly stable for our division in the United Arab Emirates (UAE) during 2014/15, as part of a two-year plan that includes the incorporation of additional consultants in Dubai, the development of formal education programmes and partnerships, and the opening of a new facility in a second emirate, Abu Dhabi.

Moorfields Eye Hospital Dubai (MEHD), our first private patient facility in the UAE, now has 10 consultants covering all the major ophthalmic sub-specialties, and is 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.

MEHD's memorandum of understanding with Dubai Healthcare City (DHCC) aims to promote the development of specialised eye healthcare in the UAE, as well as education and research initiatives. MEHD provides regular teaching sessions in collaboration with DHCC and participates in scientific meetings. Ultimately, education and research in the Gulf will benefit both the local population and the Arabic population in the UK. Initial conversations are also underway with a leading medical school in the Emirates, where Moorfields is seeking to provide the ophthalmic teaching part of the curriculum for medical students.

As the first overseas hospital established by an NHS organisation, MEHD supports other UK healthcare organisations to develop their activities in the region. In January 2015, the healthcare working group UAE-UK Business Council, which aims to co-ordinate healthcare efforts between the UK and the UAE, met in Dubai. Moorfields was invited to attend the council meeting to collaborate and provide feedback on their initiatives.

In October 2014, MEHD was named Eye Hospital of the Year at the ninth World Healthcare Tourism Congress in Dubai.

Work has taken place during 2014/15 to expand Moorfields' presence in the UAE. Through MEH Ventures LLP we have established a joint venture with United Eastern Medical Services (UEMS), a healthcare operator and investment company in Abu Dhabi, to provide a new eye centre in that emirate. UEMS is a respected local provider of healthcare and has a strong track record of clinical partnerships with European and Asian organisations. Under this arrangement, UEMS will provide the physical and administrative infrastructure, while Moorfields will provide the clinical expertise. Alongside our existing provision in Dubai, we expect the new venture in Abu Dhabi to embed

Moorfields' multi-specialty offering across the UAE and support our growth ambitions for the region.

At the end of the year, agreement was also reached to provide clinical services to the University Hospital of Sharjah – a general hospital located in the emirate of Sharjah, 30 minutes north of Dubai – which will extend provision to the population of the northern emirates.

2.3.11 Financial report

2014/15 was both an exciting and challenging year financially for Moorfields. Our underlying financial performance for 2014/15 was a £4.4 million surplus. After one-off impairment charges of £35.1 million, the net deficit for the year was £30.7 million.

Income continued to grow strongly in year with total operating income increasing by £24.1 million (14%) to £198.0 million (2013/14: £173.9 million) as a result of continued growth in activity and a number of non-recurrent NHS income sources, offset by a fall in income from the pharmaceutical division.

Total operating expenses before impairments increased by £29.0 million (18%) to £191.5 million (2013/14: £162.5 million). This significant increase was as a result of costs to deliver the increased level of activity, increased depreciation costs associated with capital investment, non-recurrent investment to ensure that the trust was seeing patients on time and non-recurrent closure costs for pharmaceutical manufacturing.

We delivered an ambitious capital programme in year of £57.3 million. Alongside the continuing record investment in equipment, facilities and software, we acquired additional land and buildings to relieve short- and long-term capacity pressures. We financed this using some of our cash reserves supplemented by new borrowings of £45.5 million. Lower interest rates and reduced dividends mean our cost of capital, at £2.0 million in 2014/15, remains below the £2.3 million cost five years ago when borrowing was lower.

The surplus, together with prudent management of working capital, enabled us to maintain a continuity of services risk rating of four at the end of the year – the best rating possible.

Review of 2014/15

Statement of comprehensive income

Income continued to grow strongly in year with total income increasing by £24.1 million (14%) to £198.0 million (2013/14: £173.9 million). This growth was as a result of a continued increase in activity levels, non-recurrent settlement of funding for research infrastructure and non-recurrent release of reserves as a result of settlement of long-standing contractual provisions.

Operating costs before impairments increased by £29.0 million (18%) to £191.5 million (2013/14: £162.5 million). This significant increase was as a result of costs to deliver the increased level of activity, increased depreciation costs associated with capital investments, non-recurrent investment to ensure that we were seeing patients on time and non-recurrent expenditure on the closure of the trust's pharmaceutical manufacturing operations.

The overall cost of finance, including interest on borrowings and dividends on public dividend capital, decreased marginally by £0.1 million to £2.0 million as a result of increased interest charges from new borrowings, offset by reduced public dividend capital charges.

After impairments of £35.1 million, the surplus of £4.4 million fell to a deficit of £30.7 million (2013/14: £9.3 million surplus).

There were two sources of impairment to asset values in the year. Both were non-cash items. The first impairment – £7.0 million – was to pharmaceutical manufacturing assets on closure of that activity. The second impairment – £28.1 million – was to land and buildings at City Road that were bought to provide short-term capacity and to facilitate the long-term development of services to patients. This impairment arose from NHS valuation rules and is expected to be recovered over time as future development plans are realised.

After arriving at the surplus for the year, the statement of comprehensive income deals with non-cash revaluation effects, principally the assessed NHS market value in continuing use of land and buildings. Following a standard valuation methodology, existing land and building assets increased in value by £0.8 million. The total comprehensive loss for the year was £29.8 million.

Income and expenditure

The table below presents a high-level comparison of income and expenditure, excluding one-off impairments to show the underlying financial performance for 2014/15 and 2013/14. Segmental information for the year is given at note 2 to the accompanying accounts.

All figures in £million	2014/15 Actual	2013/14 Actual
Income		
Income from activities		
– NHS income	146.6	123.0
– Private	21.3	21.3
Total income from activities	**167.9**	**144.3**
Other operating income	30.1	29.5
Total other operating income	**30.1**	**29.5**
Total income	**198.0**	**173.9**
Expenses		
Pay costs	107.1	90.7
Non-pay costs	76.9	65.7
Depreciation and amortisation	7.5	6.1
Total operating expenses	**191.5**	**162.5**
Operating surplus excluding impairments	**6.4**	**11.3**
Interest and dividends	2.0	2.1
Underlying surplus for the year	**4.4**	**9.3**

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 growth, non-recurrent settlement of long standing contract provisions, non-recurrent agreement of funding for research infrastructure and other price increases meant that

our income from NHS activities continued to grow, increasing by £23.6 million (19%) to £146.6 million (2013/14: £123.0 million).

Income from our private and overseas patient activities in London and Dubai was stable at £21.3 million.

Other operating income is from activities including the pharmaceutical division, research and development, education and training, charitable income, and other income and settlements.

Other operating income increased to £30.1 million (2013/14: £29.5 million). This performance included a fall in income related to closing manufacturing in the trust's pharmaceutical operations but was largely offset by the settlement of long-standing contractual provisions which led to the release of reserves. Both of these measures are non-recurrent. The closure of pharmaceutical manufacturing arose from mounting trading losses as a result of delays in restarting production combined with a deteriorating outlook for the unlicensed medicines that the unit made. This triggered an impairment in that unit's assets of £7.0 million, and restructuring and closure costs of £2.1 million. The impairment and losses were set against current and accumulated commercial profits. A profitable set of activities continues.

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 2014/15, 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 net income from outside the NHS which can then be reinvested in services for all our patients.

Operating expenditure, excluding impairments, increased in year by £29.0 million (18%) to £191.5 million (2013/14: £162.5 million), following investments and growth in our core NHS clinical services and a range of non-recurrent costs.

Pay costs increased by £16.4 million (18%) to £107.1 million (2013/14: £90.7 million), 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 and non-recurrent costs associated with pharmaceutical operations changes. Note 5 within the annual accounts provides further details.

Non-pay costs increased by £11.2 million (17%) to £76.9 million (2013/14: £65.7 million). The main components of non-pay expenditure are shown in the table below. Drug costs increased due to changes in the drug price and volume in the drug used for the treatment of age-related macular degeneration (AMD). Costs of clinical supplies increased during the year, mainly due to increased clinical activity.

Expenses type All figures in £million	2014/15 Actual	2013/14 Actual
Drug costs	22.5	17.0
Clinical supplies and services	17.4	13.6
Establishment	5.4	4.4
Transport	2.5	2.6
Premises and lease rental	17.7	16.8
Other	11.4	11.3
Total	**76.9**	**65.7**

The total cost of finance, including interest on borrowings and dividends on public dividend capital, decreased marginally to £2.0 million (2013/14: £2.1 million). This decrease was as a result of interest charges from new borrowings, offset by reduced public dividend capital charges.

Statement of financial position

The headline fall from last year in total assets employed from £93.7 million to £64.9 million occurred despite significant investment in land, buildings and equipment in the year to 31 March 2015. This was principally due to revaluation effects.

In particular, the trust acquired land and buildings for £48.3 million, financed by matching loans of £45.5 million, in order to relieve long- and short-term capacity pressures at its City Road site in central London. Taken together, these have a net effect of a £1.7 million reduction in the total assets employed figure. Pending development, these assets have to be valued on the basis of continuing use in healthcare. This resulted in a reduction in valuation of £28.1 million. As the value of loans roughly matched the value of these assets, it is the reduction in asset value on revaluation that reduces the trust's total assets employed. Given the trust's plans to increase its facilities and thus increase the density of development at its core site, this reduction in value is expected to be recovered. This impairment was included in operating expense in line with accounting standards.

Non-current assets increased by £15.6 million to £97.9 million (2013/14: £82.3 million) principally due to significant capital acquisitions in year and their associated revaluation reduced further by depreciation charges. Leaving aside major building and land acquisitions, last year's investment in facilities, software and equipment of £9 million has been exceeded with capital spending of £13.5 million, another record year of investment in the trust's services to patients.

Current assets increased by £3.1 million to £47.2 million (2013/14: £44.1 million) as trade and other receivables increased in line with income and some payment delays with key commissioners. Cash holdings fell during the year by £4.5 million to £19.8 million (2013/14: £24.3 million) as cash reserves were in part used to finance the capital investment programme.

Current liabilities increased by £4.5 million to £36.7 million (2013/14: £32.2 million) due to the classification of principal repayments due on loans within one year and normal variations in the timing of payments to suppliers.

Non-current liabilities increased to £43.5 million (2013/14: £0.6 million) as a result of the new borrowing drawn down in year to finance the capital investment programme.

The taxpayers' equity section (augmented by the statement of change in taxpayers' equity) highlights the principal drivers of the fall of £28.8 million in total assets employed. The key areas which have led to this change are the deficit in year of £30.7 million, public dividend capital

increases of £1.0 million due to a cash grant from the Department of Health for use in discrete capital projects and the net decrease to the revaluation reserve of £1.7 million. This was due to the upward revaluation of the existing land and building assets of £0.8 million and a reduction of £2.5 million relating to the impaired assets from the pharmaceutical manufacturing facility.

Statement of cash flows

The trust generated a net cash surplus of £8.5 million from operations in year. Cash from operations fell from previous years due to the reduced surplus and slower collections from NHS debtors.

In 2014/15, trust capital expenditure payments were £56.1 million (2013/14: £8.8 million). To finance this investment, new borrowings were drawn down of £45.5 million and additional public dividend capital was made available to support investment in information technology. The remainder of the capital investment programme and the servicing of the debt is being funded through cash generated from operations and existing cash reserves.

The trust ended the year with an acceptable level of cash, £19.8 million, to fund the monthly pattern of income and expenditure.

Counter-fraud arrangements

The trust has established a counter-fraud policy and response plan to minimise the risk of fraud or corruption, together with a code of conduct and 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.

Accounting policies for pensions and other retirement benefits are set out in note 1.15 to the accounts, and details of senior employees' remuneration can be found in note 4.3 to the accounts.

Disclosures relating to financial instruments can be found in note 20 to the accounts.

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

The trust undertook £146.6 million of contracted clinical activity in 2014/15 for commissioners from across the UK. Of this, £127.5 million relates to our contracts with more than 75 clinical

commissioning groups (CCGs) and £19.1 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 has been in excess of those planned for in our contract. NHS debt is normally collected during the early months of the new financial year.

Our largest contracts are with north-west London CCGs, south London CCGs, north and east London CCGs, NHS England, and Hertfordshire CCGs. Together, these clusters account for 90% of our total contracted activity.

Financial outlook for 2015/16 and beyond

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, our 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 trust faces this 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 2015/16. However, there are a number of significant uncertainties, particularly for 2015/16, including the unknown future 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 both for growth and cost control as it works to secure future surpluses.

2.3.12 Looking ahead

We believe that our 10-year strategy, *Our Vision of Excellence*, remains relevant and fit for purpose. We also consider it to be coherent with the underlying themes within the *NHS Five-Year Forward View*, the *Dalton Review* and our 2014/19 strategic plan, although we anticipate that it will need to be refreshed during 2015/16 to ensure that it is fully aligned with these important policy documents.

There is little doubt that the external environment will remain challenging for the foreseeable future, due to ongoing uncertainty around government and regulatory policy, health funding settlements, commissioning contract settlements, and changes in quality and clinical models which could lead to unfunded cost pressures. There is also the risk of fundamental change in the wider health system which could present further risk to the trust.

On a more positive note, although long-term commissioner plans are not defined in detail, there is general consensus that clinical services should continue to be delivered away from acute hospital settings, and for care to be provided on a day-case basis. This is consistent with our overall strategy and we will continue to develop our services in this way during 2015/16.

We also anticipate that the National Institute for Health and Care Excellence (NICE) approved treatments, population growth and an ageing population will increase our activity over the next year and beyond. We intend to be transparent about these growth assumptions with commissioners and will be seeking to contract at activity levels expected to be delivered in 2015/16.

For 2015/16, we have identified 13 corporate priorities, all of which are consistent with *Our Vision of Excellence*, as follows:

1 Continue the development of OpenEyes, our electronic medical record system, by:

- Agreeing and delivering a commercial and technical solution to ensure a strong future foundation for the application
- Ensuring its applicability across all Moorfields sites and services
- Commencing implementation of the planned clinical and operational benefits of the system

2 Implement key workstreams in our transformation programme to deliver significant improvements in patient experience and operational effectiveness, including:

- Reducing the amount of time our patients wait when they visit the hospital
- Improving theatre efficiency throughout our network
- Improving administrative processes at all points along the patient pathway, including booking processes to reduce the incidence of appointments being cancelled and rescheduled, and the management of medical records to minimise the number of missing notes
- Progressing plans to implement six-day working where appropriate

3 Continue the development and implementation of the Moorfields Way project through:

- Integrating the commitments and behaviours into key organisational processes and systems, including appraisals and recruitment
- Making appropriate connections to other relevant organisational initiatives such as the transformation programme, Care Quality Commission (CQC) readiness planning, and learning and development programmes
- Directorate and department-level action planning, tailored to their specific needs and linking to staff survey action plans

4 Progress the development of our new joint facility with the UCL Institute of Ophthalmology by:

- Securing a site for the new building
- Agreeing the financing of a new site
- Commencing the design team procurement process
- Linking the outputs of the transformation work to the building design programme
- Launching the fundraising campaign

5 Continue to drive improvements in quality and safety across the organisation by:

- Implementing the 20 key objectives set out in our quality plan
- Continuing to prepare for the forthcoming CQC inspection, anticipated in 2015, with an ambition to achieve a rating of at least "good"

6 Execute the City Road theatres maintenance plan efficiently and safely, with as little disruption to our patients and staff as possible.

7 Conclude the safe transfer of the management of the ocular oncology service from Barts Health to Moorfields, ensuring that the service is operationally and financially sustainable

8 Progress planning for the reprovision of Moorfields' facilities at St George's by:

- Agreeing a revised relocation plan with St George's University Hospitals' management
- Creating and implementing a delivery plan
- Agreeing and implementing a solution for our short-term space requirements

9 Progress the establishment of a surgical hub in the east of London:

- Concluding the options appraisal and finalising the business case
- Establishing a financing plan
- Securing appropriate premises
- Creating and implementing a delivery plan

10 Progress the implementation of the education strategy:

- Recruiting a new director of education
- Creating an integrated education directorate
- Formalising the strategic partnership with the UCL Institue of Ophthalmology
- Developing an education business plan
- Agreeing the education requirements for the new building

11 Maintain our excellence in research and development through continued progress in the implementation of the joint R&D strategy, focusing on:

- Recruiting and retaining outstanding research talent
- Increasing commercial trials and developing commercial partnerships
- Increasing patient access to research
- Demonstrating value to funders and research impact via improved communication output, especially but not limited to, translational research
- Developing the case for National Institute for Health Research biomedical research centre and clinical research facility renewal with the UCL Institute of Ophthalmology formal review of academic position and future projections

12 Following closure of the Moorfields Pharmaceuticals manufacturing unit, implement the agreed restructuring of our pharmaceuticals commercial activities to deliver a commercially viable business

13 Continue the development and expansion of our private patient services:

- Expanding the City Road outpatient facilities through the development of the Cayton Street building
- Continued expansion of private patient services in the West End and at Moorfields Croydon/ Purley, Ealing, Stratford and Northwick Park
- Working in collaboration with Moorfields Private consultants through the newly-formed advisory group, and continuing to explore joint venture opportunities

Performance against the priorities will be monitored both by our board of directors and our trust management board, and we will ensure that they 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 2015/16 contains further detail and is published on our website.

John Pelly, chief executive

28 May 2015

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.

In the event of a dispute between the membership council and the board of directors, the chairman first seeks to resolve the dispute. If this is unsuccessful, the chairman appoints a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the membership council and the board of directors. If those recommendations are unsuccessful in resolving the dispute, the chairman may refer it to an external mediator appointed by the Centre for Dispute Resolution or another appropriate organisation.

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.

The directors are additionally responsible for reviewing the annual report and accounts. Taken as a whole, they consider these are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess Moorfields' performance, business model and strategy.

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

Non-executive directors, including the chairman, are appointed by the membership council following recommendations from the nominations committee for non-executive directors (see section 4.1 below).

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 has not been subject to a membership council-led selection process. Executive directors are appointed by the nominations committee of the board of directors.

Directors during 2014/15

Board member	Position	Date and length of appointment
Rudy Markham (11) (Background – finance director)	Chair Chair of remuneration and nomination committees	1 April 2008 for three years; renewed 1 April 2014 for one year; renewed 1 April 2015 for one year (appointed as a non-executive director from 1 April 2007)
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; renewed 1 January 2015 for one year
Sir Roger Jackling (11) (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; retired from 1 April 2015
Professor Phil Luthert (10) (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 (10) (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; renewed 1 April 2015 for one year
Sumita Sinha (9) (Background – architect)	Non-executive director	22 April 2013 for three years
Steve Williams (7) (Background – lawyer)	Non-executive director	15 March 2012 for three years; renewed 15 March 2015 for one year
John Pelly (11) (Background – accountant and health service management)	Chief executive	
Mr Declan Flanagan (11) (Background – ophthalmic surgeon)	Medical director	
Professor Sir Peng Tee Khaw (10) (Background – ophthalmic surgeon and clinician scientist)	Director of research and development	
Tracy Luckett (11) (Background – registered nurse)	Director of nursing and allied health professions	
Charles Nall (11) (Background – finance and corporate services management)	Chief financial officer	
Mary Sherry (11) (Background – health service management)	Chief operating officer	

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 2014/15 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	
Director of strategy and business development	Rob Elek	(until 30 January 2015)
Director of human resources	Sally Storey	
Director of corporate governance	Ian Tombleson	

3.2 Committees of the board

Audit committee

The board is required to maintain a sound system of internal controls to safeguard its NHS clinical services, assets, and non-NHS commercial services and investments. An independent audit committee (in conjunction with the other board committees) is a means by which the board receives evidence of independent checks concerning 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 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 support 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 NHS foundation trust 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 2014/15, the audit committee met as follows:

Members/dates	22/5/14	23/7/14	2/10/14	16/12/14	10/3/15	Totals
Deborah Harris-Ugbomah	✓	✓	✓	✓	✓	5/5 (100%)
Roger Jackling	✓	✗	✓	✓	✓	4/5 (80%)
Andrew Nebel	✓	✓	✓	✓	✓	5/5 (100%)
Total attendance	**3/3 (100%)**	**2/3 (67%)**	**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 2014/15 from a number of sources. Key issues that were considered in those reports included HR and payroll system implementation, the new hospital development, a review of the outsourced procurement service, and theatre management and utilisation. The audit committee received expert advice as required for consideration of management assurances relating to these issues.

The audit committee also considered significant financial matters as part of its ongoing work, including consideration of debtor balances and their recoverability, and the valuation and accounting treatment of the trust's property portfolio.

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.

	2014/15 £000	2013/14 £000
Statutory audit services	86	73
Other non-audit services VAT consultancy services	55	26

Deloitte's work about VAT delivered total recoveries of £0.1 million in 2014/15 (2013/14: £0.1 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.

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Council of governors

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 (Project Oriel)

The Project Oriel committee has six principal roles relating to the development and construction of a new facility to replace the existing City Road campus.

The committee continues 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 we comply 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 includes two non-executive directors, one of whom chairs the committee, the chief executive, the director of strategy and business development, and two co-opted members with relevant industry experience. There is an open invitation for other non-executives to attend, and other directors and senior managers are invited to attend as appropriate.

During 2014/15, the committee met five times as follows:

Members/dates	14/5/14	6/8/14	23/9/14	3/12/14	4/2/15	Totals
Rob Elek	✓	✓	✓	✓	N/A*	4/4 (100%)
David Hills	✗	✗	✓	✓	✗	2/5 (40%)
Andrew Nebel	✓	✓	✓	✓	✓	5/5 (100%)
Andrew Newland	✗	✓	✗	✓	✓	3/5 (60%)
John Pelly	✓	✓	✓	✓	✓	5/5 (100%)
Sumita Sinha	✓	✓	✓	✓	✓	5/5 (100%)
Total attendance	**4/6 (66%)**	**5/6 (83%)**	**5/6 (83%)**	**6/6 (100%)**	**5/6 (83%)**	

*Director of strategy and business development Rob Elek left the trust at the end of January 2015; his successor is due to join in July 2015.

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. Rigorous selection processes took place during 2014/15 to recruit a new director of strategy and business development and a chief information officer via a competitive external process and the trust board agreed a recommendation to recruit to these posts.

During 2014/15, the nominations committee met as follows:

Members/dates	30/10/14	18/12/14	4/2/15	26/2/15	Totals
Deborah Harris-Ugbomah	✓	✓	✗	✓	3/4 (74%)
Roger Jackling	✓	✓	✗	✓	3/4 (74%)
Phil Luthert	✓	✓	✓	✓	4/4 (100%)
Rudy Markham	✓	✓	✓	✓	4/4 (100%)
Andrew Nebel	✓	✓	✓	✓	4/4 (100%)
John Pelly	✓	✓	✓	✓	4/4 (100%)
Sumita Sinha	✗	✓	✓	✓	3/4 (74%)
Steve Williams	✓	✓	✓	✓	4/4 (100%)
Total attendance	**7/8 (87%)**	**8/8 (100%)**	**6/8 (75%)**	**8/8 (100%)**	

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 2014/15, the remuneration committee met as follows:

Members/dates	24/7/14	10/9/14	18/12/14	22/1/15	19/3/15	Totals
Deborah Harris-Ugbomah	✓	✓	✓	✗	✓	4/5 (80%)
Roger Jackling	✓	✓	✓	✓	✓	5/5 (100%)
Phil Luthert	✗	✓	✓	✗	✓	3/5 (60%)
Rudy Markham	✓	✓	✓	✓	✓	5/5 (100%)
Andrew Nebel	✓	✓	✓	✓	✓	5/5 (100%)
Sumita Sinha	✓	✓	✓	✗	✗	3/5 (60%)
Steve Williams	✗	✗	✓	✓	✗	2/5 (40%)
Total attendance	**5/7 (71%)**	**6/7 (85%)**	**7/7 (100%)**	**4/7 (57%)**	**5/7 (71%)**	

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

Accounting policies for pensions and other retirement benefits and details of senior employees' remuneration can be found in notes 1.15 and 4.3 respectively of the annual accounts at appendix 5.

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 NHS finance director/deputy CFO, the medical director, and the director of strategy and business development as members.

During 2014/15, the strategy and investment committee met as follows:

Members/ dates	10/4/14	14/5/14	18/6/14	27/8/14	26/9/14	27/11/14	14/1/15	13/3/15	Totals
Steven Davies	✓	✓	✓	✓	✓	✓	✓	✓	8/8 (100%)
Rob Elek	✓	✓	✓	✓	✓	✓	✓	N/A	7/7 (100%)
Declan Flanagan	✓	✗	✗	✗	✗	✓	✓	✗	3/8 (38%)
Roger Jackling	✓	✓	✓	✓	✓	✓	✓	✓	8/8 (100%)
Charles Nall	✓	✓	✓	✗	✓	✓	✓	✓	7/8 (88%)
Andrew Nebel	✓	✓	✓	✓	✓	✓	✓	✓	8/8 (100%)
John Pelly	✓	✓	✓	✓	✓	✓	✓	✓	8/8 (100%)
Total attendance	**7/7 (100%)**	**6/7 (86%)**	**6/7 (86%)**	**5/7 (71%)**	**6/7 (86%)**	**7/7 (100%)**	**7/7 (100%)**	**5/6 (83%)**	

Quality and safety committee

The quality and safety committee provides an 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, and seeks assurance that where issues have been identified they are being managed robustly via the appropriate mechanism.

In 2014, the quality and safety committee and the management executive agreed that a more robust system of board assurance for quality and safety was required, and that this would be supported by the new compliance function in the organisation. The compliance function has developed an internal compliance assurance model and supporting processes (based on existing/ known areas of concern, corroborated with evidence analysis and engagement of staff), which highlights key areas of concern that are prioritised on a risk and evidence basis. Specific areas of concern in relation to quality and safety (as generated by the model), contribute to the formulation of the quality and safety committee's annual work plan, and the committee's response (supported by the compliance function) to a concern is determined by the level of risk posed.

The committee is chaired by a non-executive director and its membership also includes two other 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 2014/15, the quality and safety committee met as follows:

Members/dates	23/5/14	4/7/14	17/10/14	12/12/14	27/2/15	Totals
Declan Flanagan	✓	✓	✗	✗	✓	3/5 (60%)
Melanie Hingorani	✓	✓	✓	✓	✓	5/5 (100%)
Tracy Luckett	✗	✓	✓	✓	✓	4/5 (80%)
Phil Luthert	✓	✓	✓	✓	✓	5/5 (100%)
John Pelly	✓	✓	✓	✓	✓	5/5 (100%)
Mary Sherry	✗	✗	✓	✗	✓	2/5 (40%)
Sumita Sinha	✓	✓	✓	✓	✓	5/5 (100%)
Ian Tombleson	✓	✓	✓	✓	✓	5/5 (100%)
Steve Williams	✗	✗	✗	✓	✗	1/5 (20%)

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

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 that 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.

External quality review

We are currently graded at band 2 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.

Preparation for inspection

It is anticipated that Moorfields will be inspected by the Care Quality Commission (CQC) sometime in 2015/16. Preparation for inspection (as part of our wider quality and safety initiative) began in the third quarter of 2014. A staff engagement programme was initiated at the clinical governance

half-day in March, where staff were informed about inspection processes, and what this means for Moorfields, its teams and individual staff. Individual teams and units have been briefed as part of the preparation process, and this will continue until the inspection.

Development of a variety of resources – including a dedicated intranet page, a handbook for all staff and a range of information and guidance for managers and leaders – got underway, providing comprehensive guidance on ways to manage and embed quality and safety, and prepare for an inspection.

Another key element of the preparation process was the development of a CQC readiness self-assessment tool, which will enable Moorfields to undertake a gap analysis and highlight any areas needing additional support or improvement, as well as best practice that can be shared. The tool has been developed with longevity in mind, and will continue to be used as a quality and safety assessment tool for the organisation post inspection.

External inspections in 2014/15

The following external inspections took place during 2014/15:

- Our service at Darent Valley Hospital, Dartford, was subject to a routine, planned pre-registration visit from the CQC in September. The visit went well and the new service was registered successfully
- Our service at Bedford Hospital was subject to an inspection by the local Healthwatch in February 2015, which also went well

Monitor risk ratings

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

- 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 or green

Moorfields' performance against these measures in 2014/15 is set out below, alongside data for 2013/14 where applicable for comparative purposes.

	2014/15	2013/14
Continuity of service risk rating		
Annual plan	4	4
Quarter 1	4	N/A
Quarter 2	4	N/A
Quarter 3	4	4
Quarter 4	4	4
Governance risk rating		
Annual plan	Green	Green
Quarter 1	Green	Green
Quarter 2	Green	Green
Quarter 3	Green	Green
Quarter 4	Green	Green

Serious incidents involving data loss or confidentiality breach

Moorfields Eye Hospital did not have any reportable serious incidents involving personal data in 2014/15.

The table below represents a summary of other personal data related incidents in 2014/15.

Category	Breach type	Total
A	Corruption or inability to recover electronic data	None
B	Disclosed in error	42
C	Lost in transit	None
D	Lost or stolen hardware	None
E	Lost or stolen paperwork	2
F	Non-secure disposal – hardware	None
G	Non-secure disposal – paperwork	3
H	Uploaded to website in error	None
I	Technical security failing (including hacking)	None
J	Unauthorised access/disclosure	1
K	Other	41

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.

The board of directors last completed a self-evaluation in 2013/14, a summary of which was reported to their meeting in June 2014. Responses consisted of completed evaluation forms and as part of the methodology, some engagement from directors with the director of corporate governance about the responses they had provided.

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.

3.6 Other Companies Act disclosures

Further disclosures required by schedule 7 of the Companies Act are included in our strategic report as follows:

Requirement	Section reference
An indication of likely future developments	2.3.12
Significant activities in the field of research and development	2.3.6
Policies applied during the year for: giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities; continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period; training, career development and promotion of disabled employees	2.3.8
Actions taken to: provide employees systematically with information of matters of concern to them as employees; consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions that are likely to affect their interests; encourage the involvement of employees in the trust's performance; achieve a common awareness on the part of all employees of the financial and economic factors affecting the trust's performance	2.3.5
In relation to the use of financial instruments, an indication of the trust's financial risk management objectives and policies and the exposure of the entity to price, credit, liquidity and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	Appendix 5 – annual governance statement

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 on our annual plan; and scrutiny of our annual accounts and the quality account.

The council met five times during 2014/15 to discuss a wide range of subjects, including quality and safety, the patient experience, Moorfields' business agenda and our strategic plans.

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.

The process for resolving any dispute between the membership council and the board of directors is described in the introduction to section 3.

Composition of the membership council 2014/15

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

Elected governors	Representing	Other responsibilities
Jane Colebourn (5)	Public: Bedfordshire and Hertfordshire	Non-executive director nomination committee
Ron Wallace (5)	Public: Bedfordshire and Hertfordshire	
Bill Tidmas (4)	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 (4)	Public: North East London and Essex	Non-executive director remuneration committee
Paul Murphy (4)	Public: North Central London	Lead governor Non-executive director remuneration committee Non-executive director nomination committee Catering forum Patient experience committee
Mir Habibur Rahman (3)	Public: North Central London	
Simon Mansfield (4)	Public: North West London	
Brian Watkins (5)	Public: North West London	Non-executive director remuneration committee
Allan MacCarthy (5)	Public: South East London	
Suryanarayanan Naga Subramanian (4)	Public: South East London	Quality and safety committee Non-executive director nomination committee
Patricia Davies (2)	Public: South West London	
Bernard Dolan (2)	Public: South West London	
Brenda Faulkner (4) (re-elected from July 2014)	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 (5)	Patient	Quality and safety committee
Alexandra Edwards (4)	Staff – City Road class	Joint staff consultative committee Catering forum
Eilis Kennedy (3)	Staff – City Road class	Joint staff consultative committee Catering forum
Colin Carter (5)	Staff – satellite class	Joint staff consultative committee
Mary Masih (1)	Staff – satellite class	Joint staff consultative committee

Nominated governors	Represented organisation
Vacant	London Borough of Islington
Fazilet Hadi (3)	Royal National Institute of Blind People (RNIB)
Valerie Greatorex (1) (term ended August 2014)	International Glaucoma Association
Helen Doe (3) (term commenced September 2014)	International Glaucoma Association
Professor Peter Mobbs (0)	University College London
John Lawrenson (0)	City University

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 met during the year.

The remuneration committee reviewed the remuneration of the non-executive directors supported by the advice of the director of human resources and with reference to benchmarks for similar roles elsewhere in the NHS. The committee subsequently recommended a 1.5% increase for all non-executive directors.

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. It is chaired by a governor to maintain its independence.

During 2014/15, the nominations committee considered the reappointments of four of the non-executive directors (including the chairman), via a formal and rigorous interview process composed of a panel consisting only of governors. Following the panel, the committee recommended the reappointment for one year of all four non-executive directors. This is in line with the NHS foundation trust code of governance which states that there must be sufficiently strong reasons why reappointments should be made for those non-executive directors who have already served more than two three-year terms. In addition, following a rigorous external recruitment process involving an external search agency, a new non-executive director was selected to replace Sir Roger Jackling who retired at the end of 2014/15. The membership council agreed all of the committee's 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

Following the introduction of the trust's new membership database in 2014/15, our membership figures have been further refined and their accuracy improved (for example, members have been removed from the database where they have moved outside the constituency area). Therefore, from 1 April 2014, the restated figures for the total patient membership are 10,460 and 7,553 for our

public membership. In addition, our new staff database has more accurate staffing information and therefore the numbers of staff members is now 1,898. Based on those figures, the largest growth has occurred in our patient constituency, with an increase of about 9%. The increase in the public constituency membership has been about 3%.

Overall, Moorfields continues to grow its membership and we currently have more than 21,000 members, an increase of more than 12,000 since our authorisation as an NHS foundation trust in 2004, and about a 6% increase since 31 March 2014.

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 locations. As new locations emerge, we will carry out further membership recruitment drives.

A successful membership week was held in July 2014, during which governors spent time at our central London hospital in City Road, gathering feedback from patients. Governor engagement sessions and recruitment drives took place at several of our other locations during the year. Feedback from the governors (many of whom are also patients) after these visits 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 2015/16.

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 23 July 2014, attracted more than 200 members.

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

Constituency	Number of members
Patient constituency	11,405
Bedfordshire and Hertfordshire public constituency	516
North Central London public constituency	1,415
North East London and Essex public constituency	1,970
North West London public constituency	2,253
South East London public constituency	436
South West London public constituency	477
Other public	697
Staff constituency – City Road and satellite	1,898
TOTAL	**21,067**

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. Eligible 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 to foundation@moorfields.nhs.uk.

Elections

Elections were held in July 2014 and March 2015 in the constituencies set out below where sitting governors had come to the end of their terms of office.

Date	Constituency	Number of seats	Successful candidate(s)
July 2014	Patient constituency	1	Brenda Faulkner
March 2015	North East London and Essex	2	Bill Tidmas and Istvan Selmeczi (both uncontested)
	North Central London	1	Paul Murphy
	North West London	1	Brian Watkins (uncontested)
	South East London	1	Suryanarayanan Naga Subramanian (uncontested)
	Bedfordshire and Hertfordshire	1	Ron Wallace (uncontested)
	Patient constituency	2	Robert Jones and Jill Wakefield (both uncontested)

Full details of the composition of the membership council from 1 April 2015 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 2014/15.

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. Moorfields NHS Foundation Trust has applied the principles of the NHS foundation trust code of governance on a comply or explain basis. The NHS foundation trust code of governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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	Section 3, directors' report introduction
Board, nomination committee(s), audit committee, remuneration committee	A.1.2	Sections 3.1 and 3.2
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	Section 3.1
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 a combination of performance assessment, benchmarking, and the risks to the organisation should the individual leave.

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. No new components of directors' remuneration packages have been introduced during 2014/15.

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 5.7 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 2014/15 financial year was £29,502 (2013/14: £33,463). 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 £167,500 (2013/14: £162,500) – only those directors whose remuneration the trust is directly able to determine are included in this calculation
- The ratio of the two amounts is 5.68:1 (2013/14: 4.86:1) – that is, the mid-point of the banded remuneration of the highest-paid director of the trust was 5.68 times that of the median remuneration for all staff employed at the trust

No payments for compensation for loss of office were made during 2014/15.

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 2014/15 were £4,701 (2013/14: £5,044), and that the total out-of-pocket expenses paid in 2014/15 to the directors were £6,968 (2013/14: £3,538).

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

John Pelly, chief executive

28 May 2015

Appendices

Quality report

Staff survey

Sustainability report

Equality and diversity report

Annual accounts

Appendix 1

Quality report 2014/15

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 four strategic themes. It is also embedded in our business planning process and was identified as one of our five corporate objectives for 2014/15. Moorfields has developed a quality plan to implement its quality agenda which is designed to improve the patient experience, and the safety and effectiveness of clinical care across all our sites and services, using a patient journey as its framework. Implementing the quality plan and preparing for our forthcoming Care Quality Commission (CQC) inspection form two key parts of our quality and safety agenda for the future, and are part of our operational plan.

Progress against the quality themes of clinical effectiveness, patient safety and patient experience during 2014/15 are described in section 2 below, which summarises how we have performed against seven key quality themes. These themes were identified in consultation with patients, staff, governors, and our commissioners, and have been approved by the membership council and trust board.

Although further work will be required during 2015/16 to make the delivery of the quality plan feel like a cohesive piece of work with an overarching implementation strategy, some good progress has been made in the last year in delivering some of its key objectives.

We also continued to drive and embed improvements in quality, safety and compassionate care in response to the Francis inquiry and other government reports commissioned to help support making improvements.

National targets remain an important consideration in relation to the quality of services offered by the organisation. We maintained our strong performance for the four-hour target in A&E despite increasing demand for the service, and also for infection control measures. We were disappointed not to achieve the 18-week referral-to-treatment targets (RTT18) again for 2014/15, the result of several interlinking issues, including capacity and process shortcomings. Thanks to the hard work and dedication of many of our staff, we restored our performance against the RTT18 targets towards the end of 2014/15 and we will work hard to maintain this progress in future. However, there are some serious limitations to some of the data reliability and/or accuracy in relation to our RTT18 targets as this report explains.

We are registered without conditions with the CQC, and are currently graded at band 2 in their intelligent monitoring system, which groups all NHS trusts 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 for inspection and band 6 the lowest. Work to prepare for our next CQC inspection, which we expect to happen before the end of 2015/16, got underway in the final quarter of 2014/15.

The CQC also visited our new service at Darent Valley Hospital in Dartford in September 2014. This was a routine, planned pre-registration visit and resulted in the successful registration of the unit.

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 a programme of patient information days and via a wide range of feedback systems.

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

In addition to the quality report, and as this report explains, 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 about the overall quality and safety of our care. In addition, we produce more detailed reports about clinical audit and effectiveness, patient safety and patient experience.

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 2014/15

Moorfields identified seven priority areas when it prepared its previous quality report. These were developed in consultation with patients, staff, governors and our commissioners. They were supported by the membership council and approved by the trust board. Progress with these priorities is set out below.

2.1 Patient experience – service redesign and transformation

Objective:

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

Progress in 2014/15:

2014/15 has been a very challenging year for the trust operationally, particularly in relation to meeting the 18-week referral-to-treatment (RTT18) access standard, and this report explains more about those challenges in section 4.

During the year it has become clear that the proposals for service redesign and transformation set out in our previous quality report were not achievable in the way we described them, given the other pressures within the organisation. However, work has progressed in several areas, as described below.

Reducing the amount of time our patients wait when they visit the hospital:

- Scoping exercises have been completed involving multidisciplinary staff in two high-priority specialty services – glaucoma and uveitis
- A review has been completed of the electrophysiology department (EDD) – this was identified as a bottleneck in the clinical pathways for glaucoma and uveitis
- A demand and capacity model has been developed for the cataract service covering all Moorfields sites

- Key work streams have been identified as follows:
  - The stratification of patients and pre-planning of care
  - New ways of working and the potential to transfer work between staff roles
  - The development of a business case to support the development of the EDD service following the review
  - Improving the clinical environment in which glaucoma clinics currently take place
  - The development of a suite of measures to support a more efficient clinic model

Improving theatre efficiency throughout the network:

- A baseline theatre utilisation assessment has been completed
- Key work streams have been identified
- An external theatre diagnostic review has been completed

Improving administrative processes at all points along the patient pathway, including booking processes to reduce the incidence of appointments being cancelled and rescheduled, and the management of health records to minimise the number of missing notes:

- First stage review of the booking centre completed
- Standard operating procedures (SOPs) developed for the management of health records
- A management review of the health records department has been completed
- A "deep dive" review of the health records department has been completed on behalf of the trust's quality and safety committee

Progressing plans to implement six-day working where appropriate:

Due to the operational pressures described above, this piece of work has not progressed during 2014/15, but remains a corporate priority for 2015/16.

2.2 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
- To improve how the trust manages and responds to telephone enquiries

Progress in 2014/15:

As explained in the quality report last year, these improvements take considerable time to make an impact and progress needs to be viewed within that context. Different issues exist at different sites and progress at different locations has been reflected.

Communicating with our patients while they wait:

Live clinic information screens are present in most of the main clinical areas across City Road and at other sites, and display patient-centred information about clinics and waiting times, application of eye drops and general health. These are kept up-to-date more regularly now and are therefore used in a more consistent way than was previously the case. Best practice is achieved when white boards are used in combination with live screens; white boards can be updated more quickly and the writing is usually much larger than the live screen font, which makes them more accessible to our patients.

Some clinics now have floor walkers who help to keep clinics flowing and provide information to patients as needed, including about waiting times.

Most clinics have a supply of leaflets relevant to the specialty for patients to read while they are waiting.

Further work continues on scenario-based customer care training, including communicating with patients, for frontline staff.

The trust's governors have spent considerable time on these issues during the year and, while they recognise that the trust is making efforts in this area, they are seeking clearer improvements in 2015/16.

Health information hub:

The health information hub was completed and opened in May 2014. As planned, the hub provides written and electronic information about eye conditions and other public health information. Additionally, it is being used as a platform where patients can engage with such groups as Diabetes UK, the Macular Society and Blood Pressure UK, among others. We are working with the charity Action for Blind People to grow the hub to become a focal drop-in point for patients on their way into and out of the hospital, and in which to receive specialist advice.

Managing and responding to telephone enquiries:

Following the introduction of a new telephone system at our City Road hospital, the following improvements were made:

- Installation of additional lines to the main switchboard enabling external calls to be answered in a more timely manner
- Additional line capacity for booking appointment lines, making it easier for patients to contact the correct extension and speak to the most appropriate person to deal with their query. This initiative was supported by a training programme for frontline staff, with a particular focus on customer care skills
- Extended operational hours for Moorfields' nurse-led advice line at City Road, improving access for patient callers by extending hours into the evening and weekends. Three additional nursing staff have also been recruited to cover the service
- Improved call handling in the booking centre and optometry department

The system allows activity to be monitored through a live-feed dashboard, which identifies call volumes, call waiting times, call duration and calls abandoned. The system can identify problems with waiting times as they occur so they can be dealt with promptly. The impact on the patient experience has been positive; there has already been a reduction in the number of adverse patient advice and liaison service (PALS) enquiries associated with telephone problems.

2.3 Patient experience – improving the environment

Objective:

- Commence and complete expansion of the ocular prosthetics department (paediatric and adult) at City Road
- Complete the installation of a liquid oxygen supply to replace the current bottled gas supply at City Road
- 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 at City Road

Progress in 2014/15:

- Work began in early April 2014 on the expansion of paediatric ocular prosthetics in the Richard Desmond Children's Eye Centre (RDCEC). The project was successfully completed in July 2014. Adult ocular prosthetics work commenced on site in October 2014 and was successfully completed in December 2014
- The medical gas project at City Road was successfully completed and delivered a new liquid oxygen compound. The hospital's previous oxygen supply was provided from bottles which now operate as a standby unit. This project has mitigated a significant health and safety risk as the oxygen bottles required frequent changing by porters
- The first phase of works at our Croydon district hub was completed, and has improved patient flows in the outpatient entrance as well as staffing facilities
- Works at Ealing Hospital were completed and ready for use from 1 September 2014, which has delivered the much-needed expansion of a previously overcrowded facility
- The board approved the St George's business case in October 2013. Further discussions with St George's indicated several new clinical issues and operational constraints, and it has subsequently been agreed that this scheme cannot proceed in its current form. A new solution is in development and is explained in section 5.8 below
- Work in 2014/15 focused on finding a new site to replace the current City Road buildings. A preferred site has been found in the King's Cross/Euston area and work continues to secure this; in parallel, we are considering other possible locations as contingencies

2.4 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; to include results in regular trust-wide quality reports and directorate reports (see below)
- To publish the clinical outcomes on our website and present the results of our work with major international eye units to compare and standardise outcomes internationally at international scientific meetings, and publish them in major ophthalmic scientific journals
- To complete work to ensure that all our sub-specialty services develop outcomes with input from stakeholders, including patients
- To continue to integrate the routine collection of clinical outcomes data into the relevant modules of OpenEyes (our electronic patient record) and to ensure that automated generation of results occurs for those modules which are already live at a minimum

Progress in 2014/15:

All services continue to report at least three key clinical outcome indicators, known as core outcomes. Standards for comparison are obtained from outcomes published in medical literature, from national benchmarks such as those produced by the Royal College of Ophthalmologists, and benchmarks gained from other major international ophthalmic units through our links with the World Association of Eye Hospitals (WAEH). During the year, data has been collected and analysed by a combination of electronic data capture, prospective data collection and retrospective analysis of case notes. As OpenEyes clinical modules are developed, specific data fields are incorporated to ensure outcomes data is entered as part of routine clinical care. Generally the trust's performance against these standards demonstrates excellent clinical care, with many services achieving results well above standard. All results are detailed in an annex at the end of the quality report, but the following are of particular note:

- The results for the predictability of biometry, which indicates how accurately and reliably we are able to achieve the planned post-operative spectacle prescription and visual outcomes for all cataract surgery patients, including those who are high risk and complex
- The very low rates of failure in drainage surgery for glaucoma, both for the more common procedure, trabeculectomy, and the very specialist procedure performed in more complex cases of tube drainage
- The excellent results of all lid surgery – surgery for in-turning and out-turning lids, and drooping eyelids
- The very low rates of serious complications of squint (strabismus) surgery
- The low rates of serious infection (endophthalmitis) after procedures
- Excellent safety and accuracy for refractive laser procedures
- For corneal graft outcomes, Moorfields' performance is consistent with performance nationally, but we aim to compete with the better results generated by high-volume high-performing units such as King's College and Addenbrookes hospitals. Differences in the risk profile of cases between the units could explain some of the variation in performance and requires

further analysis. The trust management board has discussed approaches that should lead to improvements, including closer supervision of junior staff, greater standardisation of techniques and more consistent corneal scrub teams for theatres

The process of collecting outcome data remains time and labour intensive, which means that current reporting is only possible annually for a limited number of outcomes. Work is underway to produce an automated audit function for cataract outcomes in OpenEyes, so that clinicians can obtain real-time audit results.

Surveys on how to achieve better outcomes have been completed in all clinical services, with input from patients and other stakeholders, including GPs, optometrists and commissioners. The results of these surveys have supported the continued collation of the current set of outcomes and further measures have been identified to be included as the OpenEyes functionality is developed to generate audit data.

Outcome results are available on the Moorfields website via the quality report, and we are investigating the possibility of including searchable outcome results, with ongoing liaison with stakeholders to ensure the results are presented in an understandable and accessible format with appropriate explanation both for professionals and patients/carers. Results of our outcome programme have been presented at international meetings, including the Royal College of Ophthalmologists annual congress and the World Association of Eye Hospitals (WAEH) congress in Singapore in May 2015. We share our outcomes twice yearly with members of the WAEH via their electronic outcome webtool. A paper has been submitted to a major international scientific journal and is currently being revised for resubmission following reviewers' comments.

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

Objective:

- To roll out the successfully piloted patient safety walkabout and safety review programme, and to continue regular modified global trigger tools (mGTT) case note reviews across all sites and areas for this and future years
- To ensure reports are presented and actions monitored at directorate performance meetings, and to ensure that key findings and issues are reported to executive and board level via the appropriate clinical quality and safety reports

Progress in 2014/15:

In 2014/15, the trust continued to progress and develop the patient safety walkabout and site/service review programme.

CQC-style walkabout: Governors, board members, senior managers and other staff accompany staff from the quality team on unannounced visits to enable two-way communication between patients and frontline staff, and those at the most senior levels of the trust. The walkabouts also provide a way to test performance against the CQC's fundamental standards.

Following the successful CQC-style pilot visit to St George's in February 2014, the quality team refined the process further and completed a CQC-style visit of the medical retina (MR) and glaucoma clinics at City Road. Eight staff from different disciplines embarked on a four-hour walkabout, questioning 40 patients/parents/carers, 14 staff, and conducting four environmental reviews, including an interview with the person in charge and a review of medical notes.
A comprehensive action plan was subsequently developed, with input from the glaucoma and MR

services, and was agreed by both the outpatient and diagnostic service directorate and the clinical governance committee.

Actions completed so far include improved signage, the painting of supporting pillars using a contrasting colour to improve visibility for visually-impaired users, patient advice and liaison service (PALS) posters, staff reminders, updates and training, and various refurbishment projects undertaken by the estates team. Further actions will be monitored by the directorate to ensure they are completed.

Site and service quality performance reviews: The quality team meet with site/service leads to discuss and take action after having considered and reviewed their quality and safety data. Three data reviews took place in 2014/15 with the service leads from the medical retina (MR), external disease and theatres services. Numerous actions were generated from the meetings, many of which have been completed. These actions include the development and implementation of a standard operating procedure for checking intraocular pressure, the inclusion of uveitis specialist nurses and diabetic specialist nurses in the MR service review, and closer liaison of service staff with the clinical audit team.

Plans to increase the frequency of data reviews for each service and site in 2015/16 have progressed, and the strabismus and paediatric services, as well as our Bedford and Croydon sites, have imminent dates already booked.

Staff safety walkabouts: The head of clinical governance, the risk team and patient experience manager undertake risk assessment visits to provide an accessible and approachable way for local staff to raise safety concerns. During 2014/15, staff safety walkabouts took place with the pre-operative assessment team at City Road and the pharmacy team. Staff in the pre-assessment department raised a variety of concerns, including the locking of security doors, completion of conflict resolution training, inappropriate bookings, patient information and risk assessments within the phlebotomy room. An unsafe digi-lock has since been removed from one of the doors, and a process for better communication between the booking team and pre-assessment team has been developed. The pharmacy team also raised a security issue following an incident in the street next to the pharmacy department; as a result, better lighting has been installed at the exit. Other concerns included better information for waiting patients, space at satellite sites, delivery issues and temperature control in and around the pharmacy area. The temperature flow and control valves were all checked and were working correctly.

Modified global trigger tools (mGTTs): Trigger tools help identify adverse effects and areas for improvement by auditing a small sample of patient notes regularly. During 2014/15, 35 mGTT proposals were received and approved at Moorfields. Several fully-completed reports were received, with many more near to completion. Completed projects covered medical retina (MR), general ophthalmology, neuro-ophthalmology and paediatrics/A&E in several locations. Pleasingly, 90% of the notes reviewed as part of this work demonstrated excellent practice. In the other 10% of cases, no harm was identified. However, areas for improvement were identified, for example poor handwriting or slight delays in obtaining a clinic date.

In those where the management was not optimal, the risk category was low – mostly a category A grade (capacity to cause error) due to some inadequacies in record keeping or filing, or short delay in annual follow-up reviews. Issues due to breaches of the 18-week referral-to-treatment (RTT18) target were noted in neuro-ophthalmology; this was a known issue and has now been addressed. One patient reached a category D (error reached patient, did not cause harm but required additional visits, monitoring or treatment). In this instance, the patient left the clinic without a full assessment, but was subsequently called back and the assessment was completed without any harm. Two cases were given a category C grade (error reached patient but did not cause harm, although there was potential to cause harm through, for example, delayed management). These risks arose as a

result of other healthcare providers' actions: in one, a patient at another hospital was running out of medication because her appointment had been delayed and came to Moorfields for a repeat prescription; a second patient was sent to Moorfields for intravenous medication despite the referring doctors being told that the trust does not administer such medication.

Several actions have arisen from the mGTT programme, including the need to ensure clinical and administrative teams complete and file clinic notes and letters appropriately, and to improve access and timeliness of neuro-ophthalmology appointments.

2.6 Patient experience and clinical effectiveness – developing PROMs

Objective:

- Complete the pilots and analyses of our patient reported outcome measures (PROMs) projects in adult general ophthalmology and cataract surgery; publish the results and begin use of these tools in routine clinical care
- Complete the development of a paediatric general ophthalmology PROM and pilot this with patients
- Work collaboratively with the UCL Institute of Ophthalmology (IoO) to support the joint development of PROMs tools for clinical and research work

Progress in 2014/15:

The pilot and analysis of our general ophthalmology PROM has been completed, and the tool has been found to be useful and simple. It is now in routine use and is being used in two projects for patients at sites with larger general ophthalmology services. It will form part of the annual clinical audit plan for all sites with general ophthalmology clinics. The paediatric tool is still under development for use with parents and children to ensure it is suitable for use for all paediatric patients, whatever their age. We continue to support the UCL IoO where required in developing PROMs for research, with Moorfields' clinical staff providing time and input.

Data for cataract PROMs from 100 patients has been collected and is being analysed and written up for submission to a scientific journal. The "Catquest" tool appears to be the best and discussions will now take place to decide the methodology for regular use within cataract clinics.

2.7 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. Quarterly directorate performance meetings will have clinical governance and risk staff in attendance, and will include a minuted item on quality and safety performance noting any actions required

Progress in 2014/15:

Twice-yearly quality and safety performance reports, broadly covering all aspects of quality and safety, have continued to be produced for the trust management board and the trust board, supplemented by more frequent and detailed reports about clinical effectiveness, patient experience, patient safety, safeguarding, infection control, aggregated data, and a number of other quality and safety areas. The quality and safety report has expanded to cover other key areas in more detail, including safeguarding of children and adults, information governance and medicines safety.

The quality team has worked closely with performance and information staff and directorate staff to ensure that the directorate monthly and quarterly performance reports contain consistent key quality data such as friends and family test results, incident rates and details, complaints, "never events" and "serious incidents", and endophthalmitis rates. Quality and risk staff attend directorate quarterly meetings, and ensure support and expertise in the discussion of quality data and decisions about actions arising.

3 Performance against key indicators for 2014/15

Each of the indicators listed below was selected to provide comparable data over time to demonstrate compliance with the agreed corporate objectives for 2014/15 relating to Moorfields' quality and safety agenda. Some indicators were new for 2014/15 and the rationale for changing or selecting new indicators was set out in the 2013/14 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 result	2014/15 target	2014/15 result
Patient experience						
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	73%	73%	74%	No day-care survey took place in 2014/15 so this indicator is N/A	N/A
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	48 complaints	<36 complaints	12 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%	82.3%	>=80%	81.8%
*% reduction in average patient journey time for cataract surgery at City Road	Internal performance monitoring	6hrs 27 mins	5hrs 53 mins (9% reduction on prior year)	5hrs 11 mins (12% reduction on prior year)	No target was set (see 2013/14 quality report)	5hrs 22 mins (3% increase on prior year)
**% of all City Road theatre lists starting on time	Internal performance monitoring	N/A – new indicator	59%	74% for all adult lists (best result 91% for Monday morning lists)	90%	69.4%
Development of a standard operating procedure (SOP) for operating theatres	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Not achieved	This target was rolled over from 2013/14	A near final SOP is now being tested prior to implementation
Progress on the transformation 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	See section 2.1	See section 2.1

Indicator	Source	2011/12 result	2012/13 result	2013/14 result	2014/15 target	2014/15 result
Patient safety						
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	91.5%	90%	87.5%***	90%	97.9%
% overall compliance with hand hygiene standards	Internal performance monitoring	96%	97%	97%	95%	97.4%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0	0	0	0
Incidence of endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.48	0.29	0.38	<0.8	0.20
Incidence of endophthalmitis per 1,000 intravitreal injections for the treatment of AMD	Internal performance monitoring	0.30	0.35	0.18	<0.5	0.21****
Site and service safety review: patient safety walkabout and use of mGTT (see section 2.5)	Internal performance monitoring	N/A – new indicator	N/A – new indicator	17 proposals and 7 completed reports	mGTT audits to be conducted during the year in all the main sites and services; walkabout process to be in regular use reporting via directorates and patient safety report	35 mGTT audits proposed; 12 sites and 13 services proposed or completed an mGTT audit. 1 CQC walkabout, 2 staff safety walkabouts and 3 data reviews completed and included in safety reports

Indicator	Source	2011/12 result	2012/13 result	2013/14 result	2014/15 target	2014/15 result
Clinical effectiveness						
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%	100%	100%
Posterior capsule rupture rate (PCR) for cataract surgery	Internal performance monitoring	1.34%	0.8%	0.9%	<1.3%	1.1%*****
Comprehensive clinical outcome indicators in place via OpenEyes	Internal performance monitoring	N/A	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 electroni-cally due to the pace of OpenEyes rollout	Progress in developing OpenEyes has been slower than hoped, so this indicator has not made significant progress
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 to be used as planned	Reports in use as planned
Developing PROMs	Internal performance monitoring	N/A	N/A – new indicator	Final validation almost complete and regular use to start shortly	General ophthalmology and cataract PROM in regular clinical use	General ophthalmology PROM in regular use; cataract PROM data collection complete and analysis nearing completion

*The data for this indicator has been restated. Previously the best performance against the indicator had been stated but this has now been corrected to use the average.

**This indicator was redefined in the 2013/14 quality report to reflect what was actually being measured. Prior to 2013/14 it was defined as: % increase in all City Road theatre lists starting on time. In 2013/14 it was redefined as % of all City Road theatre lists starting on time. However all data has been published in line with the correct definition.

***The trust marginally underperformed against this indicator. The overall performance figure is a composite of several different elements. These elements are audited each year and 2013/14's 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 planned to work with staff to improve this result, which was successfully achieved in 2014/15.

****This indicates a 0.03 lower performance than 2013/14. Endophthalmitis rates are discussed at the infection control committee and assessed using a probability-based tool, which confirms that rates are within acceptable limits and that the changes from last year were not statistically significant. Endophthalmitis rates are known to fluctuate for undetermined reasons, but our outcomes have been very good for the previous two years.

*****This represents a 0.2 lower performance than 2013/14, but again this is not statistically significant. The trust's posterior capsule rupture (PCR) rate is much better than the national standard and we have achieved a consistently low rate over the past four years. Our target has been stretched year on year.

4 Performance against national performance measures

Moorfields reports compliance with the requirements of Monitor's risk assessment framework, the NHS constitution and NHS outcomes framework to every meeting of the trust board as part of monthly operational performance reports. We consider that this data is described accurately in the sections and tables below subject to the analysis of data inaccuracies relating to 18-week referral-to-treatment (RTT18), which are expanded in sections 4.3 and 4.4 below. The NHS outcome indicator on 28-day emergency readmissions for inpatients requires specific mention, as our performance has been restated slightly in 2014/15. Where required we provide analysis with actions to support improving the quality of our services.

4.1 National performance data

Achievement against each of the national indicators relevant to Moorfields is set out in the table below and has been assessed using a red, amber, green (RAG) rating. A green rating indicates that the performance indicator has been fully achieved, an amber rating indicates that it has nearly been achieved and a red rating indicates a failure to meet the target.

Table summarising performance against national performance measures

Description of target	Performance 2013/14	Target 2014/15	Performance 2014/15	Average for applicable trusts 2014/15	Highest performing trust 2014/15	Lowest performing trust 2014/15
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)	98.4%	>=95%	98.5%	96% (to Jan 2015)	100% (to Jan 2015)	87.2% (to Jan 2015)
Waiting times						
Two-week wait from urgent GP referral for suspected cancer to first outpatient appointment	97%	>=93%	93.1%	94% (YTD to Dec 2014)	100% (YTD to Dec 2014)	81.9% (YTD to Dec 2014)
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	99.7%	>=95%	99.2%	90.8%	100%	70%
18-week standard from point of referral to treatment for admitted patients	89.8%	90%	86.2%	88% (YTD to February 2015)	100% (YTD to February 2015)	68.7% (YTD to February 2015)

Description of target	Performance 2013/14	Target 2014/15	Performance 2014/15	Average for applicable trusts 2014/15	Highest performing trust 2014/15	Lowest performing trust 2014/15
18-week standard from point of referral to treatment for non-admitted patients	95.3%	95%	95.1%	95.7% (YTD to February 2015)	100% (YTD to February 2015)	68.7% (YTD to February 2015)
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks	92.1%	92%	93.7%	94.3% (YTD to February 2015)	100% (YTD to February 2015)	80.7% (YTD to February 2015)
6-week diagnostic test waiting time	100%	99%	100%	98.3% (YTD to February 2015)	100% (YTD to February 2015)	50.6% (YTD to February 2015)
Cancelled operations						
*Patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	2	0	3	16.1 (per acute trust)	0	186
Other						
Mixed-sex accommodation breaches	0	0	0	14.6 (per acute trust)	0	324
28-day readmission rate (over 16 years old)	3.6%**	N/A	3.8%	11.5%***	N/A	N/A
28-day 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 description 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; both outcomes are reported as breaches of the 28-day standard for cancelled operations.

**This is a restatement of the 2013/14 performance, which was previously reported as 3.8%, as explained in section 4.2.

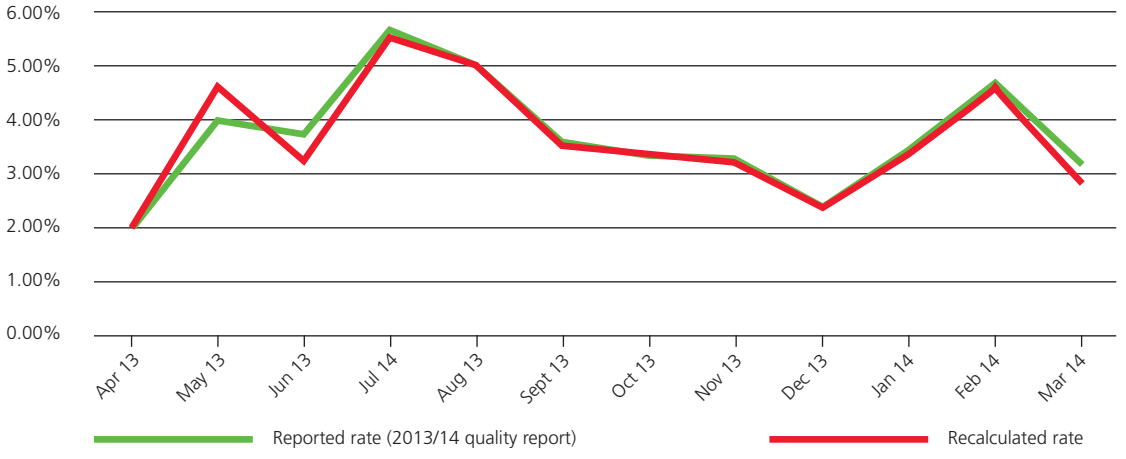
***The most recent national average figure available for readmission rates is from 2011/12.

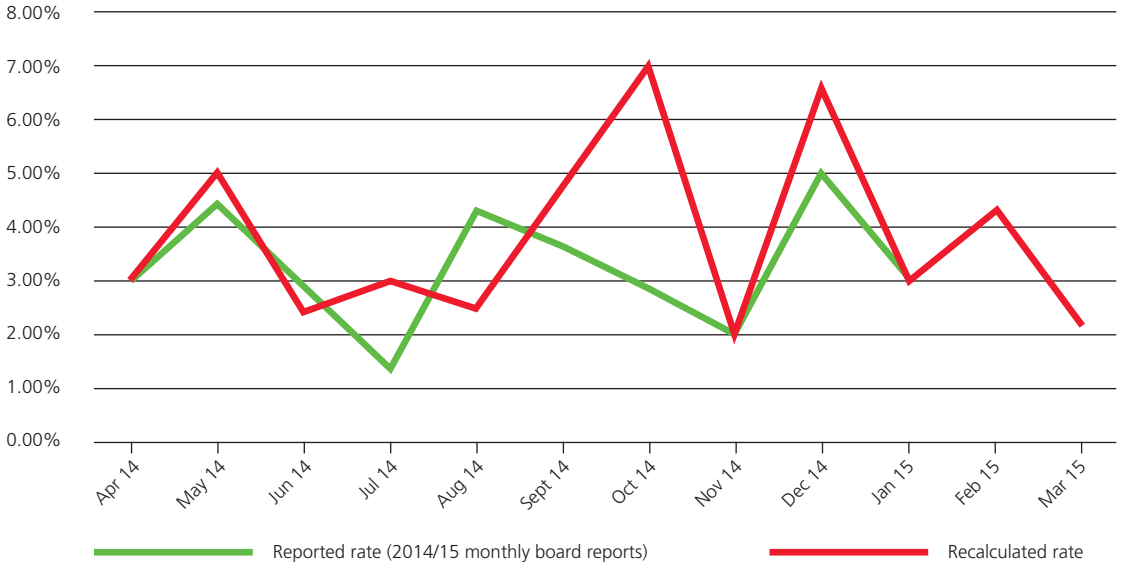
4.2 28-day emergency readmissions (for inpatients)

In 2014/15, Moorfields calculated readmissions based on the number of patients who were admitted as an emergency within 28 days. There was a minor error in the script extract for this data which was detected in December 2014, where the date of the original discharge was incorrectly used as the reporting period instead of the date of the readmission (as per Health and Social Care Information Centre (HSCIC) guidance). This had two implications:

- Where the original admission and readmission within 28 days occurred in different months, this would have been recorded in the month in which the original admission took place in error, instead of in the month in which the readmission occurred
- Due to the reporting deadlines for external publication (such as the board report), there were instances where a readmission within 28 days occurred after the figures were published and so were not included in that report as they were yet to happen. The next monthly report would then include neither this figure under the month in which the original admission took place as this figure was not backdated within the board report, nor in the month in which the readmission occurred. In this scenario, these readmissions within 28 days would have been accidently excluded from the board papers and in external reporting

This error has an impact on the data stated in the 2013/14 quality report as well as the data reported in 2014/15. The correct data for both years has therefore been stated in full below.





There is no material impact on the 2013/14 data as that year's figures were backdated as part of a previous audit so would have included all 28-day readmissions. For the 2014/15 figures, there was an impact until January 2015 where readmissions previously excluded (as they were after the reporting period) are now included. From April to December 2014, this increased the year-to-date position by 0.4%. For both 2013/14 and 2014/15, there were also adjustments to the reported month of some readmissions (now reported against the date of readmission rather than the date of original admission). As these issues were corrected in January, the January to March 2015 figures are unchanged.

4.3 Referral-to-treatment time (RTT18) performance

The trust is required to report performance against three indicators in respect of 18-week referral-to-treatment (RTT18) targets. For patient pathways covered by this target, the three metrics reported are:

- Admitted – for patients admitted for first treatment during the year, the percentage who had been waiting fewer than 18 weeks from their initial referral
- Non-admitted – for patients who received their first treatment without being admitted, or whose treatment pathway ended for other reasons without admission, the percentage for the year who had been waiting fewer than 18 weeks from the initial referral
- Incomplete – the average of the proportion of patients, at each month end, who had been waiting fewer than 18 weeks from initial referral, as a percentage of all patients waiting at that date.

Further to reporting that we had not met the RTT18 target for 2013/14, we are very disappointed that we did not achieve the admitted target again this year, with an outturn of 86.2% against a threshold of 90%. We did not achieve the admitted and non-admitted standards in quarters 1 and 2 of 2014/15, but a steady rise in performance month on month resulted in the trust achieving all three standards in quarter 4.

		Performance 2014/15				
Indicator		Q1*	Q2*	Q3*	Q4*	Year end*
18-week referral-to-treatment – admitted	≥ 90%	80.9%	83.4%	89.2%	91.2%	86.2%
18-week referral-to-treatment – non-admitted	≥ 95%	94.95%	94.1%	95.7%	95.6%	95.1%
18-week referral-to-treatment – incomplete	≥ 92%	92.2%	92.1%	95.3%	95.2%	93.7%

*Published using best available data.

The measurement and reporting of performance against these targets is subject to a complex series of rules and guidance published nationally, but the complexity and range of the services offered at Moorfields means that local policies and interpretations are required, including those set out in our access policy.

As a tertiary provider receiving onward referrals from other trusts, a key issue is reporting pathways for patients who were initially referred to other providers. We are required to report performance against the 18-week target for patients under our care, including those referred from other providers. Depending on the nature of the referral and whether the patient has received their first treatment,

this can either "start the clock" on a new 18-week treatment pathway, or represent a continuation of their waiting time, which began when their GP made an initial referral. In order to report waiting times accurately, we therefore need other providers to share information on when each patient's treatment pathway began.

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

Our approach for reporting the indicators is as follows:

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

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

During 2014/15, 0.5% of our admitted patients had unknown clock starts and 0.7% of non-admitted patients had unknown clock starts (0.7% overall). Due to how the incomplete indicator is calculated, it is not possible to give an equivalent percentage figure of the impact of "unknown clock starts", but it will be similar to the overall level for patients treated for the year.

The absence of timely sharing of data by referring providers impacts our ability to monitor and manage whether patients affected are receiving treatment within the 18-week period set out in the NHS constitution, and requires significant time and resource for follow-up.

Due to the time-consuming efforts to capture accurate clock start dates from other trusts (known as inter-provider trust referrals or IPTs), additional administration resources are now in place, which has reduced the number of "unknown clock start" dates being reported in quarter 1. These resources will remain in place.

4.4 RTT18 data quality

In relation to the overall data quality for measuring and recording RTT18, the trust has identified that there are substantial errors and inconsistencies in its data; we acknowledge that our data contains inaccuracies, which are difficult to quantify.

In 2013/14, an internal audit report raised concerns about our data quality as reported in the previous quality report. Further data testing by internal audit during 2014/15 has, through using a limited and non-statistically valid sample (10 records) and only including the first part of the patient pathway, indicated an error rate of up to 60%. In-house audits of the first part of the pathway have been performed and also confirm high error rates.

In terms of day-to-day processes for increasing the accuracy of our reported data, our data validation team undertakes daily audits and data correction processes against a defined set of RTT data reports. The team is being expanded, and will implement a robust timetable of monthly and quarterly audits building on the audits that took place in 2014 but which have not yet been completed. Clearer RTT guidance and data entry training is being provided for operational staff to support further improvements.

Additional work to capture accurate clock start dates for inter-provider trust referrals from other healthcare providers has been ongoing throughout quarter 4 and this has led to a reduction in our reported "unknown clock start" dates.

We believe that we now better understand where there are weaknesses in our data accuracy, and that we are making progress in improving systems and processes as set out below.

Our focus in 2014/15 has been on improving our RTT18 systems and processes by carrying out an end-to-end review. This review was undertaken with the support of the Intensive Support Team (IST), a unit that provides help nationally to improve the processes that support care and treatment. A detailed action plan was developed following the review's recommendations, and this is monitored at executive level internally and externally by Islington, our lead clinical commissioning group.

The main elements of the action plan include a full rewrite of the access policy, trust-wide training for administration staff, IT system reviews for both recording and monitoring compliance, full review of both inpatient and outpatient booking processes, the creation of an inpatient waiting list module on our patient administration system (PAS), and the development of demand and capacity plans.

Further objectives within the action plan to support improvements in the RTT18 process and to achieve better data quality for 2015/16 are to:

- Increase the speed and accuracy of recording RTT outcomes following outpatient clinics and surgery
- Recruit a trust-wide validation/training team to support validation, the generation of better data quality and operating an effective in-house audit service
- Perform a further in-depth review of the management of long-term follow-up patients to ensure they are being clinically reviewed appropriately
- Clean the inaccurate data migrated into our PAS from the transfer of ophthalmology services from Croydon
- Develop an inpatient waiting list module in PAS to remove duplicate data entry via OpenEyes
- Remodel the patient tracking list in line with IST recommendations
- Provide trust-wide refresher training for all staff groups in the application of the correct processes to record data
- Further improve standard operating procedures for all administration areas across all sites
- Continue scrutinising patient-level data at weekly directorate performance meetings

Progress against achieving these objectives and completing the action plan for 2015/16 is monitored by an RTT steering group and at weekly directorate performance meetings.

4.5 Patient safety incidents, serious incidents and never events

Patient safety incidents data

Indicator	Moorfields data									National comparisons – 20 acute specialist trusts[5]		
	2012/13			2013/14			2014/15			Best result 2013/14	Worst result 2013/14	Average 2013/14
Period	Q1/2	Q3/4	Year[1]	Q1/2	Q3/4	Year[1]	Q1/2	Q3/4	Year[1]			
Patient safety incident number sent to NRLS (published data)	434	677	1,111[2]	1,086	1,985	3,071[3]	2,619	2,150	4,769	3,426	210	1,727
Rate per 100 admissions[8]	3.1	4.8	3.9	7.6	13.8	10.0	13.7	11.9	12.8	27.9[6]	3.7[6]	8.9[6]
Number of severe harm or death incidents based on NRLS (published data)	2	5	7[7]	5	3	8[7]	3	0	3	0	40	8.4
Severe harm or death as a % of total incidents based on NRLS (published data)	0.5	0.7	0.6	0.5	0.2	0.3	0.1	0	0.06	0	2.0	0.5

[1] The annual total has been obtained through the summation of data for the two six-months of published NRLS data. All data has been sourced from NRLS published data unless specified (ie quarter 3 and quarter 4 of 2014/15 only).

[2] The 2013/14 quality account erroneously recorded that the data provided for 2012/13 was for the period April to September 2012 (ie six months), when it was actually an annual total. Also, the reported figure provided is a combination of NRLS (six months) and data extracted from the incident reporting system (six months); this accounts for the difference in the number published in this report. The increase in reported incidents is due to the timing of the data extract. Since the original upload to the NRLS, further incidents have been recorded and uploaded.

[3] Data published in the 2013/14 quality account was extracted from the incident reporting system only; no reference to the published NRLS data was made. Since the last quality report, data has been published to cover the full 12-month period and it is the published data that has been presented. Note 2, above, explains why there is likely to be a difference between published NRLS data and data in the trust incident reporting system.

[4] Published NRLS data for quarter 3 and quarter 4 of 2014/15 is not yet available, therefore this data has been extracted from the trust incident reporting database system.

[5] Data has been taken from two six-month NRLS organisational patient safety reports and combined to provide an annual total, unless otherwise specified.

[6] National NRLS comparative data over a 12-month period is not available; the data presented in the table is relevant to quarters 1 and 2 of 2013/14 only and therefore provides a comparison with the six-month reporting rates only.

[7] The annual totals for serious harm/death incidents as reported in the 2013/14 quality account (eight in 2012/13 and 11 in 2013/14) differ from those presented in this report. The previous figures represent the data extracted at the time, which was after the submission to the NRLS, meaning that further incidents had been recorded. The most recent data available from the trust database gives annual severe harm/death figures as follows: nine in 2012/13, 11 in 2013/14 and five in 2014/15. One death was recorded in 2012/13.

[8] Note, the figures have been restated from the previous report because the data for 2012/13 and 2013/14 has been re-presented (see note 2 above). Also, the previous report only provided an annual reporting rate and not six-monthly reporting rates.

Serious incidents and never events

In 2014/15, we declared 16 serious incidents, six of which were classed as never events (which are untoward events that are deemed to be serious enough that they should never occur – for example, surgery on the wrong limb). Serious incidents are also reviewed and agreed by Islington, our host commissioners.

The never events concerned a retained foreign object under the eyelid following surgery, and five occurrences of the insertion of an incorrect strength intraocular lens (IOL) which needed to be replaced. Further detail is provided in the table below:

Never event title	Brief details	Learning and improvement
Wrong IOLs	Five incidents with the same cause, four occurring at Bedford South Wing and one at St George's. A change in the presentation of lens choices on the biometry printout resulted in the surgeon selecting the correct lens type, but the incorrect strength. In all five cases the error was detected after the incorrect IOL had been implanted and lens replacement surgery was required (requested by the patient)	A comprehensive action plan, which was combined with the actions from two other unrelated wrong IOL incidents for ease of monitoring, was developed as a result of these incidents. The actions include, but are not limited to: ■ Introduction of a new process for the maintenance and monitoring of the IOL masters (the equipment that is used to perform biometry – the process which supports selection of the lens type and strength to be implanted), which will be overseen by the clinical technical services department ■ Review and revision of the three clinical guidelines associated with IOL selection and implantation, to reflect modifications in process introduced and revised audits ■ Raising the awareness of staff who are not normally involved in the IOL selection process (eg theatre nurses, anaesthetists) so that they are better informed to be able to identify any errors ■ Communication of specific pieces of information to staff
Retained foreign object	A trocar cannula, a device which is inserted into the eye and is used to keep open an entry hole through which surgical devices are passed into and out of the eye, was left behind. This was not detected prior to the end of surgery	This was not the first incident of this type and several actions had been previously undertaken including, but not limited to: ■ Identification of the need to include trocar cannulas within the surgical count and amendment of the surgical count form to reflect this ■ Review and re-issue of the surgical count standard operating procedure (SOP) ■ All relevant staff had their competency against the surgical count SOP verified ■ An audit and re-audit of compliance with the SOP was completed. The re-audit identified a significant improvement with compliance The investigation into the most recent incident identified that there is variation in the terminology used by medical and nursing staff to describe the trocar cannula. Further review and subsequent re-issue of the SOP will be undertaken, along with competency re-assessment for the staff directly involved, on-going competency checks for all relevant staff and a re-audit of compliance with the SOP

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

Serious incident title	Brief details	Learning and improvement
Delayed appointment at Moorfields at St Ann's	Four SIs were reported and investigated because patients had appointments scheduled on more than one occasion. The time interval exceeded that which the doctor had requested and harm occurred as a result of the delay in review	It was identified that clinics were routinely being overbooked and that clinicians were not being routinely asked to review the notes of patients who were to have an appointment changed to identify clinical priority/appropriateness. Several improvements have been made, including the appointment of an additional consultant, and a review of and subsequent improvements to staffing levels and staff education
RTT18 – incorrect application of the "clock pause" rules	Patients have a right to start consultant-led treatment within a maximum of 18 weeks. As reported in the 2013/14 quality account, it was identified that the "clock pause" rules were being inadvertently misapplied. Patients can be offered the choice of receiving treatment by a different hospital/site/consultant, but their waiting time clock cannot be paused if they choose not to accept this opportunity	An element of the SI investigation was completion of a clinical harm review of all patients who had waited for more than 18 weeks before starting their consultant-led treatment. No patients were found to have come to harm. A number of areas for improvement were identified, and the trust access policy has been reviewed and updated to reflect the changes agreed. Implementation of the revised policy is being accompanied by a comprehensive staff-awareness programme
Eye bank flood	The eye bank, which is located in the basement at City Road, was flooded as a result of heavy rainfall and equipment failure. The department was closed for 10 days while the necessary repairs and cleaning took place. There was no patient harm but the service was disrupted and donor tissue was lost	The incident occurred as a result of heavy rainfall and infrastructure and equipment failures, which had not been previously detected. A conclusion of the investigation was that the eye bank is located in part of the building that is wholly unsuitable. Several immediate remedial actions were completed by the estates department, which included repair/replacement of faulty equipment and a revised programme of equipment inspection. A longer-term action regarding the relocation of the eye bank continues
Delayed diagnosis of endophthalmitis	The trust was notified, via receipt of a clinical negligence claim, that there had been a failure to diagnose and subsequently treat endophthalmitis	Investigation continues
Lost to follow-up, glaucoma	The patient was last seen by the glaucoma service seven years ago	Investigation continues
Incomplete discharge	The patient was seen in 2003 and then subsequently did not attend (DNA) the next two appointments. The GP did not receive notification of the patient's discharge	The majority of learning from this SI has already been addressed in previous SIs. Specifically, several improvements have been addressed through the review, revision and implementation of the access policy. An important outstanding action identified in this report is the need to audit compliance with the access policy, several months after implementation
Unfiled clinical documentation	A large quantity of various types of clinical documentation was discovered, unfiled, in an office drawer	Investigation continues

All completed serious incident and never event 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 never events and serious incidents are completed and learning is shared via various mechanisms, such as clinical governance half-days and through aggregate data reports.

4.6 Friends and family test for patients

One of the expectations behind the introduction of the friends and family test (FFT) was to give patients a voice and ask them to state an opinion they would not have previously expressed. A 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 in the overnight admission wards.

Although there was no target FFT score, for 2014/15 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.

Overnight admissions ward scores were rated green for all quarters and A&E was rated amber for all quarters. From October 2014, the FFT net promoter type score was abandoned in favour of a simpler score of the percentage who would recommend the trust (positive responses) against those who would not (negative responses). This is in line with national guidelines and is not RAG rated. The results for quarter 4 are in the final columns.

The FFT results are, on the whole, a fair reflection of how positively patients view Moorfields. In the coming year, the trust will focus on the patients who did not provide a positive indication of our performance.

2014/15 response rates and scores are shown in the tables below:

	Response rate				
	2014/15 performance				
	Q1	Q2	Q3	Q4	Yearly average
A&E City Road	27%	27%	26%	24%	26%
Observation bay	75%	69%	63%	72%	70%
Cumberledge (NHS)	64%	51%	86%	66%	66%
Duke Elder	56%	35%	100%	71%	68%

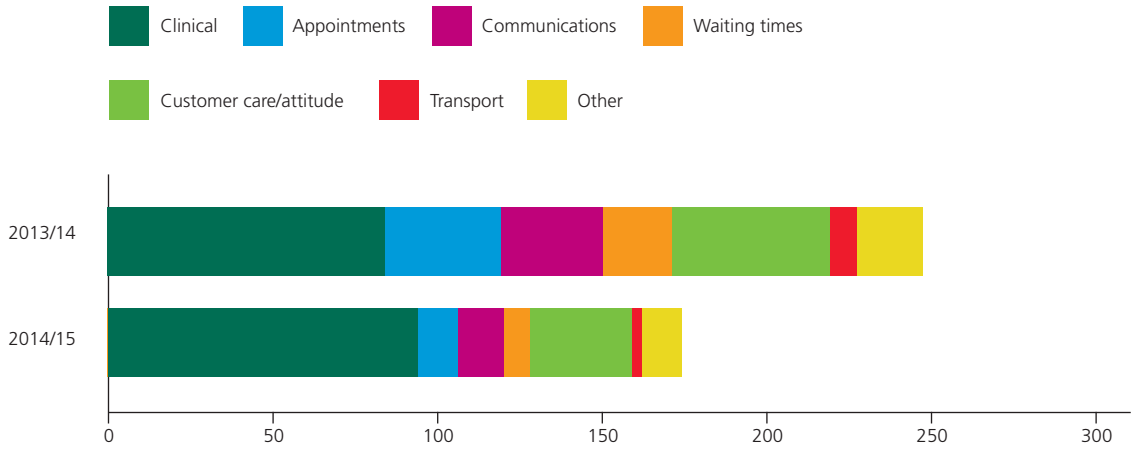
	Friends and family score						
	2014/15 performance					Q4: Recommend	
	Q1	Q2	Q3	Q4	Yearly average	Would	Would not
A&E City Road	72	74	73	74	**74**	95%	1%
Observation bay	95	92	90	93	**93**	100%	0%
Cumberlege (NHS)	90	88	86	95	**89**	100%	0%
Duke Elder	83	81	87	100	**87**	100%	0%

Percentage of patients who would not recommend the trust (ie scoring "unlikely" or "extremely unlikely")				
Q1 (15,526 pts)	Q2 (20,438 pts)	Q3 (23,102 pts)	Q4 (26,084 pts)	Year (85,150 pts)
1.4%	1.4%	1.2%	1.1%	1.3%

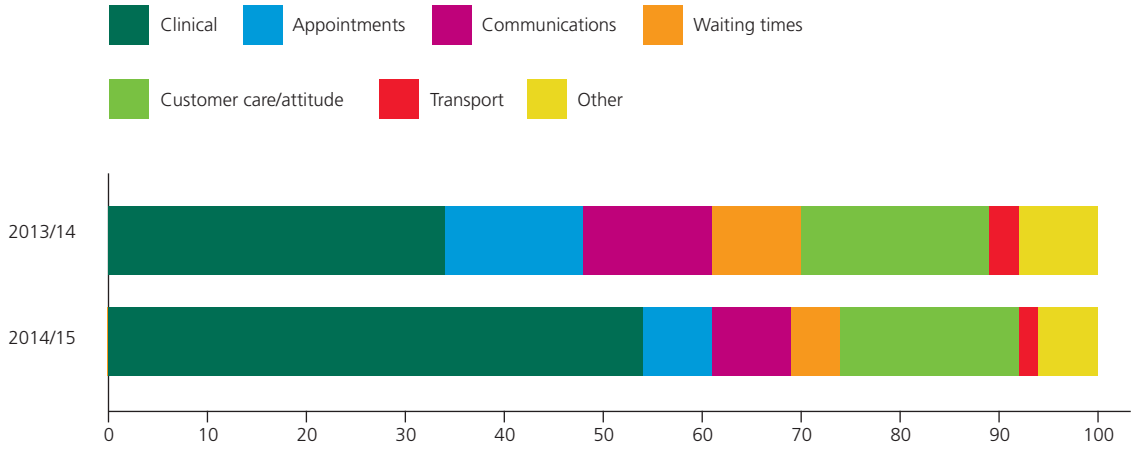
4.7 Compliments and complaints

Complaints: The trust produces regular reports for the board about compliments and complaints. In 2014/15 Moorfields received 174 complaints as opposed to 247 in 2013/14. The diagrams below illustrate the complaints received by theme.

Themes of complaints – by number



Themes of complaints – by percentage



In 2014/15 clinical concerns were the most common cause of complaint. These typically include what the patient felt were problems with treatment, including receiving the wrong surgical or medical treatment; not having their concerns taken into account; concerns about the outcome of treatment, which might be due to doctor error, delays to surgery, errors made in the past, or that treatment did not work. All clinical complaints are unique and can depend on the patient's understanding of their condition and treatment plan. There do not appear to be trends relating to staff, area or service. Not all the issues raised in clinical complaints suggest the need for specific service change, but rather a clarification of treatment and care given. This includes meeting with patients to explain perceived misunderstandings.

Other types of complaint relate to the perceived unprofessional or offhand behaviour of staff, and issues around appointment bookings and cancellations. Communication complaints focus on the receipt and standard of correspondence, and patients being unable to contact the trust efficiently. Waiting times on arrival both in clinics and for surgery, as well as the physical environment, are also issues raised by complainants.

Some of the organisational weaknesses identified through the complaints process are being addressed through trust-wide initiatives aimed at addressing the underlying process and behavioural issues that give rise to patient frustration. The Moorfields Way project is bringing staff and patients together to identify shared beliefs and values that will inform future staff training, appraisal, recruitment and behaviours. A transformation project and surgical services review (which is addressing issues around the day care pathway), and telecommunication projects will address issues such as delays, appointments handling, telephone access and customer service, among others. Other trust-wide initiatives include a full review of all patient letters to make them clearer for patients, and a regular transport meeting with the trust provider. Some specific changes made in response to patient complaints are:

- The medical director has issued guidelines for how patients should be informed if they are no longer eligible for Moorfields care (rather than only receiving a copy of the GP letter)
- More effective devices are being issued to patient transport drivers to keep them better informed of changes to transport arrangements when they are on the road
- Improved guidelines for the recording of capacity assessments as part of the consent process have been established, which will include all clinical staff receiving a pocket prompt on how to deal with mental capacity issues
- Copies of GP letters sent to patients will include a line at the top explaining that the letter is for the patient's information
- The OpenEyes patient record system will be adapted to include patient allergies on prescription forms, following an incident where this was missed

Compliments: The PALS office was forwarded 133 compliments for 2014/15 (equivalent to 7% of PALS enquiries). We believe that different departments in the trust receive many more which are not formally recorded. In addition, the trust received about 50 positive comments via NHS Choices and approximately 60,000 compliments are received from FFT cards. Below are three examples of the compliments which have been received:

" *Every member of staff I have met at Moorfields – from healthcare assistants to consultants – have treated me with both consideration and respect. All were uniformly polite and helpful. This hospital is, without doubt, a centre of excellence. I feel very fortunate to have been treated there."* Glaucoma clinic

" *I am writing to you to say a big thank you for looking after me so well during my recent stay and operation. You were very kind. I had many dietary requests and you made sure that it all went ok. Nurses on both shifts were extremely nice to me even though I had to ask for their help through the night. I appreciate your help and kindness – I know you all do a hard job. Your kindness brought tears to my eyes. A big thank you!"* Observation bay

" *This is not so much an enquiry as a thank you. I attended casualty today and was overwhelmed by the staff at all levels. Directions to the casualty department were clear and courteous, the welcome at the casualty department was like no other I have come across in London (or any) hospitals. "Welcome to Moorfields" was said with absolute sincerity and warmth. Treatment was second to none. Easy-going, pleasant professionals who obviously knew their stuff with exceptional abilities to communicate and engage."* A&E

4.8 Staff recommending the trust to friends and family

In 2014/15, NHS England extended the coverage of the friends and family test (FFT). Trusts are required to survey either a sample or their entire workforce every quarter, asking whether individuals would recommend their organisation as a place to be treated and as a place to work.

Like the patient FFT survey, there is no national target for response rates or scores. During our first quarter we experienced a low response rate and scores were inconsistent with our national staff survey results from the previous year. We reflected on our approach and made changes to how we engaged with staff. As shown below, results in quarters 2, 3 and 4 consistently demonstrated that many staff are proud to recommend Moorfields as a place for treatment and likewise as a place to work, keeping us in the upper quartile of all NHS organisations.

	Q1	Q2	Q3	Q4
% staff recommending Moorfields as a place for treatment	76	96	92	96
% staff recommending Moorfields as a place to work	26	84	76	77

4.9 Trust-wide patient (Picker) surveys 2014/15

Day-care, outpatient and A&E surveys are undertaken on behalf of the trust by the Picker Institute, allowing Moorfields to monitor year-on-year progress and draw comparison between sites.

Around 2,000 outpatients and day-care patients who were seen in the early part of 2014 completed the surveys. Overall, the two surveys showed that for nearly all questions, more than 90% of patients recorded "total" or "partial" satisfaction with the service and care they received. The goal, through locally-created action plans, is to reduce the number of "partially" satisfied scores.

Some of the positive feedback, where questions scored more than 90% for total satisfaction, included the following:

- Their care was excellent, very good or good
- They would definitely or probably recommend Moorfields to their friends or family
- They were treated with dignity, all of the time
- The environment of outpatients was very or fairly clean, with 97% saying the same of the toilets
- The courtesy of the receptionists was excellent, very good or good
- 72% of patients received copies of all their GP letters – a rise of 9% on the previous year

And for day care more than 90% of patients:

- Felt their admission was very or fairly well organised
- Rated the courtesy of the receptionist as excellent, very good or good
- Found the hospital room or ward very or fairly clean
- Felt that they were given the right amount of information about their condition and treatment

- Felt their discharge was delayed fell by 7%
- Felt that they were treated with respect and dignity while in the trust
- Felt that doctors and nurses worked well together

There were some areas where improvements could be made:

- Giving patients more involvement in decisions about the best medication for them
- Giving patients a choice of appointment times and not changing their appointments
- Giving patients an explanation and apology if there is a delay in their appointment time
- Better informing patients of the possible side effects of their medication and who to contact should they have concerns about their condition or treatment
- Reducing waiting times on the ward before a procedure
- Staff talking less in front of patients ("as if they weren't there")
- Reducing discharge delays

The NHS national A&E survey 2014 captured the opinions of a random selection of patients who attended the trust between February and March 2014. The survey is part of the series of surveys required by the Care Quality Commission (CQC), the results of which are published, alongside the other 142 trusts taking part, on their website. This survey was reported in October 2014.

The CQC survey is scored differently from the Picker surveys, giving a score out of 10. Areas in which we scored nine or above were as follows:

- Patients did not feel threatened by other patients or visitors
- A member of staff explaining the purpose of medications to the patient
- Doctors and nurses listening to what the patient had to say
- Patients being given enough privacy when being examined or treated
- Members of staff contradicting each other
- Overall, patients felt they were treated with respect and dignity
- Sufficient information being provided about condition or treatment
- Doctors or nurses talking in front of patients as if they are not present

Where we scored less highly was around waiting times and ensuring patients are assessed appropriately for pain levels, although this may be due to the specialist nature of our A&E department. Typical survey comments included:

"I have nothing but praise for the way I was treated, and for the patience and caring attitude of all staff at all levels. My problem was a scare but turned out to be something I just have to live with. I was very worried when I arrived but was reassured by my treatment, examination and the explanation I was given. So many people were seen to with dignity, compassion and professionalism, which was was truly wonderful. Many thanks to all involved."

The A&E management team and their staff reviewed the findings of the survey and are developing an action plan to address the issues raised. These improvements will be driven though A&E service meetings and reported to the patient experience committee, and outcomes included in future patient experience reports.

5 Priorities for 2014/15

The development of the trust's quality report was led by the director of corporate governance in close liaison with the clinical director of quality and safety, director of nursing and allied health professions, 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. The quality priorities have been agreed by the management executive, and the full report has been reviewed by the quality and safety committee; the report has been finalised as a balanced representation of the trust's quality priorities. A group of the trust's governors, on behalf of the membership council, have also considered the contents of the quality report, which was agreed by the trust board on 26 May 2015.

5.1 Patient experience – service redesign and transformation

Objective: To build on the diagnostic and foundation work completed during 2014/15 to redesign processes, care pathways and services to transform the patient experience.

Rationale for inclusion: This programme has been divided into four sections, each of which can be directly related to issues of direct concern to our patients. Across the four different aspects of the programme, we will be outlining plans to cut patient journey times and non-value added waiting, improve theatre efficiency and patients' experience of the surgical pathway, reduce incidences of appointment cancellation/rescheduling, manage clinical records to minimise the number of missing notes, and continue to develop six-day working.

How we will monitor, measure and report on progress: The different aspects of this linked programme of work are detailed below:

1. Reducing the amount of time patients wait when they visit the hospital. This work will focus initially on the glaucoma and uveitis services, where our patients tell us that excessively long journey times are a particular problem
2. Improving theatre efficiency throughout the network. This year will see the launch of a trust-wide theatre improvement project focused on all aspects of theatre utilisation and efficiency as well as patients' experience of the surgical pathway, and the development and organisation of theatre staff
3. Improving administrative processes at all points along the patient pathway, including booking processes to reduce incidents of appointment cancellations/rescheduling and the management of clinical records to minimise the number of missing notes
4. Progressing plans to implement six-day working where appropriate

These individual work streams will be clearly defined and performance milestones established against which progress can be monitored by the executive team and trust board.

5.2 Clinical effectiveness – expansion of the clinical outcome and performance indicator programme

Objective: This is our sixth year of building on our clinical outcomes and performance indicator programme. We propose to do three things during 2015/16:

1. 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 quality reports and on the website
2. To continue to integrate the routine collection of clinical outcomes data into the relevant modules of OpenEyes as they are developed; where it is a feature of a module, we will ensure that the automated generation of outcome results occurs
3. To develop OpenEyes functionality to deliver data to the Royal College of Ophthalmologists' national cataract audit

Rationale for inclusion: This will continue to provide information about the results and safety of our care for patients, commissioners and referrers. Such information will support decision making, ensure high standards of care, and allow benchmarking by external clinicians and units. Clinicians will have access to up-to-date results of cataract surgeries, for their individual work and for the surgeons they supervise. This will support clinician appraisal and revalidation and management of poor performance, and will allow improved individualised risk advice and consenting for patients. It will also allow Moorfields to participate in the Healthcare Quality Improvement Partnership (HQIP) national cataract audit – the first major national ophthalmic audit.

How we will monitor, measure and report on progress: Results will be published via the corporate quality reporting systems and will be available on the website. We will have submitted data successfully to the national audit, and clinical staff will be using the OpenEyes cataract audit system regularly to counsel pre-operative patients, for audit and appraisal purposes, and for performance management meetings.

5.3 Patient safety – to promote improved quality and safety across the organisation by preparing the trust for a Care Quality Commission (CQC) inspection, including expansion of the patient safety walkabout programme

Objective: To use the prospect of a CQC visit to Moorfields in the next year to further drive and embed quality and safety in everyday practice at all sites and for all staff. This will take place through a combination of education, mock CQC-style inspection walkabouts, reviews of quality and safety data, the provision of information for staff, and support with action-planning to address gaps and issues. We will also link preparations to the Moorfields Way initiative, which outlines a new set of commitments and behaviours for Moorfields.

Rationale for inclusion: The CQC is likely to visit Moorfields in the coming months, and this provides the ideal opportunity to promote quality and safety further across the organisation, and support staff in all disciplines and across all sites to improve their skills and knowledge in these areas. Staff will be better informed about the role of the CQC and how to examine working practices against CQC standards. They will be able to identify areas for improvement and how to take action to make improvements prior to a visit. Information will be provided to staff via seminars,

workshops, handbooks and self-assessment tools. A programme of mock CQC-style inspection walkabouts is already underway and these will continue throughout 2015/16, as will quality performance data reviews and trust-wide data gathering. These will be used to identify gaps and formulate action plans for improvement. The longer-term aim is to standardise this approach within working practices.

How we will monitor, measure and report on progress: Education events will be held for all staff across all sites, and staff will receive handbooks and self-assessment tools. Tools and action plans will be completed, and the necessary actions taken to facilitate improvements across the trust. CQC-style monthly performance data reviews and/or walkabouts will occur across the majority of sites and services.

5.4 Patient safety and clinical effectiveness – expand the breadth and depth of regular quality reporting

Objective: This has developed and increased over time, and this is the third year of expanding this indicator. We propose the following in 2015/16:

1. To continue to produce twice-yearly global quality and safety performance reports supplemented by more detailed reports on specific areas for greater analysis, qualitative data, clear analysis of actions taken and future plans for improvement
2. To expand local quality performance reports and dashboards to incorporate more key data, including infection control, audit and outcomes, and to provide more frequent (monthly) reports. This will be for directorates, sites, services and, if possible, specific wards and clinics. Accessible and attractive presentation will be used with straightforward graphics and tabulated performance data

Rationale for inclusion: We have had detailed discussions internally and with our commissioners about the underlying drivers for this quality priority which are clearly linked to an expanding organisation, both in terms of the number of sites geographically and the number of patients we treat. We need to ensure that we can not only provide an overview of quality and safety across the trust, which covers key themes and provides assurances, but also be able to analyse in depth key areas of quality, safety and patient experience with clear actions documented so that improvements can be made and monitored. We also want to ensure that each area of the trust can review its quality and safety performance with up-to-date and reliable information, and have the ability to make comparisons with other areas. This will support local ownership, enable rapid action to be taken to make improvements where necessary and to monitor improvement over time.

How we will monitor, measure and report on progress: The clinical quality and safety performance report will be produced twice yearly. More detailed reports on areas such as patient safety, aggregate adverse events, clinical effectiveness, safeguarding and patient experience will also be produced at least twice a year. Sites, areas and services will receive, discuss and act upon a monthly standardised quality dashboard containing outcomes, audit, infection control, staffing, incidents, and "never events", and similar data and dashboards will demonstrate change over time. We have also agreed that regular summary feedback will be provided to our commissioners for assurance purposes via the new dashboards.

5.5 Patient experience, patient safety, clinical effectiveness: quality and safety staffing support in directorates and satellite sites – a new decentralised model

Objective: To create a more extensive quality and safety staff structure in non-City Road sites to support the delivery of high-quality, safe care by providing local experts in clinical governance, risk and quality.

Rationale for inclusion: The main professional support function for quality and safety is based centrally at City Road, which limits some interaction and communication between quality and safety staff and staff on the ground in other locations. In addition, the significant increase in the quality and safety work programmes introduced over the last few years have been difficult to support with current staffing levels. The trust will be appointing quality partners, with expertise and a proven track record in quality and safety management, to provide new support in a decentralised structure. Quality partners will spend the majority of their time in satellites, working with staff and patients to promote and support the highest quality of safe care with local knowledge of each site's particular situation and patient population. They will also work directly with the central team to ensure effective two-way communication and direction, so that trust quality and safety priorities are acted on locally and issues escalated.

How we will monitor, measure and report on progress: Initially there will be a quality partner in post for each non-City Road directorate, supporting staff in all areas of the work, including walkabouts, quality training, action planning, generating outcomes, incident reporting and investigation, complaint handling, improving patient experience, quality dashboard analysis, CQC preparation and clinical governance half-day organisation.

5.6 Patient experience – improving patient information and communication

Objective: To continue to improve communications with our patients, ensuring that we contact them in their preferred way, and that the information we provide is timely, current and informative, and that when patients contact Moorfields, we are responsive and receptive.

Rationale for inclusion: Patient feedback suggests that we need to continue to improve the way in which we communicate with our patients. The implementation of an upgraded telephone system has improved our ability to respond to patient calls more efficiently. However, there are still improvements to be made and we need to demonstrate a consistent improvement across all departments at our City Road site. We will do this by evaluating the effectiveness of the upgraded system, assessing our performance against key performance indicators (KPIs) and agreeing a strategy for the next phase of implementation.

We have already started to review the quality of correspondence, but we will also ensure that the information is sent in the most acceptable form. We will focus on the quality of GP correspondence and patient appointment letters, ensuring that information is sent in the preferred format.

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

5.7 Patient safety and patient experience – improving care for patients who lack mental capacity

Objective: To improve care delivery for patients who may not have the mental capacity to consent to treatment.

Rationale for inclusion: We continue to make good progress in ensuring that we have systems in place to protect vulnerable patients, but at times we know we could do better when we are expected to support clinical decisions about patients who lack capacity to consent for treatment. We will raise awareness and strengthen the processes of consent, particularly regarding capacity to consent, by focusing on good practice, learning from other organisations and increasing training provision. We will demonstrate the effectiveness of this approach by auditing our practice.

How we will monitor, measure and report on progress: We will complete an audit of case notes for patients who have been flagged as potentially not having capacity to consent. In the first quarter we will conduct a baseline audit that will be followed with a re-audit in quarter four. The importance of assessing mental capacity will continue to be raised through training.

5.8 Patient experience – improving the environment

Objective: Moorfields has set itself several objectives for 2015/16, including:

- Securing a site for a joint facility with the UCL Institute of Ophthalmology to replace our current hospital at City Road
- Progress the planning for the reprovision of Moorfields' facilities at St George's by agreeing a revised relocation plan, and agreeing and implementing a solution for our short-term space requirements
- Complete the refurbishment of the eight City Road theatres with as little disruption to patients and staff as possible
- Secure appropriate premises for a surgical hub in east London
- Continue the development and expansion of our private patient services at City Road by developing our Cayton Street building
- Expand and refurbish the intravitreal suite at City Road

Rationale for inclusion: The delivery of high-quality clinical care requires an appropriate setting. Moorfields has made good progress in previous years to upgrade and improve facilities, and we continue to have ambitious plans for further improvements at City Road and our other locations. Our strategic focus is on replacing our ageing hospital building at City Road.

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 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.

6 Key indicators for 2015/16

We have made some changes to the indicators for 2015/16, as set out in the table below. The significant changes can be summarised as follows:

- **Developing patient-reported outcome measures (PROMs):** PROMs will remain in general use within the trust for general ophthalmology and cataract care, and potentially their use may be expanded locally within departments
- **Patient satisfaction:** Over recent years the trust has measured patient satisfaction in relation to waiting times in outpatient clinics using an indicator focused on patient complaints. The number of patient complaints focused on clinic waiting times and/or the communication of the reasons for delays has reduced by approximately 82% over the last two years, but patient journey times in outpatient clinics remain too long. The trust has therefore decided to replace this indicator with one that we consider to be more sensitive to patients' views, which is the number of negative comments submitted via the friends and family test about these issues. We consider that patients are more likely to comment in this way than make a formal complaint. As this is a new indicator, 2015/16 will be the baseline year for this data
- **Theatres utilisation:** The limited success of the trust's surgical improvement plan resulted in the reduction in journey times for cataract surgery patients at City Road (illustrated in the table in section 3). Unfortunately, we failed to make the more fundamental changes required to maintain and continue this progress, and as a result the journey time in 2014/15 increased by 3% compared to the year before. During 2015/16, we will launch a theatre improvement programme, for which we have selected surgical pathway indicators that are directly related to the aims and objectives of this programme. The existing indicator will be used and will focus on theatre lists starting on time, for which a more realistic target of 85% has now been set. Overall theatre utilisation and turnaround times between cases at City Road will also be measured (see table below). If we are successful in improving our efficiency in these areas this will have an enormously beneficial effect on the overall patient journey
- **Transformation programme:** The successful delivery of a transformational change programme continues to be a corporate priority going into 2015/16. However, we now consider the indicator set in relation to this programme last year to have been too non-specific, and although a significant amount of work has been done, we recognise the challenges of defining "progress" and measuring performance against this very wide-ranging indicator. We have therefore replaced the indicator this year with three separate measures, all of which are directly related to the aims and objectives of the transformation programme. These are: the number of temporary records created as a percentage of the number of records used – an indicator focused on the risk to patients posed by missing clinical records; the number of outpatient appointments subject to hospital-initiated cancellation and rescheduling; and the percentage of glaucoma patients managed via the stable monitoring service. The latter has been chosen because the work on this pathway to date has demonstrated a 70% reduction in patient journey times between a traditional hospital-based glaucoma outpatient clinic and the stable monitoring service. For all three indicators it has been possible to include data for 2014/15
- **Theatres standard operating procedure (SOP):** This was developed in 2014/15 but has not yet been implemented. The indicator for 2015/16 will therefore be renamed "implementation of a standard operating procedure for theatres"

Indicator	Source	2012/13 result	2013/14 result	2014/15 result	2015/16 target
Patient experience					
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	72%	74%	No day-care survey took place in 2014/15 so this indicator is N/A	No day-care survey will take place in 2015/16 so this indicator is N/A
Number of negative comments submitted via the friends and family test about long waits in clinic and/ or lack of information about delays and the reasons for long waits	Internal performance monitoring	New indicator	New indicator	New indicator	Baseline year
% of patients whose journey time through the A&E department was three hours or less	Internal performance monitoring	81.7%	81.7%	80%	80%
Overall theatre utilisation in City Road theatres	Internal performance monitoring	New indicator	New indicator	New indicator	Baseline year
% reduction in average patient journey time for cataract surgery patients at City Road	Internal performance monitoring	18% reduction – four hours four minutes compared to four hours 56 minutes previously	See footnote to the table in section 3	See footnote to the table in section 3. Further use of this indicator is under consideration and others are likely to be developed	This indicator will no longer be used (see above)
% increase in all City Road theatre lists starting on time	Internal performance monitoring	59%	74%	90%	85%
Turn-around time between theatre cases at City Road	Internal performance monitoring	New indicator	New indicator	New indicator	Baseline year

Indicator	Source	2012/13 result	2013/14 result	2014/15 result	2015/16 target
Implementation of a standard operating procedure for operating theatres	Internal performance monitoring	N/A – new indicator	Not achieved and was rolled over into 2014/15	At year end a near final SOP is being tested prior to implementation	The SOP will be implemented as a suite of documents
Progress on the transformation programme	Internal performance monitoring	N/A – new indicator	There has been progress in testing a number of operating principles, but not as much as we had wanted	Refer to the text above	This broad indicator will no longer be used – refer to the text above
The number of temporary records compiled as a percentage of the number of records used	Internal performance monitoring	New indicator	New indicator	0.7%	<0.5% (new indicator from 1 April 2015)
Transformation: the number of outpatient appointments subject to hospital-initiated cancellation	Internal performance monitoring	New indicator	New indicator	Hospital-initiated cancellations – 3.8%	Hospital-initiated cancellations – <3% (new indicator from 1 April 2015)
Transformation: rescheduling as a percentage of the total number of appointments	Internal performance monitoring	New indicator	New indicator	Rescheduling of appointments – 15.9%	Rescheduling of appointments – <12% (new indicator from 1 April 2015)
Transformation: percentage of glaucoma outpatients managed through the stable monitoring service	Internal performance monitoring	New indicator	New indicator	3%	10% (new indicator from 1 April 2015)

Indicator	Source	2012/13 result	2013/14 result	2014/15 result	2015/16 target
Patient safety					
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	90%	87.5%	90%	90%
% overall compliance with hand hygiene standards	Internal performance monitoring	97%	97%	95%	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 endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.29	0.38	0.20	<0.8
Incidence of presumed infective endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	0.35	0.18	0.21	<0.5
Site and service safety review: patient safety walkabout and use of mGTT	Internal performance monitoring	N/A – new indicator	17 proposals and 7 completed	35 mGTT audits proposed; 12 sites and 13 services proposed or completed an mGTT audit; 1 CQC walkabout, 2 staff safety walkabouts and 3 data reviews completed and included in safety reports	Staff will receive CQC handbooks and self-assessment tools, and these will have been completed and returned; action plans will be implemented; walkabouts will have occurred in 80% of sites

Indicator	Source	2012/13 result	2013/14 result	2014/15 result	2015/16 target
Clinical effectiveness					
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%	100%
Posterior capsule rupture rate for cataract surgery	Internal performance monitoring	0.8%	0.9%	1.1%	<1.3%
Comprehensive clinical outcome indicators in place via OpenEyes	Internal performance monitoring	N/A – new indicator	Broad range of outcomes generated, but only a portion are currently generated electronically	Progress in developing OpenEyes unexpectedly slow therefore not significantly progressed	Outcomes present in the quality section of the website; outcome data submitted to national cataract audit; clinicians using OpenEyes outcome audit function for appraisals and performance management
Developing quality reporting – overview and detail	Internal performance monitoring	Corporate clinical quality and safety report in use and regularly presented to the trust board	Trust-wide clinical quality and safety perfor-mance report published twice a year and biannual detailed reports on clinical effective-ness, patient safety and the patient experience	Reports in place as planned	Trust-wide clinical quality and safety performance reports, plus quarterly reports for directorates and monthly directorate and site quality dashboards in use
Developing PROMs	Internal performance monitoring	N/A – new indicator	General ophthal-mology PROM validation near completion; regular clinical use to start early in 2014/15	General ophthalmology PROM in regular use; cataract PROM data collection complete and analysis nearing completion	See text introducing section 6

7 Statements of assurance from the board

The board receives assurance about quality and safety from a number of sources. Two major ones are a twice-yearly thorough review of quality and safety by the clinical director of quality and safety via a comprehensive report. A second is via reports from the chair of the quality and safety committee, which as a board committee provides overview and scrutiny. The board also receives regular reports about safeguarding, compliments and complaints, and separate reports about patient experience, patient safety and clinical effectiveness.

Review of services

During 2014/15, Moorfields Eye Hospital NHS Foundation Trust provided ophthalmic NHS services covering a range of ophthalmic sub-specialties. We regularly review all healthcare services that we provide. During 2015/16, 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 2014/15.

Participation in clinical audits and national confidential inquiries

During the period 1 April 2014 to 31 March 2015, 24 national clinical audits and no confidential inquiries (as none were relevant to our specialty) covered relevant health services that Moorfields provides.

During the period 1 April 2014 to 31 March 2015, Moorfields participated in 100% of the national clinical audits which it was eligible to participate in. Moorfields was not eligible to participate in any national confidential inquiries.

Due to the single speciality nature of the trust, many national audits are not relevant. The trust audits against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists, National Institute for Health and Care Excellence (NICE) and national service frameworks.

The 24 national clinical audits that Moorfields was eligible to participate in from1 April 2104 to 31 March 2015 were:

Audit project title	Sites	Service	Reason
Intraoperative monitoring of the elderly at Moorfields	City Road Ealing Homerton Loxford Mile End Northwick Park Potters Bar St Ann's St George's	Anaesthetics	NICE
Audit of suspected lid cancer patient referral in adnexal oncology	City Road	Adnexal	NICE
Sprint national anaesthesia projects (SNAP-1): patient survey on quality of anaesthesia in UK hospitals and accidental awareness under general anaesthesia	Bedford City Road Ealing Mile End Northwick Park Potters Bar St Ann's	Anaesthetics	National audit

Audit project title	Sites	Service	Reason
DMO compliance audit	City Road Ealing Loxford Northwick Park St Ann's St George's	Medical retina	NICE
DMO Lucentis new referral forms	City Road	Medical retina	NICE
A prospective evaluation of patient knowledge of diabetes, diabetes self-care and diabetic retinopathy associated risk factors (the patient knowledge of diabetes audit, PKDA)	Ealing	Medical retina	NICE
Retrospective glaucoma optic nerve head imaging audit	Bedford Ealing Potters Bar Queen Mary's	Glaucoma	NICE
Evaluation of acute optic neuritis management: towards a diagnostic approach and therapeutic protocol using up-to-date procedures	City Road	Neuro-opthalmology	NICE
Patient glaucoma awareness study	Bedford	Glaucoma	NICE
A retrospective evaluative audit of visual and anatomic outcomes of patients with refractory or recurrent wet age-related macular degeneration who were converted from ranibizumab to aflibercept	Bedford	Medical retina	NICE
An audit of patients who are "lost to follow up" in the glaucoma service	City Road	Glaucoma	NICE
Audit on intravitreal treatment of macular oedema from retinal vein occlusion	Bedford, Bridge Lane, City Road, Ealing, Harlow, Homerton, Loxford, May Day, Mile End, Northwick Park, Potters Bar, Princess Alexandra, Queen Mary's, St Ann's, St George's, Teddington, Upney Lane, Watford	Medical retina	NICE
Implantation of an opaque intraocular lens for intractable double vision: adherence to NICE guidance	City Road	Strabismus	NICE
Causes of clinic non-attendance of diabetic patients in the medical retina service at City Road	City Road	Medical retina	NICE
An evaluation of A&E child protection documentation where there has been a disclosure of domestic abuse	City Road	A&E	NICE
Prescribing compliance within the adnexal service	City Road	Adnexal	NICE
Decision-making for treatment of patients with pigment dispersion syndrome (PDS) using visual field and optic disc imaging	City Road	Glaucoma	NICE
Cataract surgery audit in the glaucoma service – PCR rate	Trust-wide	Glaucoma	NICE

Audit project title	Sites	Service	Reason
Intra-operative DVT prophylaxis	City Road	Anaesthetics	NICE
Cystoid macular oedema after cataract surgery	All sites	Cataracts	NSF
Non diabetic retinopathy referral outcomes from Tower Hamlets' diabetic screening service	City Road Homerton Mile End	Medical retina	NICE
Glaucoma service at City Road compared to NICE guidelines CG85/2009	City Road	Glaucoma	NICE
Adherence to local protocols for scheduling of aflibercept injections in wet AMD	City Road	Medical retina	NICE
Ocriplasmin for vitreomacular traction and stage II macular holes	City Road St George's Ealing	Vitreo-retinal	NICE

Moorfields does not currently have sufficiently detailed or reliable data recorded for the number of cases submitted for each audit. However, we are improving our data recording and collection systems to support our audit work, and we expect to be in a better position towards the end of 2015/16.

The reports of 62 local clinical audits were reviewed by the provider during the period 1 April 2014 to 31 March 2015, although not all of these will have commenced in 2014/15. Included are a sample range of actions that Moorfields has completed following review of local audit reports:

Audit title	Issue/ recommendation	Action	Lead
Annotations of prescription forms by pharmacists and pharmacy technical staff at City Road (6–12 May 2014)	100% compliance for all audit standards not achieved	Staff working in the pharmacy dispensary to be trained to annotate prescriptions accurately and consistently as per the pharmacy standard operating procedures (SOPs), particularly OpenEyes prescriptions	Principal pharmacist/ specialist pharmacist
Endophthalmitis rates in the AMD service following intravitreal injections of Lucentis/Avastin/Eylea	Cluster of cases at Moorfields at Bedford	Staff retrained, patient flow modified, infection control team to assess service and possible causes	Infection control matron
Swabs, needles and instruments count (re-audit April 2014)	Surgical count should continue to be part of the theatre nurses' competency process and abridged version of the SOP should be placed in theatres	Ensure that all relevant staff are signed off as competent against the revised SOP and competency statement	Theatre leads for all sites

Audit title	Issue/ recommendation	Action	Lead
Audit of the treatment of conjunctivitis in children	Higher number of conjunctivitis cases receive follow-up appointments	Ask paediatric staff to discharge with leaflet where possible (discuss at clinical governance half-day) and continue to include information about this at trainee paediatric and general medical induction	Clinical director for quality and safety and consultant ophthalmologist
Individual funding requests (IFR) process followed in the medical retina department	IFR coordinator to monitor progress with CCG (timeframe: maximum six weeks) and to inform AMD fellow of all panel decisions copying in panel response documents	IFR coordinator to keep up-to-date information and communicate with other stakeholders	IFR coordinator
Efficiency and safety of optometrist-led maculopathy (M1) clinics	The longer term follow-up of low-risk M1 patients has now been remodelled. Patients with mild/stable untreatable maculopathy will now be reviewed in a digital surveillance clinic	Phase out optometrist M1 follow-up clinics	Clinical director and lead optometrist
Retinopathy of prematurity (ROP) screening audit, Moorfields at Bedford Hospital 2014	One infant transferred in from another unit with incorrect date for first screening; also infants had been screened before 28 days postnatal age	Advise neonatal unit staff, suggest use of excel spreadsheet to calculate correct date range for first screening	Consultant ophthalmologist
Modified global trigger tool – medical retina and primary care at Loxford	Lack of clinic entry and lack of GP letter	Ensure clinic notes are completed on paper notes or OpenEyes and that all clinic patients have GP letter (on OpenEyes). To update team and alert them to issues	Consultant ophthalmologist

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 that were recruited during that period to participate in research approved by a research ethics committee was 5,117.

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 2014/15, the trust had six CQUIN requirements and 2.5% (£2.5 million) of Moorfields' income was conditional on achieving quality improvement and innovation goals agreed between Moorfields and Islington Clinical Commissioning Group through the CQUIN framework. The total for 2013/14 was 2.5% (£2 million).

Set out below are the key achievements for the seven CQUINs in 2014/15:

- Achievement of the target response rate for the friends and family test for A&E, inpatient care, day care and outpatients
- Remaining in the top quartile of trusts reporting that staff would recommend Moorfields as a place to work to family and friends
- Improvements in dementia care within the organisation by training more staff in dementia awareness and auditing the robustness of local policy
- Increasing the awareness of domestic violence and improving the signposting for patients requiring support to deal with domestic violence
- Introducing a new telephone system that has improved call handling for patients resulting in an improved patient experience
- Implementing the learning from "never events" relating to wrong insertion of intra-ocular lenses
- Transformation:
  - Baseline assessment of theatre utilisation undertaken and now forming the basis of theatre improvement programme. Journey times through theatre included in this baseline assessment indicating timings at all stages of the patient journey enabling targeted action by theatre at all sites
  - Baseline assessment of journey times through clinics not undertaken as would have been reliant on manual systems which have proved to be cumbersome and impractical. Instead consideration is being given to how we can use digital tracking to achieve this more effectively. In addition, some patient journey measures will be attempted in transformation projects going forward in 2015/16

It has been agreed with the trust's commissioners that there will be no CQUINs for the year 2015/16.

Registration with the Care Quality Commission

Moorfields 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 in 2014/15, nor at any time.

Moorfields has not participated in any special reviews or investigations by the CQC during the reporting period.

Quality of data

Moorfields submitted records during 2014/15 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:

- 99.3% for admitted patient case
- 99.1% for outpatient care; and
- 96.3% for accident and emergency care

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

- 99.8% for admitted patient care
- 99.9% for outpatient care; and
- 100% for accident and emergency care

Moorfields was subject to the payment by results clinical coding audit by the Audit Commission during 2014/15. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 93.4% for secondary diagnosis and 97.4% for secondary procedure.

Moorfields will be taking the following actions to improve data quality during 2015/16:

- The data quality policy was revised in 2014/15 to reflect the implementation of the data assurance framework. The policy is undergoing further minor amendments in 2015/16
- Data cleansing activities to improve the quality of data in the patient administration system (PAS)/ data warehouse are being taken forward and will continue into 2015/16
- A&E data quality dashboards showing core demographic areas have been developed alongside the data assurance framework implementation and will be used in 2015/16
- The data quality audit programme has been expanded to include all new sites, paediatric services and manual data entry processes for friends and family test data. The programme will continue to be expanded across new sites. The audit programme in 2015/16 has been expanded as recommended by KPMG and now includes:
  - Assurance that the referral receipt date is equal to the RTT18 "clock start" date for all new outpatient referrals
  - Discharge dates and times are the same on PAS and patient notes for all A&E attendances
  - Overseas flags are being used appropriately by the overseas officer
  - Regular review of the face-to-face communication that takes place between patients and staff to ensure accuracy of patient data, particularly information about GPs
  - A data-quality campaign focused on core data quality areas will support the continued training and awareness programmes delivered across the trust
- Information is now available in clinics to inform patients and staff to update all demographic details
- Process audits have now been rolled out across all trust sites to test whether staff have entered demographic details accurately
- The profile of data quality has been raised across the organisation and it is frequently raised as an issue during operational meetings. A data quality campaign to further emphasise the importance of maintaining data accuracy will be taken forward in 2015/16

Information governance assessment

The information governance assessment report overall score for 2014/15 was 68% and was graded "red". This was because two level 2 requirements were not achieved – one relating to the handling of medical records and the other to meeting the required deadlines for subject matter requests (access to patient records). Action plans have been put in place to address both shortcomings.

8 Statement of support from partner organisations

Our quality report for 2014/15 has been shared with the trust's governors as well as with colleagues at our host clinical commissioning group, the London Borough of Islington's health and care scrutiny committee and Islington's Healthwatch.

The health and care scrutiny committee commented as follows:

"The health and care scrutiny committee has an annual meeting with the chief executive of Moorfields and at that meeting the chief executive provides a high-level summary of the performance of the organisation, including an overview of quality and safety. The review of 2014/15 has already taken place and also involved the vice-chairman of Moorfields' membership council. The committee was very satisfied with the information that [Moorfields' CEO] John Pelly provided at his presentation and is supportive of the quality and safety improvements that the trust is proposing for 2015/16 in its quality report."

Councillor Martin Klute,
Chair, health and care scrutiny committee

NHS Islington CCG commented as follows:

Commissioners' statement for 2014/15 quality accounts

"NHS Islington Clinical Commissioning Group (NHS Islington CCG) is responsible for the commissioning of health services from Moorfields Eye Hospital NHS Foundation Trust on behalf of the population of Islington and on behalf of all 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 East London (NEL) commissioning support unit. Moorfields has engaged with Islington CCG to ensure that the commissioners' views are incorporated within the priorities of the organisation and in the content of these accounts.

"We have reviewed the content of the account and confirm that it 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 past year, Islington CCG has continued to build on the good working relationship with the trust, and appreciates the openness and transparency this relationship has fostered. We hope that as lead commissioner we have helped the trust identify areas of strength and supported work on areas of weakness. Throughout 2014/15 we note there has been greater emphasis on patient and staff engagement, with programmes such as the Moorfields Way supporting the development of a set of core values owned by staff and patients, and identifying areas for improvement as well as areas of good practice. The trust has adopted "deep dive" reviews to improve quality and safety in areas of concern, such as the management of health records. As commissioners we welcome this approach and can see tangible benefits being delivered as a result. In addition we recognise the work the trust has carried out to overcome the difficulties in meeting referral-to-treatment times, and engagement with commissioners in this process.

"We are supportive of the eight priorities identified for 2015/16. We especially welcome the continued focus on the service redesign programme to reduce waiting times and improve patient experience, and the significant work the trust will undertake to adopt a decentralised model,

strengthening the quality and safety structures, and governance arrangements for satellite services. We hope this will ensure patients receive consistently high-quality care, no matter which site they are seen at.

"As a priority for 2015/16 we will continue to monitor the trust's progress against the priorities outlined. In addition we will focus on staff experience, and implementing the learning from 'serious incidents' and 'never events'.

"We look forward to the year ahead working with associate commissioners and the trust to support the delivery of priorities identified within these quality accounts."

Alison Blair,
Accountable officer, NHS Islington Clinical Commissioning Group

9 Statement of directors' responsibilities in respect of the quality report

Under the Health Act 2009 and the National Health Service quality accounts regulations, the directors are required 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 NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

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

- The content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2014/15*
- 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 2014 to May 2015
  - Papers relating to quality reported to the board over the period April 2014 to May 2015
  - Feedback from the commissioners dated 21 May 2015
  - Feedback from governors received on 27 April 2015
  - Feedback from the health and care scrutiny committee dated 22 May 2015
  - The trust's complaints report published under regulation 18 of the local authority social services and NHS complaints regulations 2009, dated May 2014
  - The 2014 national A&E patient survey
  - The 2014 national staff survey
  - The head of internal audit's annual opinion over the trust's control environment dated 31 March 2015
  - CQC intelligent monitoring report of 27 May 2015
- The quality report represents a balanced picture of the NHS foundation trust's performance over the period covered

- There are a number of limitations in the preparation of quality reports, which may impact on the reliability and/or accuracy of the data reported. These include:
  - Data is derived from a large number of different systems and processes. Only some of these are included in internal audit programme work each year and even fewer are subject to rigorous external assurance checks
  - Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified the case differently
  - National data definitions do not necessarily cover all circumstances and local interpretations may differ
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data. The trust has sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the limitations noted above. Following these steps, to our knowledge, the information in the document is accurate with the exception of the matters identified in respect of 18-week referral-to-treatment pathways as described in sections 4.3 and 4.4
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual)

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

28 May 2015

John Pelly, chief executive

28 May 2015

10 Further information

Further information about this quality report can be obtained from the director of corporate governance at Moorfields Eye Hospital NHS Foundation Trust: ian.tombleson@moorfields.nhs.uk.

This report will be available on the NHS Choices website from June 2015.

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 2015 (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 on 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 2015, 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 2015, subject to limited assurance, consist of the national priority indicators as mandated by Monitor:

- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway, prepared on the basis set out in section 4.4 (page 93)
- Emergency readmissions within 28 days of discharge from hospital, prepared on the basis set out in section 4.2 (page 90)

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the directors and auditors

The directors are responsible for the content and 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 2014/15

- 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 1 April 2014 to 28 May 2015
- Papers relating to quality reported to the board over the period 1 April 2014 to 28 May 2015
- Feedback from the commissioners
- Feedback from the governors
- Feedback from local Healthwatch organisations
- Feedback from health and care scrutiny committee
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS complaints regulations 2009
- The latest national patient survey
- The latest national staff survey
- The head of internal audit's annual opinion over the trust's control environment dated May 2015

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* and the explanation of the basis of preparation of the 18-week referral-to-treatment incomplete pathway indicator set out on pages 91 and 92, which sets out the approach the trust has taken to patients with "unknown" clock start dates.

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.

Basis for qualified conclusion – 18-week referral-to-treatment indicator

As set out in section 4.4 of the trust's quality report, the trust identified a number of issues in respect of data quality in its 18-week referral-to-treatment (RTT18) reporting during the year. The key issues include cases where incorrect pathway start dates or stop dates are being applied, or where pathway pause rules are being applied incorrectly. While corrective action has been taken by the trust on a number of cases during the year, it is not possible to quantify the impact of the errors on the reported indicator.

We performed substantive procedures on a limited sample of cases which confirmed the variety and nature of issues identified by management. As a result of the issues identified, we have concluded that there are errors in the calculation of the RTT18 incomplete pathway indicator. We are unable to quantify the effect of these errors on the reported indicator for the year ended 31 March 2015.

Qualified conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 2014/15

- 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

Deloitte LLP
Chartered accountants
St Albans
28 May 2015

Core outcomes

Speciality	Metric		Standard	Performance 2014/15
Cataract	Posterior capsular rupture (PCR) rate*	% phaco operations complicated by PCR	<1.8%	1.1%
Cataract	Endophthalmitis after cataract surgery*	% phaco operations with postoperative endo-phalimitis	<0.08%	0.02%
Cataract	Biometry accuracy in cataract surgery	% postoperative refraction +/- 1D of that planned in those undergoing phaco	>85%	91.2%
Cataract	Good vision after cataract surgery	% postoperative corrected visual acuity ≥ 6/12 after phaco	>50%	91.8%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	% failed trabeculectomies at 12 months postop	≤15%	9.6%
Glaucoma	PCR in glaucoma patients	% phaco surgery complicated by PCR in those with glaucoma	<NOD****	1.3%
Glaucoma	Glaucoma tube drainage	% drainage tube failure after one year	<10%	4.8%
Medical retina	Endophthalmitis after injections for macular degeneration*	% suspected infective endophthalmitis after intravitreal Lucentis for wet AMD	<0.05%	0.02%
Medical retina	Visual improvement after injections for macular degeneration	VA improvement: % gaining ≥ 15 letters at 12 months	>20%	26.9%
Medical retina	Visual stability after injections for macular degeneration	VA loss: % losing <15 letters at 12 months	>80%	96.2%
Medical retina	Time from referral to assessment of proliferative diabetic retinopathy*	% patients referred from screening with R3 attending clinic within four weeks	80%	87%
Vitreo-retinal	Success of primary retinal detachment surgery	% cases with attached retina three months after primary RD operation	>75%	83%

Speciality	Metric		Standard	Performance 2014/15
Vitreo-retinal	Success of macular hole surgery	% cases with macular hole closed three months after primary macular hole surgery	>80%	95%
Vitreo-retinal	PCR in cataract surgery in vitrectomised eyes	% phaco surgery complicated by PCR in those with previous vitrectomy	<NOD	3.3%
Neuro-ophthalmology, strabismus and paediatrics	Serious complications of strabismus surgery*	% serious intraop or postop complications in strabismus surgery	<2.2%	0.23%
Neuro-ophthalmology, strabismus and paediatrics	Premature baby eye (ROP) screening compliance*	% adherence to ROP screening guidelines	99%	100%
Neuro-ophthalmology, strabismus and paediatrics	Success of probing for congenital tear duct blockage	% success rate lacrimal probing in young children	>85%	85.7%
External disease	DSAEK corneal graft failure rate	% failure DSAEK graft by one year	≤12%	9% low risk 21% higher risk cases**
External disease	PK corneal graft failure rate	% failure primary PK graft by one year	UKTS*****	11%**
External disease	DALK corneal graft failure rate	% failure DALK graft by one year	UKTS	5%**
Refractive	Accuracy LASIK (laser for refractive error) in short sight*	% +/- 0.5D planned after LASIK in myopia up to -6D	>85%	93.7%
Refractive	Loss of vision after LASIK*	% losing two or more lines of vision after LASIK	<1%	0%
Refractive	Good vision without lenses after LASIK*	% uncorrected visual acuity > 6/12 after LASIK	≥90%	96.1%
Adnexal	Ptosis surgery failure	% patients undergoing primary ptosis procedure requiring further ptosis procedure	<15%	0%
Adnexal	Entropion surgery success	% patients undergoing primary entropion repair who require further procedure in one year	>95%	96.2%
Adnexal	Ectropion surgery success	% patients undergoing primary ectropion repair who require further procedure in one year	>80%	95.2%
A&E	Unplanned re-attendances*	% unplanned adult re-attendance at A&E within seven days	<5%	0.6%

Speciality	Metric		Standard	Performance 2014/15
Trust-wide	Wrong patient*	Number of patients undergoing surgical, laser or injection procedure where wrong patient treated	0	0
Trust-wide	Wrong side*	Number of patients undergoing surgical, laser or injection procedure where wrong side or site treated	0	0***
Trust-wide	Wrong IOL*	Number of patients undergoing cataract surgery where wrong intraocular lens implanted	0	3

*Indicators marked with an asterisk are based on a whole year's data for all relevant cases. Indicators without an asterisk are based on a sample of cases collected over a one- to three-month period during 2014/15.

**For all cases data is from NHS BT national audit data.

***The trust had one patient with local anaesthetic delivered to the wrong eye/site; no harm occurred and immediately following the procedure/surgery was delivered to the correct side.

****NOD = Royal College of Ophthalmologists national ophthalmic dataset.

*****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.

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

Following a planned communication campaign this year our staff participation in 2014/15 increased to 38% compared to 30% the previous year. However, this is still lower than the national average for specialist acute trusts.

Where we are doing well

For another year running we have some very positive messages arising from 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 motivated and enthusiastic about their work
- Our incident reporting processes are fair and effective
- The overall work pressure felt by staff is lower than the national average
- Staff feel satisfied with the quality of work and patient care they are able to deliver
- Communication between senior management and staff is better than the national average

We have seen two areas where there have been significant improvements from previous years: the number of staff experiencing discrimination and the number of individuals who experience bullying, harassment or abuse from patients have both decreased, but they are still higher than our benchmark group.

With all of these positive messages, our level of staff engagement is higher than average and one of the highest across the NHS.

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
- A high proportion of staff feel they have been discriminated against at work

- Staff feel we do not provide equal opportunities for career progression or promotion
- Fewer staff have received equality and diversity training than in our benchmark group
- Fewer staff have received health and safety training than in our benchmark group

Top four ranking scores for 2014/15

2014/15 score		2013/14 score		Trust improvement/ deterioration
Moorfields	National average for acute specialist trusts	Moorfields	National average for acute specialist trusts	
Statement 1: Staff motivation at work				
4.06	3.90	4.05	3.89	Improvement
Statement 2: Fairness and effectiveness of incident reporting				
3.72	3.63	3.70	3.60	Improvement
Statement 3: Work pressure felt by staff				
2.68	2.91	2.64	2.88	Deterioration
Statement 4: Percentage of staff feeling that their role makes a difference to patients				
89%	94%	94%	91%	Deterioration
Statement 5: Percentage of staff reporting good communication between senior management and staff				
44%	37%	41%	34%	Improvement

Bottom four ranking scores 2014/15

2014/15 score		2013/14 score		Trust improvement/ deterioration
Moorfields	National average for acute specialist trusts	Moorfields	National average for acute specialist trusts	
Statement 1: Percentage of staff experiencing discrimination at work in the last 12 months				
14%	9%	18%	9%	Improvement
Statement 2: Percentage of staff experiencing physical violence from staff in the last 12 months				
3%	1%	3%	2%	Unchanged
Statement 3: Percentage of staff believing the trust provides equal opportunities for career progression or promotion				
82%	90%	83%	90%	Deterioration
Statement 4: Percentage of staff receiving equality and diversity training in the last 12 months				
46%	68%	49%	65%	Deterioration
Statement 5: Percentage of staff receiving health and safety training in the last 12 months				
63%	78%	68%	78%	Deterioration

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 2015)
- Start to embed "We Make Moorfields" – our living values and behaviours. We will do this with directorate management teams, and set action plans which demonstrate how the behavioural framework can be used to address issues within their own areas. These should draw on ways to understand and prevent staff being bullied, harassed, abused or discriminated against
- Report on progress through the established Moorfields Way steering group, management executive and quarterly reports to the board
- Review how we use the quarterly friends and family test for staff surveys to assess changes in staff experience

Appendix 3

Sustainability report

1 Introduction

NHS organisations are required by the Department of Health to report on sustainability performance as part of their annual report. However, 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, and therefore has produced the following report using guidance provided by the Department for Energy and Climate Change (DECC) and the NHS Sustainable Development Unit.

2 Summary of performance

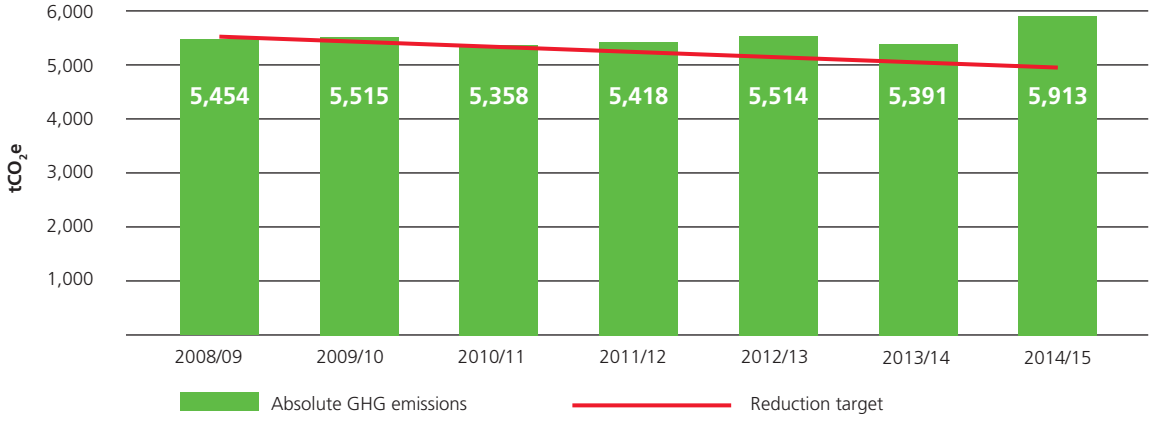
At present our primary focus is to reduce energy consumption, improve asset efficiency and meet all statutory requirements such as the carbon reduction commitment (CRC). Measures to improve energy efficiency over the last financial year include the rollout of LED lighting, installation of a new chiller, building management system optimisation and the installation of voltage optimisation units.

Moorfields is currently reviewing its performance against the Good Corporate Citizenship assessment tool and will incorporate the outcome of this review into its updated sustainable development management plan.

3 Greenhouse gas emissions

Moorfields has a target to reduce carbon emissions by 10% (to 4,909 tCO_2) by March 2015 from a 2008/2009 baseline level of 5,454 tCO_2. We follow the methodology as set out in 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 (tCO_2e)



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

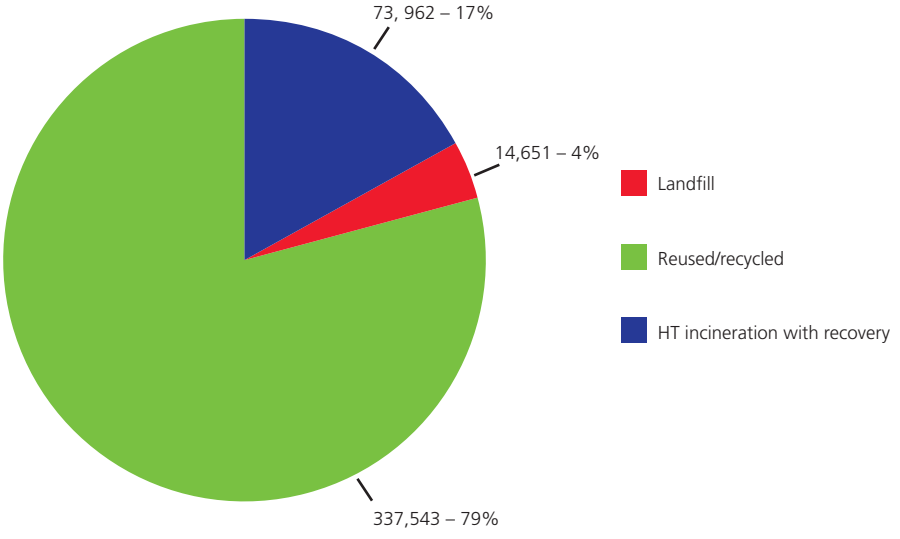
We do not currently measure emissions resulting from transport or waste as the appropriate monitoring systems are not in place. However the trust is implementing measures for this to be established in future years.

The total carbon emissions for the trust from April 2014 to March 2015 were 5,913 tCO_2 compared with the baseline year of 5,454 tCO_2 – an increase of 459 tCO_2 (or 8.4%). This increase is the result of issues with the combined heat and power (CHP) system during the year which has increased the trust's use of relatively carbon intensive grid electricity. As stated in the summary of performance a number of energy efficiency measures have been implemented during the last two months of the 2014/15 financial year. These are expected to deliver reductions in the trust's carbon footprint over 2015/16 to mitigate this increase.

4 Waste

The 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 2014/15 has been provided below.

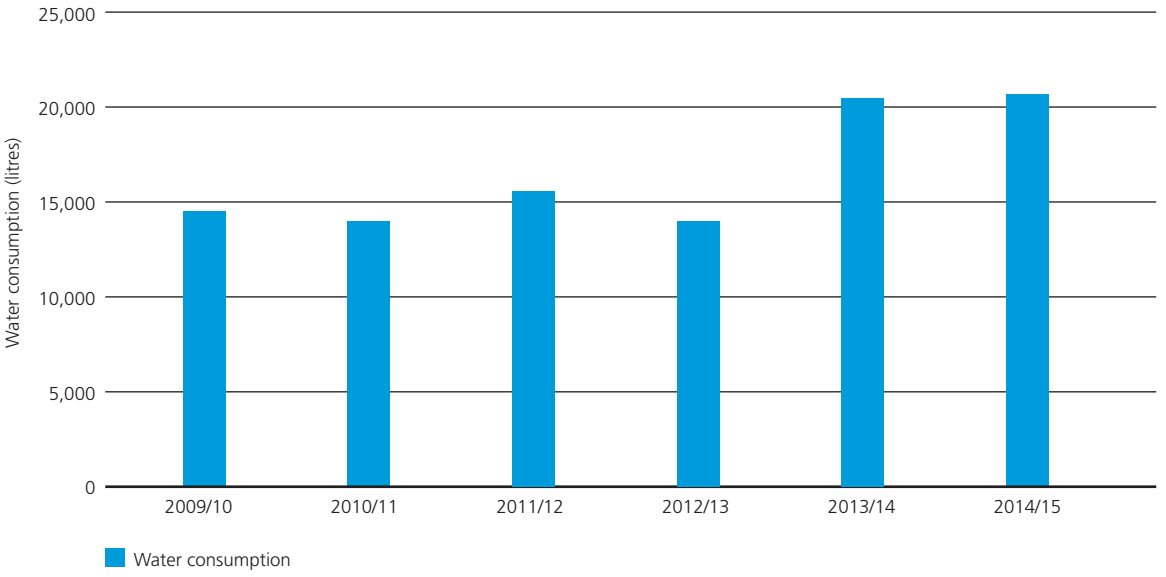


5 Use of finite resources – water

Water consumption has increased by 29% over the last five years. This is primarily due to increased patient activity numbers which have increased by 29% between 2008/09 and 2013/14.

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



6 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.

7 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 compliance requirements, we are undertaking an external audit of our carbon reduction commitment participation.

8 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 has several ambitions in relation to equality, diversity and inclusion:

- To have the confidence and respect of our patients, the community, our staff and partners
- To provide high-quality ophthalmic services, including promotion of better eye care and the prevention of eye problems, that meet the needs of different communities
- To enhance our patients' quality of life through a more holistic approach to their physical and emotional needs
- To have equality, diversity, inclusion and dignity embedded in its culture
- To work 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
- To recruit, support and retain 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 meet the needs of different communities and have 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 through the publication of an annual equality report – *Focus on Inclusion* – in line with the requirements of the public sector equality duty. This duty supports organisations carrying out public functions to consider the needs of those who use services in shaping policy and the provision of services, in relation to their own employees and in relation to local communities. Focus on Inclusion also includes a range of equality information and analysis, including break-downs of patients, job applicants, new recruits and workforce by age, gender and ethnicity.

Our fourth *Focus on Inclusion* was published in January 2015 and covers progress during the previous 12 months, which includes much of 2014/15 financial year.

Highlights include:

- Capturing more data both about patient experience and about our workforce to help us to work in a more meaningful way; the introduction of a new HR and payroll system, known as Route 66, during 2013/14 has been especially helpful in this regard as we are now able to collect data consistent with our national reporting requirements

- Supporting 37 staff to participate in new development programmes provided by the NHS Leadership Academy, and developing a new module for our managers' induction session about understanding unconscious bias
- Launching the Moorfields Way project and engaging with a wide range of patients and staff to understand what it is like to work and receive treatment at Moorfields (see section 2.3.9 for more details on the Moorfields Way)
- Continued selection of and training for staff contact officers, who work as a confidential support network for colleagues who have worries or concerns arising at work
- Reviewing our data around certification of vision impairment (CVI) to provide us with richer information about patients at Moorfields who are CVI registered to inform how we might develop services in future

The report from this 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 good progress against the objectives.

A full copy of *Focus on Inclusion* and our equality and diversity objectives are available on our website at www.moorfields.nhs.uk/equality.

Appendix 5

Annual accounts 2014/15

1 Foreword to the accounts

The accounts for the year ended 31 March 2015 have been prepared by Moorfields Eye Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of The National Health Service Act 2006.

John Pelly, chief executive
28 May 2015

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
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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
28 May 2015

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, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically, and that 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 to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Moorfields Eye Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Moorfields Eye Hospital NHS Foundation Trust for the year ended 31 March 2015, and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board of directors is responsible for ensuring that a system of internal controls is in place. As accounting officer I have overall accountability for risk management in the trust – I chair the trust management board and the management executive through which executive responsibility for risk management is exercised. The control of risk is embedded within the roles of executive directors and managerial staff within the organisation.

The risk strategy of the organisation is to maintain systematic and effective arrangements for recognising and managing risks to an acceptable level. The director of corporate governance has responsibility for the design, development and maintenance of operational risk systems, policies and process, with the day-to-day working of the risk systems being managed through the trust's operational teams. The director of corporate governance chairs the risk and safety committee which provides additional support to ensure that risk management processes are working effectively. The committee reviews themes and trends in risk and incident management, and shares and encourages best practice across the trust's network. The committee also has a role in ensuring policies are kept up to date and compliance is maintained.

Staff are required to maintain mandatory training in a number of areas, some directly relating to risk management, others indirectly. Examples of mandatory training related to risk management are child protection, safeguarding adults, fire, general health and safety, incident reporting for managers, infection control and risk and safety management. Different roles and responsibilities have associated 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 trust's risk and safety team hold specific masterclass sessions for senior managers to support risk management.

The trust continues to build upon the board assurance framework (BAF). The BAF is integrated with the trust's corporate risk register and together they detail the principal risks to the organisation, including the risks of not achieving aspects of the trust's strategy and how those risks are being mitigated. The BAF and corporate risk register have been reviewed during the year by the management executive and the board.

The risk and control framework

The trust has a risk management strategy and policy, and this document is currently being reviewed to ensure that it remains relevant and fit for purpose. Levels of accountability and responsibility for risk are set out within this document. The trust has risk management systems in place for recording, evaluating, monitoring and controlling risks. The systems are consistently applied across all operational areas. The management of risks is embedded in management roles at all staff levels, and primary control for risk management takes place through directorates, departments and frontline teams. Directorate dashboards are available for monitoring all types of performance activity, both clinical and non-clinical. Specific dashboards to monitor quality and safety performance are in development, and will be used across directorates, departments and locations. The organisation continues to have a low risk appetite in relation to patient care and treatment, and aims to minimise avoidable risk – this approach is built into all our risk systems. Being safe and minimising risk also form part of the core values of the trust. These were revised during 2014/15 through the Moorfields Way initiative (discussed elsewhere in the annual report), which was informed by the views of staff and patients.

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. Although this was more than three years ago, the organisation continues to benefit from the high baseline that this achieved which raised the standard of the trust's policies and also generated fresh impetus into the trust's risk management processes. The trust's policies are readily accessible to all staff through the intranet. The new processes introduced through preparation for the NHSLA assessment have been embedded in the organisation and continue to be developed.

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 operational level to the trust board. Oversight and scrutiny of these governance arrangements is provided by the quality and safety committee – a committee of the board. These quality systems are described in the annual quality report which forms part of the annual report.

The trust has several quality systems which have evolved over the past few years, and these work in combination to provide a wide range of internal challenge and assurance across the organisation. A programme of risk and safety assessments has been in place for several years led by the risk and safety department. In certain areas where this has matured sufficiently, self-assessments take place. A programme of patient safety data reviews also takes place. These reviews consider data and information about patient safety, including trends and the need for remedial action. Patient safety walkabouts also take place which involve the quality and safety team visiting the trust's network of sites, where data and information about frontline activity is reviewed and staff have an opportunity to discuss issues with the team. The trust also undertakes a programme of Care Quality Commission (CQC) style walkabouts. These involve peer-review inspections of trust locations which are based on a similar method to that used by the CQC, and also involve board members, governors and the trust's commissioners. These walkabouts faciliate ongoing compliance with the CQC's essential standards and registration requirements, and also help staff prepare for forthcoming CQC inspections. Information gathering and data analysis will be prioritised in 2015/16 as the organisation is expecting a new style CQC inspection.This will provide an opportunity to continue to embed quality and safety standards

across the trust. It should be noted that the organisation is fully compliant with the registration requirements of the CQC.

Quality and safety performance is monitored through a range of quality reports that are provided for the trust management board and the trust board. These reports are structured around the three internationally recognised themes of patient experience, patient safety and clinical effectiveness.

The trust's corporate risk register includes the organisation's high level risks. The key risks for 2015/16 are set out in the trust's operational plan and a summary is included below:

Quality and safety risks

Risk	Mitigation
Failure to meet or exceed minimum mandatory training standards in some areas leading to possible deficiencies in patient care and governance	Implementation of a new learning management system, replacing several legacy systems and separate databases has brought greater visibility and focus in this area. Alert emails to staff and escalation alerts to managers are resulting in significantly increased levels of attendance at training.
Serious clinical incident(s) occur which could impact on the trust's reputation, compliance with contracts, compliance with regulations etc.	Robust clinical governance arrangements exist. Generally, good clinical procedures and guidelines are in place. Additional steps are being taken to focus on the causes of serious incidents and reduce the risk of them recurring.
Failure to identify and/or address the existence of poor clinical standards.	Generally, good standards and outcomes exist across the whole organisation. Performance against clinical outcome indicators is tracked closely and reviewed by the trust management board.
Failure to address significant patient experience concerns causing patients to choose to be referred elsewhere.	Significant concerns have been expressed by patients for some time about waiting times in clinics and other aspects of customer care. Both of these issues will be addressed by a combination of three corporate priorities for 2015/16: the operational delivery of the transformation programme, implementation of the quality plan and the Moorfields Way.
Failure to have adequate systems in place to ensure good quality data, impacting on the quality of patient care, performance and income.	Individual data sets are subject to different levels of scrutiny; some areas have frequent, detailed audits whereas others are reviewed on an exception basis. The structure of a new data assurance framework has been agreed internally and by the internal auditors. A review of all key data areas is underway. It will take several months to cover all areas, but in the meantime internal audit reviews will help to provide assurance.

Operational risks

Risk	Mitigation
Failure to meet RTT18 performance targets in prescribed timescales could have financial, regulatory and reputational impact.	The trust failed its RTT18 admitted target in 2014/15 (see section 4.3 of the quality report), although full compliance was achieved for all three RTT18 targets for Q4 of 2014/15. Performance against this target remains closely monitored. An action plan has been identified following a review by the intensive support team (IST) and these actions will be taken forward in 2015/16.
Failure to bring City Road main theatres to modern standards could impact on the trust's ability to deliver its surgical activity long term.	A six/eight-month refurbishment programme of the eight City Road theatres commenced in March 2015 and at the time of writing the project is running to time. To support this, some activity takes place at weekends and cataract sessions have been transferred to the Whittington Hospital. Tight infection control monitoring indicates no increased incidence of infection during this period.
Failure or delay in the recruitment of key staff could impact adversely on costs and patient care.	Targeted recruitment plans, particularly international nursing recruitment, are underway. The HR recruitment team has recently been strengthened to help improve recruitment timescales and the HR system (Route 66) is being used more fully to increase the efficiency of the recruitment process.
Failure to maintain high research governance standards.	Substantial work has taken place following an MHRA inspection. Investigators and teams have been trained further in the use of standard operating procedures and GCP. Ongoing management is provided by the research management committee which meets weekly. The research governance committee (high-level oversight) meets bimonthly.
Existing business continuity arrangements for IT could lead to disruption to operations if there was a major IT failure.	Large-scale infrastructure improvements – including a new server room in the Richard Desmond Children's Eye Centre (RDCEC) – have reduced this risk. There is additional work required to strengthen back-up server support at City Road.
The current location of the eye bank in the basement makes it subject to flooding and this could impact substantially on the key service it provides.	Controls have been put in place to deal with recent causes of flooding and the potential for further flooding has been minimised. Plans are underway to relocate the eye bank.
Additional glaucoma patients being lost to follow-up.	Following an extensive clinical review, the number of lost to follow-up patients has been considerably reduced. This work continues and regular updates are produced.

Risk	Mitigation
Important medical information may be missed and continuity of care compromised due to poor tracking of patient notes.	Medical records improvement work has been underway for several months of 2014/15. This is organised through a formal improvement project with a group overseeing the work. The patient tracking KPI has shown some improvement, indicating that more notes are being received by clinics on time. This project will continue for some time and more improvement will follow.

Financial risks

The key financial risks and their mitigations are shown in the following table.

Risk	Description	Mitigation
Changes to tariff structures for CCG and specialist commissioned activity could be detrimental to our financial position.	NHSE have proposed a marginal rate on specialist activity. A decision has yet to be taken on the final tariff structure.	Moorfields 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.	Commercial businesses experience volatility compared with anticipated growth rates with a consequent impact on profitability.	Formal submitted plans only address activities likely to be going ahead. New opportunities are likely to crystallise to some degree. Residual risk is accepted in line with past practice at Moorfields.
Inflation is above expectations.	Inflation is above expectation, leading to pay and non-pay pressures that are not fully funded.	Moorfields has limited contingency reserves (1% of NHS costs) for this eventuality. We would need to seek to generate additional savings and revenues.
Capital costs increase to address service capacity improvements.	Capital cost steps in service capacity improvements turn out to be substantial. A consistent theme at non-City Road locations is that existing and recent additional space is constrained.	Some contingency included in capital planning; reprioritisation of capital expenditure priorities to meet any new arising schemes in the year.
Cash balances could be adversely impacted upon by an array of poor commissioner practices and processes.	Cash balances are hit by continued weak commissioner operational and planning performance.	Moorfields has an additional working capital facility of £6 million; contract negotiations to target higher-base contract values to minimise payment delays.
Broader health system planning changes and political shifts could impact adversely on our operational and financial position.	Moorfields is atypical in its considerable range and scale of commissioners. There is a risk that there will be unforeseen effects from a more general health system approach on Moorfields' operational and financial position.	Engagement, where offered, in the relevant consultation processes.

Risk	Description	Mitigation
Short-term planning cycles do not represent or enable us to illustrate strategic financial performance based on our significant growth opportunities.	Moorfields is committed to change and growth. We have significant growth opportunities and these may involve decisions to invest to grow or improve, weakening historically planned financial performance in the short term. The relatively fixed nature of the planning cycle set out by Monitor therefore represents a risk to a fair interpretation of Moorfields' reported performance.	Discussions with Monitor over flexibility to change planning assumptions, and resulting plans and metrics over time, eg opening a new satellite where care is currently poor would diminish short-term financial results while improving patient care and, potentially, Moorfields' medium-term financial performance. Residual risk: potentially substantial depending on Monitor's attitude.

Governance risks

NHS foundation trust licence condition 4 sets out that foundation trusts, as providers of health care, shall apply good systems of corporate governance. The trust's board governance arrangements are set out in section 3 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 how the organisation is performing, including its governance arrangements. The chairman also aims to have six-monthly reviews with the chairs of the board committees to review the effectiveness of the committee overview and scrutiny arrangements. The board aims to undertake an annual self-assessment of its performance, which includes consideration of the trust's governance arrangements including the board committees. Last year, the trust received the highest rating following an internal audit which assessed the trust's systems for monitoring compliance with its licence conditions. As required by Monitor, the trust will also undertake a formal review of its governance arrangements every three years. 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.

Stakeholder involvement in risk management

The trust's governors are responsible for holding the board to account via the non-executive directors. Governors have considerable opportunity to raise risks; this may occur during membership council meetings or informally through discussions with the executive and non-executive directors. Examples of concerns raised by governors include access to the trust through its telecommunications systems. Considerable work has been undertaken to improve these systems and processes, and access for patients has improved. Governors are also members of the quality and safety committee, which provides an additional opportunity to challenge the work of executives and the board.

Other routes whereby stakeholders can feed in risks or concerns about the organisation include:

Patients and the public

- Patient advice and liaison service (PALS)
- Complaints processes
- Patient focus groups
- The trust's annual general meeting

- The national patient survey programme
- Healthwatch

Staff

- The annual staff survey
- Chief executive's briefing sessions
- Raising concerns through the trust's contact officers
- Raising concerns through the trust's staff governors
- Via the trust's compliance team

Health partners

- Clinical commissioning group (CCG) engagement through clinical quality review group meetings provides a regular forum to raise risks and issues, and to review the corporate risk register with a focus on quality performance
- The London Borough of Islington's health and care scrutiny committee

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. 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 requirements 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 adaptation reporting requirements are complied with.

Information governance

Data security is addressed through the trust's information governance management arrangements, structures and processes. 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. This committee is responsible for overseeing the trust's information governance processes, systems and practices across all the trust's sites. It also provides the management executive with assurance that the trust is compliant with the required standards and is managing its risk appropriately. In turn the management executive provides assurance to the board.

All key areas of the trust are represented on the IGC. The IGC has several sub-groups covering specific areas such as corporate records, information management and IT security. One of the IGC's key responsibilities is to oversee the annual information governance toolkit assessment, which has to be submitted by 31 March each year. For 2014/15 the IG toolkit assessment reported a score of 68% and was graded red. This is one per cent lower than the 69% achieved in 2013/14, which was

however a satisfactory (green) score. The grading of red is because two level 2 requirements were not achieved; one relating to the handling of medical records and the other relating to meeting the required deadlines for subject matter requests. Action plans have been put in place to address both shortcomings. During 2014/15, there were no serious incidents involving personal data.

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, and with reference to the trust's board assurance framework and corporate risk register. The audit committee monitors progress against the internal audit programme and any improvement actions for management that are identified. The management executive, the trust management board and the trust board regularly review the trust's financial position and savings programmes, and further scrutiny is undertaken by the audit committee as required.

In the case of internal audit, there are two main financial reviews. One is financial management (financial controls and processes), which covers financial stewardship, financial systems and their interdependencies with operational systems, cash and working capital management, and the use and understanding of financial targets. The other is financial reporting (scrutiny of finances at an operational level), empowering staff to manage budgets and be held accountable for them, with information and analysis supplied by the board and its committees. The outcomes of the two audits were that significant assurance was received for financial reporting and significant assurance with minor improvement opportunities was received for financial management.

Financial data generated and relied upon by the trust is subject to a number of tests as to its accuracy and the extent to which internal controls can be relied upon. Assurance about these controls is provided by a system of internal audit, as set out above.

The accuracy of clinical coding is subject to an annual audit and this has been reported in section 7 of the quality report. The accuracy of data is subject to scrutiny by the information management group via bimonthly 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 incorporate 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, and the medical director.

The trust management board has had an overview of the trust's quality priorities during the year, which fall into 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 governors of the membership council, 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 quality report was agreed by the trust board on 26 May 2015.

The quality priorities for 2015/16 are consistent with the trust's strategic priorities. A number of stakeholders have been consulted during the development of the quality priorities, including clinicians, governors, commissioners, the quality and safety committee, Healthwatch and Islington's health and care scrutiny committee. Priorities for quality have also been included in the trust's operational plan.

The trust has a data quality assurance framework which includes the trust's key indicators and those that are included in the quality report. There has been a particular focus this year in relation to the quality of data for 18-week referral-to-treatment times (RTT18) and this is described in detail in sections 4.3 and 4.4 of the quality report.

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 result of my review of the effectiveness of the system of internal control by the board and the audit 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 internal controls within the organisation, particularly the clinical governance, risk and safety and information governance committees
- Internal financial controls are implemented through finance systems, automated processes, and manual processes, and are governed by the standing financial instructions. The effectiveness of internal controls are reported through the audit committee

Conclusion

To conclude, there are no significant control issues identified, but areas where improvements are in progress, particularly in relation to RTT18 are explained in the report.

The opinion of the head of internal audit is that substantial assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the trust's objectives, and controls are generally being applied consistently.

The basis for forming that opinion is:

- An assessment of the design and operation of the underpinning assurance framework and supporting processes
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas

John Pelly, chief executive
28 May 2015

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

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of the group and trust's affairs as at 31 March 2015, and of the group's and trust's income and expenditure for the year then ended
- Have been properly prepared in accordance with the accounting policies directed by Monitor – independent regulator of NHS foundation trusts
- Have been prepared in accordance with the requirements of the National Health Service Act 2006

The financial statements comprise the consolidated statement of comprehensive income, the consolidated statement of financial position, the consolidated statement of cash flow, the consolidated statement of changes in taxpayers' equity and the related notes 1 to 22. 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.

Qualified 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 except that we have qualified our conclusion on the quality report.

Going concern

We have reviewed the accounting officer's statement on page 138 that the group is a going concern. We confirm that:

- We have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate
- We have not identified any material uncertainties that may cast significant doubt on the group's ability to continue as a going concern

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the group's ability to continue as a going concern.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Risk	How the scope of our audit responded to the risk
NHS revenue and provisions Total income from activities in 2014/15 was £167.9 million, as detailed in note 2 of the financial statements. NHS debtors as at 2014/15 is £20.5 million as detailed in note 10.1. There are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: ■ The complexity of the payment by results regime, in particular in determining the level of overperformance and commissioning for quality and innovation revenue to recognise ■ The judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4 The settlement of income from clinical commissioning groups (CCGs) continues to present challenges, leading to disputes and delays in the agreement of year-end positions such as overperformance for quarters 3 and 4.	We evaluated the design and implementation of controls over recognition of payment by results income. We performed detailed substantive testing of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. Where there were differences on the agreement of balance, we obtained an understanding of why and followed up with additional support. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners, and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Property valuations The group holds property assets within property, plant and equipment at a modern equivalent use valuation. The net book value of the land and buildings as at 2014/15 was £78.8 million, as detailed in note 8.1 of the financial statements. The valuations are by nature significant estimates which are based on specialist and management assumptions, and which can be subject to material changes in value.	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the trust to the valuer. We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the trust's properties. We assessed whether the valuation and the accounting treatment of the impairments were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in operating expenditure.

The description of risks above should be read in conjunction with the significant issues considered by the audit committee discussed on pages 53 and 54.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the group to be £1.9 million, which is below 1% of revenue and below 2% of equity.

We agreed with the audit committee that we would report to the committee all audit differences in excess of £99,570, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the audit committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the group and its environment, including group-wide controls, and assessing the risks of material misstatement at the group level.

The focus of our audit work was on the trust, with work performed at the trust's head offices in Old Street directly by the audit engagement team, led by the audit partner.

The transactions entered into by trust's subsidiary, MEH Ventures LLP, have been consolidated into the trust's accounts and is structured as a single reporting unit so the whole trust was subject to the same audit scope.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

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
- 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

Annual governance statement, use of resources and compilation of financial statements

Under the audit code for NHS foundation trusts, we are required 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 is inconsistent with information of which we are aware from our audit
- The NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources
- Proper practices have not been observed in the compilation of the financial statements

We have nothing to report in respect of these matters.

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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- Materially inconsistent with the information in the audited financial statements
- Apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit
- Otherwise misleading

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable, and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor

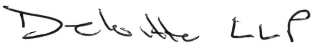
As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements, and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements 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. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the board of governors and goard 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.

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 group's and 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.



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

28 May 2015

5 Statement of comprehensive income

	Note	2015 SOCI before Impairments £'000s	2015 Impairments £'000s	2015 SOCI after Impairments £'000s	2014 SOCI before Impairments £'000s	2014 Impairments £'000s	2014 SOCI after Impairments £'000s
Income from activities	2, 3.1–3.2	**167,889**	–	167,889	**144,336**	–	144,336
Other operating income	2, 3.3	**30,071**	–	30,071	**29,529**	–	29,529
Total income		**197,960**	–	197,960	**173,865**	–	173,865
Operating expenses	4–5	**(191,511)**	(35,067)	(226,578)	**(162,518)**	–	(162,518)
OPERATING (DEFICIT)/SURPLUS		**6,449**	(35,067)	(28,618)	**11,347**	–	11,347
Finance income	6.1	**52**	–	52	**46**	–	46
Finance expense – financial liabilities	6.2	**(533)**	–	(533)	**(164)**	–	(164)
Finance expense – unwinding of discount on provisions	12	**(3)**	–	(3)	**(4)**	–	(4)
Public dividend capital dividends paid	18	**(1,565)**	–	(1,565)	**(1,942)**	–	(1,942)
(DEFICIT) SURPLUS FOR THE YEAR		**4,400**	(35,067)	(30,667)	**9,283**	–	9,283
Other comprehensive income (not reclassified to income and expenditure)							
Revaluation gains/ (losses) on property, plant and equipment	13	**840**	–	840	**2,726**	–	2,726
TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR		**5,240**	(35,067)	(29,827)	**12,008**	–	12,008

All income and expenditure is derived from continuing operations.

Notes 1 to 22 form part of these accounts.

6 Statement of financial position

	Note	31 March 2015 £'000s	1 April 2014 £'000s
NON-CURRENT ASSETS			
Intangible assets	7	**5,020**	2,840
Property, plant and equipment	8	**92,630**	79,506
Investment in associates and joint arrangements		**273**	–
TOTAL NON-CURRENT ASSETS		**97,922**	82,346
CURRENT ASSETS			
Inventories	9	**3,422**	3,508
Trade and other receivables	10	**23,955**	16,291
Cash and cash equivalents		**19,799**	24,287
TOTAL CURRENT ASSETS		**47,176**	44,086
CURRENT LIABILITIES			
Trade and other liabilities	11	**(32,288)**	(30,050)
Borrowings	11	**(1,823)**	**–**
Provisions for liabilities	12	**(2,569)**	(2,113)
TOTAL CURRENT LIABILITIES		**(36,680)**	(32,162)
TOTAL ASSETS LESS CURRENT LIABILITIES		**108,418**	94,269
NON-CURRENT LIABILITIES			
Trade and other liabilities	11	**(563)**	(451)
Borrowings	11	**(42,847)**	–
Provisions for liabilities	12	**(109)**	(131)
TOTAL NON-CURRENT LIABILITIES		**(43,519)**	(581)
TOTAL ASSETS EMPLOYED		**64,900**	93,687
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	16	**33,070**	32,029
Revaluation reserve	13	**4,618**	6,271
Income and expenditure reserve	13	**27,213**	55,387
TOTAL TAXPAYERS' EQUITY		**64,900**	93,687

The financial statements on pages 154 to 194 were approved by the board and signed on their behalf by:

John Pelly, chief executive
28 May 2015

7 Statement of changes in taxpayers' equity

	Public dividend capital £'000s	Revaluation reserve £'000s	Income and expenditure reserve £'000s	Total £'000s
At 1 April 2014	**32,029**	**6,271**	**55,387**	**93,687**
Surplus for year	–	–	(30,667)	(30,667)
Revaluation losses on property, plant and equipment	–	(2,494)	2,494	–
Other transfers between reserves	–	840	–	840
Public dividend capital received	1,041	–	–	1,041
At 31 March 2015	**33,070**	**4,617**	**27,213**	**64,900**

	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 gains 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**

8 Statement of cash flows

	2015 £'000s	2014 £'000s
Operating (deficit)/surplus	**(28,619)**	**11,347**
Non-cash income and expense:		
Depreciation and amortisation	7,514	6,098
Impairments	35,068	–
Loss on disposal of fixed assets	351	159
(Increase) in trade and other receivables	(7,489)	(3,517)
Decrease /(Increase) in inventories	86	(303)
(Decrease)/Increase in trade and other payables	(109)	2,526
Increase in other liabilities	1,241	455
Increase in provisions	431	1,481
NET CASH GENERATED FROM OPERATIONS	**8,474**	**18,246**
Cash flows from investing activities		
Interest received	52	46
Purchase of intangible assets	(3,388)	(1,222)
Purchase of property, plant and equipment	(52,740)	(7,760)
Sale of property, plant and equipment	–	163
Acquisition of business unit	(273)	–
Net cash used in investing activities	**(56,349)**	**(8,772)**
Cash flows from financing activities		
Public dividend capital received	1,041	750
Loans received	45,500	–
Loans repaid	(830)	(4,771)
Interest paid	(485)	(165)
PDC dividend paid	(1,838)	(1,611)
Net cash used in financing activities	**43,388**	**(5,796)**
(DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	**(4,487)**	**3,677**
Cash and cash equivalents at 1 April	**24,287**	**20,609**
Cash and cash equivalents at 31 March	**19,799**	**24,287**

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 Trust 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 2014/15 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 FReM, 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 and 2014/15 were at a level which were considered to be immaterial for the purposes of consolidation into the trust's accounts, therefore no separate disclosures 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 will be the actual length of stay as at the accounting date.

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 – eg 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 were carried out on properties at 162 City Road, the Richard Desmond Children's Eye Centre (RDCEC), the pharmacy manufacturing unit and Northwick Park, and a full valuation was carried out on Kemp House, a property adjacent to the main hospital site on City Road, acquired during 2014/15. These valuations were carried out during the year ended 31 March 2015 with an effective date of 1 April 2015. 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, and in a manner consistent with the consumption of economic or service delivery benefits.

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. Leasehold assets 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, except in cases where to do so would materially and detrimentally affect the presentation and interpretation of the accounts. Such cases are regarded as exceptional, and implemented in conjunction with independent advice and other relevant bodies as necessary.

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 arise from a clear consumption 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 clear consumption 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.

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"
  - 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 which is integral to the operation of hardware – eg an operating system – is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware – eg 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.

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, ie 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 recorded as 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 costs, 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, eg 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
- 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% (2013/14: 1.8%) 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 12 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 2015 or for reported prior years.

1.15 Pension liabilities

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 will determine contribution rates from 1 April 2015 onwards, covered the period from 1 April 2004 to 31 March 2012.

The conclusion from the 2012 valuation was that the scheme had accumulated a notional deficit of £10.3 billion against the notional assets as at 31 March 2012. 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. From 1 April 2014, employees' contributions are on a tiered scale from 5% to 14.5% 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 2014.

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 and those which will take effect in April 2015, 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 operations in the United Arab Emirates (Dubai and Abu Dhabi). The functional currency of operations in Dubai and Abu Dhabi 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
- 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 all other assets and liabilities, including on revaluation, are recognised as a movement in net assets.

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) average daily 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

Project Diamond income

The trust has historically received additional funding from the Department of Health to compensate the trust for the additional complexity of its case mix, which was not compensated through current tariff arrangements under arrangements across specialist trusts known as "Project Diamond". The responsibility for payment transferred to NHS England this year and the amounts payable have been under negotiation through the year, with a final settlement agreed of £2.4 million for 2014/15 alongside contract negotiations for 2015/16. The agreement reached

represents the final tranche of Project Diamond funding, with no amounts payable for 2015/16. The trust has specified that if further funding becomes available in 2015/16 it will be entitled to it fair share of such income. The trust anticipates that the introduction in 2016/17 of tariffs based on a more sophisticated coding methodology that recognises more fully the cost of highly specialist services will compensate for this loss of funding.

The trust has had to evaluate whether any element of the funding received for 2014/15 should be deferred to 2015/16, and has concluded that it is appropriate to recognise in 2014/15 in line with the agreements with its commissioners.

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 13 Fair value measurement	May 2011	Adoption delayed by HM Treasury. To be adopted from 2015/16
IFRS 15 Revenue from contracts with customers	May 2014	Not yet EU adopted. Expected to be effective from 2017/18
IFRS 9 Financial instruments	July 2014	Not yet EU adopted. Expected to be effective from 2018/19
IFRS 36 (amendment) – recoverable amount disclosures	May 2013	To be adopted from 2015/16 (aligned to IFRS 13 adoption)
Annual improvements 2012	December 2013	Effective from 2015/16 but not yet EU adopted
Annual improvements 2013	December 2013	Effective from 2015/16 but not yet EU adopted
IAS 19 (amendment) – employer contributions to defined benefit pension scheme	November 2013	Effective from 2015/16 but not yet EU adopted
IFRIC 21 Levies	May 2013	EU adopted in June 2014 but not yet adopted by HM Treasury

(*) 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 UAE, Moorfields Pharmaceuticals, and NHS activity.

2014/15	NHS (1) £'000s	Moorfields Private £'000s	Moorfields UAE (2) £'000s	Moorfields Pharmaceuticals (3) £'000s	Intra-trust elimination £'000s	Total £'000s
Income by segment						
Income from activities	146,638	15,205	6,046	307	(307)	**167,889**
Other operating income	25,651	–	–	4,420	–	**30,071**
	172,289	15,205	6,046	4,727	(307)	**197,960**
Operating and other expenditure	(162,943)	(10,936)	(6,852)	(13,137)	307	**(193,560)**
Impairment of non-current assets	(28,088)	–	–	(6,979)	–	**(35,066)**
Surplus for the year	**(18,742)**	**4,269**	**(806)**	**(15,389)**	**–**	**(30,667)**

2013/14	NHS (1) £'000s	Moorfields Private £'000s	Moorfields UAE (2) £'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**

(1) NHS income includes non-recurrent items of £8.1 million and the underlying surplus (excluding impairments) was £1.2 million.

(2) Moorfields UAE 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. The net assets of Moorfields UAE are restated on a monthly basis for exchange rate fluctuations, with movements expressed as unrealised gains or losses as appropriate. Moorfields UAE includes the operations of Moorfields Dubai, and the pre-operational costs of Moorfields Eye Centre Abu Dhabi.

(3) Operating and other expenditure for Moorfields Pharmaceuticals includes £2.1 million one-off provisions for restructuring the business.

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

	2014/15 £'000s	2013/14 £'000s
Elective income	**34,133**	29,170
Non-elective income	**5,287**	5,375
Outpatient income	**58,416**	51,890
A&E income	**8,951**	8,283
Total income at tariff	**106,788**	94,718
Non-tariff NHS income	**39,850**	28,284
Private patient income	**21,251**	21,334
	167,889	144,336

3.2 Income from activities by source

	2014/15 £'000s	2013/14 £'000s
NHS foundation trusts	**267**	228
NHS trusts	**8,450**	8,378
Clinical commissioning groups (from 1 April 2013)	**122,591**	99,156
NHS England (from 1 April 2013)	**15,699**	13,527
NHS other	**118**	–
Non NHS:		
– Total private patients activity	**21,251**	21,334
– Overseas patients (non-reciprocal)*	**174**	263
– Other	**(661)**	1,450
	167,889	144,336

* Income from non-reciprocal overseas visitors in 2014/15 was £174,000 (2013/14: £263,000).

Cash payments received in 2014/15 were £124,000 (2013/14: £242,000).

Amounts written off in 2014/15 were nil (2013/14: nil), with no impact on the provision for impaired receivables (2013/14: nil).

3.3 Other operating income

	2014/15 £'000s	2013/14 £'000s
Research and development	**9,992**	9,373
Education and training	**3,994**	3,789
Charitable and other contributions to expenditure	**1,521**	746
Pharmaceutical drugs sales	**3,267**	9,497
Other income	**11,297**	6,122
	30,071	29,529

3.4 Income from the provision of goods and services

	2014/15 £'000s	2013/14 £'000s
NHS income	**159,591**	143,737
Non-NHS income	**26,039**	25,229
Income from the provision of goods and services	**185,630**	168,967
Other income	**12,329**	4,898
Total income	**197,960**	173,865
Ratio of "non-NHS income" to "income from the provision of goods and services"	**14.03%**	14.93%

Private patient income is equal to the aggregate of services delivered to private patients through Private Patients, 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 2013/14 and 2014/15.

3.5 Income from commissioner-requested services

	2014/15 £'000s	2013/14 £'000s
Commissioner-requested services	**146,638**	123,002
Other services	**51,322**	50,864
	197,960	173,865

4 Operating expenses

4.1 Operating expenses comprise:

	2014/15 £'000s	2013/14 £'000s
Services from NHS foundation trusts	**628**	258
Services from NHS trusts	**2,832**	3,111
Services from other NHS bodies	**105**	–
Purchase of healthcare from non-NHS bodies	**943**	792
Employee expenses – executive directors	**1,099**	1,153
Employee expenses – non-executive directors	**133**	122
Employee expenses – staff	**105,825**	89,410
Drug costs	**22,475**	16,996
Supplies and services – clinical (excluding drug costs)	**17,368**	13,630
Supplies and services – general	**861**	814
Establishment	**5,431**	4,383
Transport	**2,464**	2,569
Premises	**14,219**	13,876
Lease rental	**3,466**	2,967
Increase in bad debt provision	**(98)**	(38)
Depreciation on property, plant and equipment	**6,457**	5,537
Amortisation on intangible assets	**1,057**	561
Impairments of property, plant and equipment	**34,924**	–
Impairments of intangible assets	**144**	–
Auditors'remuneration – statutory audit	**86**	73
Auditors'remuneration – taxation	**55**	26
Clinical negligence insurance premium	**152**	159
Legal fees	**445**	372
Training, courses and conferences	**658**	564
Insurance	**321**	450
Other	**4,529**	4,728
	226,578	162,518

4.2 Operating lease rentals

4.2.1 Operating expenses include:

	2014/15 £'000s	2013/14 £'000s
Other operating lease rentals	**3,466**	2,967
	3,466	2,967

4.2.2 Total future lease payments:

	2014/15 £'000s	2013/14 £'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	**3,563**	2,967
Between one and five years	**4,348**	3,476
After five years	**1,899**	2,397
	9,810	8,840

4.3 Salary and pension entitlements of the board of directors

(a) Remuneration – 2014/15

2014/15 Name and title	Executive salary (bands of £5,000) £'000s	Clinical/research salary (bands of £5,000) £'000s	Pension-related benefits (bands of £2,500) £'000s (6)	Total entitlement £'000s
Mr J Pelly – chief executive	165 – 170	–	30.0 – 32.5	195 – 200
Mr C Nall – chief financial officer	130 – 135	–	22.5 – 25.0	155 – 160
Mr D Flanagan – medical director	100 – 105	40 – 45	–	145 – 150
Prof Sir P Khaw – research director	30 – 35	185 – 190	–	215 – 220
Ms T Luckett – director of nursing and allied health professions	90 – 95	–	17.5 – 20.0	110 – 115
Ms M Sherry – chief operating officer	120 – 125	–	37.5 – 40.0	160 – 165
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 [5]	20 – 25	–	–	20 – 25
Mr A Nebel – non-executive director	15 – 20	–	–	15 – 20

2014/15 Name and title	Executive salary (bands of £5,000) £'000s	Clinical/research salary (bands of £5,000) £'000s	Pension-related benefits (bands of £2,500) £'000s (6)	Total entitlement £'000s
Mr S Williams – non-executive director	10 –15	–	–	10 – 15
Ms S Sinha – non-executive director	10 – 15	–	–	10 – 15

Remuneration – 2013/14

2013/14 Name and title	Executive salary (bands of £5,000) £'000s	Clinical/research salary (bands of £5,000) £'000s	Pension-related benefits (bands of £2,500) £'000s (6)	Total entitlement £'000s
Mr J Pelly – chief executive	160 – 165	–	42.5 – 45.0	200 – 205
Mr C Nall – chief financial officer	125 – 130	–	32.5 – 35.0	160 – 165
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	–	30.0 – 32.5	120 – 125
Ms R Russell – chief operating officer(1)	35 – 40	–	–	35 – 40
Ms M Sherry – chief operating officer(4)	55 – 60	–	45.0 – 47.5	100 – 105
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 (3)	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 2013/14 and 2014/15, and requested that this be donated for use within charities linked to Moorfields Eye Hospital, and the remainder for use within Moorfields Eye Hospital itself.

(3) Ms S Sinha was appointed as a non-executive director with effect from 22 April 2013.

(4) Ms M Sherry was appointed as chief operating officer with effect from 7 October 2013.

(5) Sir R Jackling retired as a non-executive director with effect from 31 March 2015.

(6) Pension-related benefits represent the "real increase in year in the value of accrued pension" as reported in note 4.3b less employee contributions.

(b) Pension benefits

Name and title	Value of accrued pension at 31 March 2014 (bands of £5,000) £'000s	Value of accrued pension at 31 March 2015 (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	45 – 50	55.0 – 57.5
Mr C Nall – chief financial officer	5 – 10	10 – 15	42.5 – 45.0
Ms T Luckett – director of nursing and allied health professions	25 – 30	30 – 35	30.0 – 32.5
Ms M Sherry – chief operating officer	30 – 35	35 – 40	55.0 – 57.5

Name and title	Value of automatic lump sums at 31 March 2014 (bands of £5,000) £'000s	Value of automatic lump sums at 31 March 2015 (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	130 – 135	140 – 145	5.0 – 7.5
Mr C Nall – chief financial officer	Nil	Nil	Nil
Ms T Luckett – director of nursing and allied health professions	85 – 90	95 – 100	2.5 – 5.0
Ms M Sherry – chief operating officer	100 – 105	110 – 115	5.0 – 7.5

Name and title	Cash equivalent transfer value at 31 March 2014 (bands of £1,000) £'000s	Cash equivalent transfer value at 31 March 2015 (bands of £1,000) £'000s	Real increase in cash equivalent transfer value in 2014/15 (bands of £1,000) £'000s
Mr J Pelly – chief executive	Nil	Nil	N/A
Mr C Nall – chief financial officer	87 – 88	117 – 118	27 – 28
Ms T Luckett – director of nursing and allied health professions	508 – 509	559 – 560	40 – 41
Ms M Sherry – chief operating officer	762 – 763	858 – 859	79 – 80

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 2014/15 in respect of executive directors was £72,000 (2013/14: £96,000).

4.4 Hutton disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the trust in the financial year 2014/15 was £167,500 (2013/14: £162,500). This was 5.68 times (2013/14: 4.86) the median remuneration of the workforce, which was £29,502 (2013/14: £33,463).

The increase in this ratio arose primarily from a reduction in the median remuneration of the trust's workforce. The trust significantly increased the number of clerical officers and support staff in response to capacity and demand analysis, and ophthalmic technicians supporting qualified nurses.

4.5 Expenses paid to executive directors and governors

Total out-of-pocket expenses paid to governors of the trust in 2014/15 were £4,701 (2013/14: £5,044).

	2014/15	2013/14
Governors receiving expenses	17	16
Number of governors	21	22
Aggregate sum paid (£)	4,701	5,044
Average sum paid (£)	277	315

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 UAE. 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 2014/15 were £6,968 (2013/14: £3,538).

	2014/15	2013/14
Directors receiving expenses	6	5
Number of directors	13	13
Aggregate sum paid (£)	6,968	3,538
Average sum paid (£)	1,161	708

Category of expense	2014/15	2013/14
Travel and subsistance	2,596	1,303
Hotel	1,469	2,006
Other	2,903	230
Total paid	**6,968**	**3,538**

5 Employee expenses and costs

5.1 Employee expenses

	Total 2014/15 £'000s	Permanently employed 2014/15 £'000s	Other 2014/15 £'000s	2013/14 £'000s
Salaries and wages	**79,824**	79,824	–	70,978
Social security costs	**6,490**	6,490	–	5,894
Employer contributions to NHSPA	**8,381**	8,381	–	7,635
Termination benefits	**61**	61	–	288
Agency and bank staff	**12,384**	–	12,384	7,006
	107,140	94,756	12,384	91,801

Bank staff are mainly employees of the trust working additional hours at their normal rates of pay.

5.2 Average number of employees

	Total 2014/15 Number	Permanently employed 2014/15 Number	Other 2014/15 Number	2013/14 Number
Medical	**293**	293	–	292
Administration and estates	**666**	666	–	618
Healthcare assistants and other support staff	**107**	107	–	83
Nursing, midwifery and health visiting staff	**381**	381	–	354
Scientific, therapeutic and technical staff	**250**	250	–	236
Agency and bank staff	**294**	–	294	218
Total	**1,990**	1,696	294	1,801

Bank staff are mainly employees of the trust working additional hours at their normal rates of pay.

5.3 Employee benefits

	2014/15 £'000s	2013/14 £'000s
Various employee taxable benefits in kind	**35**	88
	35	88

5.4 Retirements due to ill-health

During 2014/15 there were three early retirement on ill health grounds (2013/14: 1) at a cost of £158,000 (2013/14: £12,000). This information has been supplied by the NHS Pensions Agency.

5.5 Staff sickness absence

	2014/15	2013/14
Total days lost	**11,787**	12,109
Total staff years worked	**1,688**	1,589
Average working days lost (per WTE)	**7.0**	7.6

5.6 Staff exit packages

Exit package cost band	* Number of compulsory redundancies 2014/15 Number	* Cost of compuslory redundancies 2014/15 £'000s	* Number of compulsory redundancies 2013/14 Number	* Cost of compuslory redundancies 2013/14 £'000s
<£10,000	17	86	2	11
£10,001 – £25,000	10	172	–	–
£25,001 – £50,000	20	734	1	44
£50,001 – £100,000	7	445	3	233
£100,001 – £150,000	1	101	–	–
£150,001 – £200,000	1	170	–	–
>£200,000	–	–	–	–
Total	56	1,709	6	288

*All redundancies within 2014/15 and the prior year were compulsory and payments made in accordance with employee terms and conditions.

5.7 Off-payroll engagements

All off-payroll engagements as at 31 March 2015 (for more than £220 per day and that last for longer than six months)	
Total number of existing engagements as at 31 March 2015	28
of which	
Number existing for less than one year as at 31 March 2015	4
Number existing between one and two years as at 31 March 2015	13
Number existing between two and three years as at 31 March 2015	6
Number existing between three and four years as at 31 March 2015	3
Number existing for four or more years as at 31 March 2015	2

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 2014 and 31 March 2015 (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	10
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	10
The number for whom assurance has been requested	10
of which	
The number for whom assurance has been requested and received	10
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 2014 and 31 March 2015	
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	14

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 substantially completed as at 31 March 2015 and the arrangement has been in place since March 2012. The individual does not work solely for Moorfields and the engagement concluded in April 2015.

6 Interest

6.1 Finance income

	2014/15 £'000s	2013/14 £'000s
Interest on loans and receivables	**52**	46
Total	**52**	46

6.2 Finance expense – financial liabilities

	2014/15 £'000s	2013/14 £'000s
Loans from Foundation Trust Financing Facility	**533**	164
Total	**533**	164

7 Intangible assets

	Licences and trademarks £'000s	Information technology (internally generated) expenditure £'000s	Development expenditure £'000s	Total £'000s
Gross cost at 1 April 2014	2,050	1,856	521	4,426
Additions – purchased/internally generated	889	2,499	–	3,388
Impairments charged to operating expenses	(108)	–	(460)	(568)
Disposals	(64)	–	–	(64)
Gross cost at 31 March 2014	**2,767**	**4,355**	**61**	**7,183**
Amortisation at 31 March 2014	799	343	444	1,586
Provided during the year	438	592	27	1,057
Impairments charged to operating expenses	(2)	–	(422)	(424)
Disposals	(56)	–	–	(56)
Accumulated amortisation at 31 March 2015	**1,180**	**935**	**49**	**2,163**
Net book value				
– 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**
– Purchased at 31 March 2015	1,586	3,420	12	5,018
– Donated at 31 March 2015	2	–	–	2
– Total at 31 March 2015	**1,588**	**3,420**	**12**	**5,020**

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 2014	11,850	63,788	30,264	5	12,282	1,445	119,634
Additions purchased	37,518	10,721	3,961	–	444	186	52,829
Additions donated	–	337	871	–	18	–	1,226
Impairments charged to operating expenses	(28,088)	(6,918)	(4,668)	–	(180)	(111)	(39,996)
Gains/(losses) on revaluation	920	(80)	–	–	–	–	840
Disposals	–	–	(2,782)	–	(1,139)	(15)	(3,936)
At 31 March 2015	**22,200**	**67,848**	**27,645**	**5**	**11,424**	**1,505**	**130,627**
Depreciation at 1 April 2014	–	10,056	20,462	5	8,791	815	40,128
Provided during the year	–	2,404	2,873	–	1,023	157	6,457
Impairments charged to operating expenses	–	(1,232)	(3,583)	–	(127)	(101)	(5,043)
Disposals	–	–	(2,429)	–	(1,104)	(12)	(3,545)
Accumulated depreciation at 31 March 2015	**–**	**11,228**	**17,322**	**5**	**8,582**	**859**	**37,997**
– 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**
– Purchased at 31 March 2015	22,200	45,183	8,638	–	2,841	647	79,508
– Finance lease at 31 March 2015	–	–	379	–	–	–	379
– Donated at 31 March 2015	–	11,437	1,306	–	–	–	12,743
Total at 31 March 2015	**22,200**	**56,620**	**10,323**	**–**	**2,841**	**647**	**92,630**

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 2015	21,040	54,780	–	–	–	–	75,820
– Unprotected assets at 31 March 2015	1,160	1,840	10,323	–	2,841	647	16,810
Total at 31 March 2015	**22,200**	**56,620**	**10,323**	**–**	**2,841**	**647**	**92,630**

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

9 Inventories

	31 March 2015 £'000s	31 March 2014 £'000s
Raw materials and consumables	**120**	437
Work in progress	**0**	18
Finished goods	**3,302**	3,052
TOTAL	**3,422**	3,508

The value of inventories recognised in expenses during 2014/15 was £38,275,000 (2013/14: £28,354,000).

10 Receivables

10.1 Trade receivables

	31 March 2015 £'000s	31 March 2014 £'000s
Current:		
NHS debtors	**20,492**	12,765
Provision for irrecoverable debts	**(2,858)**	(3,409)
Other prepayments and accrued income	**2,166**	2,088
PDC receivable	**177**	–
Other debtors	**3,979**	4,847
TOTAL	**23,955**	16,291

10.2 Provision for impaired receivables

	31 March 2015 £'000s	31 March 2014 £'000s
Balance at 1 April	**3,409**	3,652
Increase in provision for debtors impairment	**2,162**	3,045
Debtors written off during year as uncollectable	**(453)**	(205)
Unused provision reversed	**(2,260)**	(3,083)
Balance at 31 March	**2,858**	3,409

10.3 Analysis of impaired debtors

	31 March 2015 £'000s	31 March 2014 £'000s
Ageing of doubtful debtors		
Up to three months	**268**	118
In three to six months	**242**	669
Over six months	**2,348**	2,622
Total	**2,858**	3,409

	31 March 2015 £'000s	31 March 2014 £'000s
Ageing of non-provided debtors past their due date		
Up to three months	**6,617**	2,993
Three to six months	**3,255**	755
Over six months	**3,441**	2,438
Total	**13,313**	6,186

The provision for impaired receivables is determined initially within operating segments, ie NHS, non-NHS, Moorfields Pharmaceuticals, Moorfields Private and Moorfields UAE.

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 Trade and other liabilities

11.1 Trade and other liabilities are made up of:

	31 March 2015 £'000s	31 March 2014 £'000s
Amounts falling due within one year:		
NHS creditors	**3,088**	2,142
Tax and social security costs	**3,164**	2,862
Receipts in advance	**1,126**	4,160
Capital creditors	**1,673**	358
Other creditors	**12,821**	10,463
Accruals	**6,147**	6,940
PDC payable	**–**	96
Deferred income	**4,269**	3,029
Sub total	**32,288**	30,050
Amounts falling due after more than one year:		
Other trade payables	**563**	451
Sub total	**563**	451
TOTAL	**32,851**	30,500

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 39,458 trade invoices were paid during 2014/15 (2013/14: 35,750) at a value of £71.0 million (2013/14: £57.9 million). 38,752 (2013/14: 35,090) of those invoices were paid within the target time at a value of £62.0 million (2013/14: £49.3 million), ie 98.2% volume and 87.4% value respectively (2013/14: 98.2% and 85.1%).

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.

11.2 Borrowings are made up of:

	31 March 2015 £'000s	31 March 2014 £'000s
Amounts falling due within one year:		
Loans	**1,823**	–
	1,823	–
Amounts falling due after more than one year:		
Loans	**42,847**	–
	42,847	–
TOTAL	**44,670**	–

The trust drew down two loans from the Independent Trust Financing Facility during 2014/15 (see note 11.3).

11.3 Loans

	31 March 2015 £'000s	31 March 2014 £'000s
Amounts falling due:		
In one year or less	**1,823**	–
Between one and two years	**1,823**	–
Between two and five years	**5,470**	–
Over five years	**35,554**	–
TOTAL	**44,670**	–
of which:		
– wholly repayable within five years	**9,116**	–
– wholly repayable after five years, by instalments	**35,554**	–
	44,670	–

The trust drew down two loans from the Independent Trust Financing Facility during 2014/15:

- £20.5 million of which £16.5 million drawn down as at 4 August 2014 and £4.0 million drawn down as at 23 March 2015, payable over 25 years at a fixed interest rate of 2.99% per annum. Outstanding capital as at 31 March 2015 was £20.2 million.
- £25.0 million of which £1.3 million drawn down as at 29 September 2014 and £23.8 million drawn down as at 1 December 2014, payable over 25 years at a fixed interest rate of 2.88% per annum. Outstanding capital as at 31 March 2015 was £24.5 million.

12 Provisions for liabilities

	Pensions relating to former directors £'000s	Pensions relating to other staff £'000s	Other £'000s	Total £'000s
At 1 April 2014	65	90	2,089	**2,244**
Arising during the year	–	–	2,144	**2,144**
Utilised during the year	(13)	(12)	(1,069)	**(1,093)**
Unwinding of discount	1	2	–	**3**
Reversed during the year	–	–	(620)	**(620)**
At 31 March 2015	**54**	**80**	**2,544**	**2,678**
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**
Expected timing of cashflows:				
Within one year	13	12	2,544	**2,569**
Between one and five years	41	47	–	**88**
After five years	0	22	–	**22**
At 31 March 2015	**54**	**80**	**2,544**	**2,678**

Pensions provisions relate to pre-1995 pension-related costs on early retirements.

"Other" opening balance 2014/15 refers principally to provisions for staff-related payments and historic taxation.

"Other" closing balance 2014/15 refers principally to provisions costs associated with the restructuring of Moorfields Pharmaceuticals.

£2,266,000 is included in the provisions of the NHS Litigation Authority (NHSLA) at 31 March 2015 in respect of clinical negligence liabilities of the trust (31 March 2014: £3,608,000). 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 premiums paid in 2013/14 (£159,000) compared to 2012/13 (£628,000) and a small reduction to £152,000 in 2014/15.

Note: These provisions are reflected only in the accounts of the NHSLA, and are not a part of the trust's accounts.

13 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 2014	32,029	6,271	55,387	**93,687**
Transfer from the income and expenditure account	–	–	(30,667)	**(30,667)**
Transfer between reserves in relation to impairments	–	(2,394)	2,394	**–**
Revaluation gains on property, plant and equipment	–	840	–	**840**
Public dividend capital issued	1,041	–	–	**1,041**
Other transfers between reserves	–	(100)	100	**–**
At 31 March 2015	**33,070**	**4,618**	**27,213**	**64,900**
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**

14 Analysis of changes in net debt

	At 31 March 2014 £'000s	Cash changes in year £'000s	At 31 March 2015 £'000s
Commercial cash at bank and in hand	3,261	(1,761)	**1,500**
Government Banking Service cash at bank	21,026	(2,727)	**18,299**
Debt due within one year	0	(1,823)	**(1,823)**
Debt due after one year	0	(42,847)	**(42,847)**
	24,287	(49,158)	**(24,871)**

15 Capital commitments

Commitments under capital expenditure contracts as at 31 March 2015 were £1,820,000 (2013/14: £2,350,000).

	2014/15 £'000s	2013/14 £'000s
Authorised	**298**	1,990
Authorised and committed	**1,820**	2,350
	2,118	4,341

16 Movement in public dividend capital

	2014/15 £'000s	2013/14 £'000s
Public dividend capital as at 1 April	**32,029**	31,279
Public dividend capital received	**1,041**	750
Public dividend capital as at 31 March	**33,070**	32,029

Public dividend capital received during 2014/15 was conditional upon it being used for capital expenditure in relation to the trust's internally-developed patient records management system (OpenEyes).

17 Movement in taxpayers' equity

	2014/15 £'000s	2013/14 £'000s
(Deficit)/surplus for the financial year	**(29,102)**	11,225
Public dividend capital dividends payable	**(1,565)**	(1,942)
Public capital received	**1,041**	750
Surplus/(deficit) on revaluations of fixed assets and current asset investments	**840**	2,726
Net (decrease)/increase in taxpayers' equity	**(28,786)**	12,759
Opening taxpayers' equity	**93,687**	80,928
Closing taxpayers' equity	**64,900**	93,687

18 Financial performance

18.1 Public dividend capital dividend

The trust is required to pay a public dividend capital dividend at a rate of 3.5% of average relevant net assets.

In 2014/15 average relevant net assets totalled £44,658,000 (2013/14: £55,492,000) and a dividend of £1,565,000 was calculated (2013/14: £1,942,000).

18.2 Availability of working capital facility

The trust has an approved working capital facility of £6 million (2013/14: £6 million).

19 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.

Certain clinical staff are employed by the trust and also engage in work for Moorfields Private, a commercial division of Moorfields Eye Hospital NHS Foundation Trust. These engagements are undertaken on an arms-length basis separately from their direct employment with the trust.

The Department of Health is regarded as a related party. During the year Moorfields Eye Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent company.

Related party transactions were made on terms equivalent to those that prevail in an arm's-length transaction.

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 £315,379 (2013/14: £199,100) to Moorfields Eye Hospital in income/donations. The Friends also made significant commitments to support the hospital. This is in addition to the work of their team of volunteers.

There was a year-end creditor of £8,565 (2013/14: £2,145). 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 the Special Trustees of Moorfields Eye Hospital was £119,068 (2013/14: £154,503), while debtors were £482,098 (2013/14: £360,912). There was no in-year expenditure or year-end creditor.

Income/donations for the year from Moorfields Eye Charity was £508,505 (2013/14: £445,317), while debtors were £219,868 (2013/14: £187,812). There was no in-year expenditure or year-end creditor.

The table on page 192 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	15,699	0	Patients of NHS body treated by the trust
NHS Croydon CCG	8,954	0	Patients of NHS body treated by the trust
Department of Health	8,467	0	Central funding for a variety of purposes
NHS Ealing CCG	8,287	0	Patients of NHS body treated by the trust
Bedford Hospital NHS Trust	7,782	3,505	Patients of NHS body treated by the trust (income)/costs of operating satellite site at NHS Body (expenditure)
NHS Harrow CCG	7,149	0	Patients of NHS body treated by the trust
NHS Wandsworth CCG	6,460	0	Patients of NHS body treated by the trust
NHS City and Hackney CCG	6,198	0	Patients of NHS body treated by the trust
NHS Islington CCG	4,749	0	Patients of NHS body treated by the trust
NHS Tower Hamlets CCG	4,506	0	Patients of NHS body treated by the trust
NHS Newham CCG	3,958	118	Patients of NHS body treated by the trust
NHS Haringey CCG	3,952	0	Patients of NHS body treated by the trust
NHS Herts Valleys CCG	3,940	0	Patients of NHS body treated by the trust
NHS East & North Hertfordshire CCG	3,866	0	Patients of NHS body treated by the trust
NHS Brent CCG	3,799	0	Patients of NHS body treated by the trust
NHS Barnet CCG	3,746	0	Patients of NHS body treated by the trust
NHS Enfield CCG	3,696	0	Patients of NHS body treated by the trust
NHS Redbridge CCG	3,679	0	Patients of NHS body treated by the trust
NHS Merton CCG	3,616	0	Patients of NHS body treated by the trust
Health Education England	3,585	0	Education, training and personal development of NHS staff
NHS Barking and Dagenham CCG	2,549	0	Patients of NHS body treated by the trust
NHS Havering CCG	2,228	0	Patients of NHS body treated by the trust
NHS Waltham Forest CCG	2,213	0	Patients of NHS body treated by the trust
NHS Camden CCG	2,133	0	Patients of NHS body treated by the trust
NHS Lambeth CCG	1,948	0	Patients of NHS body treated by the trust
NHS Richmond CCG	1,926	0	Patients of NHS body treated by the trust
NHS Greenwich CCG	1,618	0	Patients of NHS body treated by the trust
NHS Hounslow CCG	1,610	0	Patients of NHS body treated by the trust
NHS Bromley CCG	1,567	0	Patients of NHS body treated by the trust
Croydon Health Services NHS Trust	183	2,404	Patients of NHS body treated by the trust
National Insurance Fund	0	6,490	Employer NI contributions
NHS pension scheme	0	8,381	Employer pension contributions

20 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 Independent 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 and Abu Dhabi), 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 changes in net assets 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 taken out at fixed rates for a fixed period, after which outstanding balances will be nil.

20.1 Financial assets by category

	31 March 2015 £'000s	31 March 2014 £'000s
Trade and other receivables	**20,733**	13,654
Other investments	**273**	–
Cash and cash equivalents	**19,799**	24,287
TOTAL	**40,805**	37,941

20.2 Financial liabilities by category

	31 March 2015 £'000s	31 March 2014 £'000s
Borrowings excluding finance lease liabilities	**44,670**	–
Trade and other payables	**27,455**	22,861
Provisions under contract	**133**	155
TOTAL	**72,258**	23,016

20.3 Fair values of financial assets at 31 March 2015

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 2015.

	Book value At 31 March 2015 £'000s	Fair value At 31 March 2015 £'000s	Basis of fair valuation
Financial liabilities			
Creditors over one year	(563)	(563)	
Provisions under contract	(109)	(109)	**Note a**
Borrowings due after more than one year	(42,847)	(42,847)	**Note b**
TOTAL	**(43,519)**	**(43,519)**	

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.

b) Fair value of loan balances with the Independent Trust Financing Facility are the same as book value, as rates and payments are fixed for the duration of the loans.

21 Intra-Government and other balances

	Debtors: amounts falling due within one year 2014/15 £'000s	Debtors: amounts falling due within one year 2013/14 £'000s	Creditors: amounts falling due within one year 2014/15 £'000s	Creditors: amounts falling due within one year 2013/14 £'000s
NHS foundation trusts	**336**	288	**563**	113
English NHS trusts	**1,927**	2,436	**2,338**	1,740
Department of Health	**927**	–	**–**	150
Other DH bodies	**(9)**	–	**76**	–
English clinical commissioning groups	**16,626**	10,065	**116**	–
Other whole of Government accounts bodies	**–**	–	**(5)**	271
Total	**19,825**	12,788	**3,088**	2,274

22 Losses and special payments

There were 1,102 cases of losses and special payments (2013/14: 808 cases) totalling £518,000 (2013/14: £209,000) approved during 2014/15.

The majority of the value in 2014/15 related to £390,000 for one amount in respect of a prior year funding claim from a commissioning body. The remaining £128,000 related to 1,101 other instances.

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 (2013/14: nil cases).

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