Moorfields Eye Hospital NHS
NHS Foundation Trust

Annual Plan 2013/14

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1 Past year performance

1.1 Chief executive's summary of the past year

2012/13 has been a demanding year. The Health and Social Care Act came into statute, the transition continued towards the new NHS structure, and the financial environment remained challenging. Towards the end of the financial year, the publication of the Francis report into the failings in care at Mid Staffordshire NHS Foundation Trust also required a fresh focus on issues of quality and safety for patients to ensure that such failings could not occur at Moorfields.

Despite the challenging climate, we have made generally good progress towards the achievement of *Our Vision of Excellence* as outlined below and performed well against national targets and CQUINS.

Financially, we are on target to meet our planned surplus of £4.2 million and have maintained a financial risk rating (FRR) of 4 with Monitor, the independent regulator of foundation trusts. We also delivered a cost improvement programme of £3.0 million.

Our strategy remains aligned with the main thrust of the Health and Social Care Act; namely, to place patients at the heart of all we do, focus on improving further clinical safety and outcomes, and continue to lead the way in providing more ophthalmic care in community and primary care settings. The lifting of the private patient cap, set out in the Health and Social Care Act, will also enable further income growth opportunities.

1.1.1 Performance against corporate objectives

We focused activity in 2012/13 around a series of priority areas and objectives clearly linked to the strategic and enabling themes within *Our Vision of Excellence*, enabling the annual plan to become the implementation vehicle for the strategy.

These priority areas did not include issues that have become business as usual, such as our work to ensure that systems are in place to maintain compliance with our recently awarded NHS Litigation Authority level 3 status.

Our priorities for 2012/13 and examples of progress towards them are listed below.

1. What we do: how our portfolio will change

Priorities:

- Target our business development activities to ensure that we make the largest impact where it matters most, to us and our stakeholders
- Build on our successful biomedical research centre application and ensure that we continue to lead the world in eye-related research
- Develop and commence implementation of a comprehensive education, learning and development strategy for medical, nursing optometrist, other professional and non-clinical staff
- Maximise our returns from commercial Moorfields Private by commencing the implementation of our private patient strategy
- Create and establish an organisation for specialist pharmaceutical products through collaboration with leading London hospitals

We successfully tendered for 'any qualified provider' status for optometry services in Hertfordshire in partnership with local optometrists, and to run the retinal grading service for the central retinal enrichment supplementation (CREST) trials being managed by the Waterford Institute of Technology in Ireland. In south London, we continued to work closely with Croydon University Hospital NHS Trust to support the delivery of ophthalmic services locally. The community general ophthalmology service for NHS Harrow was extended to include a glaucoma and cataract pathway on a pilot basis, and we agreed a glaucoma referral refinement pilot for Islington. Our bids to run community services in the London boroughs of Brent and Haringey were unsuccessful, but we hope to apply feedback provided as part of the process to improve in this area in future.

Research and development, always one of our key strengths, was further boosted this year by the appointment of a deputy director who is providing new focus to the vital part of our work. A key early piece of work was the completion of a joint strategy for research and development with our academic partners at the UCL Institute of Ophthalmology, and the creation of a new applied clinical trials in vision and eyes unit (ACTIVE). Part of our biomedical research centre, ACTIVE is a collaborative ophthalmology resource for the design, conduct, analysis and reporting of randomised controlled clinical trials of important questions for eye health and vision.

To support better relationship s with local GPs and the emerging clinical commissioning groups, we created a GP liaison manager post as part of our business development team. The new post-holder joined us towards the end of 2012 and is now working on a range of initiatives to support GP colleagues, including an ophthalmic education tool and a comprehensive referral guide.

Moorfields Private, one of our three commercial divisions, continued with work to identify integrated outpatient space for Moorfields Private and commenced discussions to expand private patient activity into our larger satellites at Northwick Park and Bedford, in order to boost their financial returns. At the same time, Moorfields Pharmaceuticals, our specialist manufacturing branch, completed work on a full business case for the provision of specialist pharmaceutical products in association with other London trusts, to increase our reach and scope.

Progress on our education strategy has been slow, largely due to competing priorities elsewhere, but scoping meetings were completed with key internal stakeholders ahead of the further development and implementation of this strand in our work.

2. Where we work: how our geographical reach will develop

Priorities:

- Deliver the right sub-specialty services closer to patients' homes in line with our strategy and with the quality, innovation, productivity and prevention (QIPP) agenda, within a financially sustainable model of care
- Further develop our international presence

We formalised and rolled out our service line reporting system to all satellite locations to enable us to identify issues and track costs more effectively, as well as to identify new network service proposals for the future. At Mile End, St George's and Northwick Park, we identified additional surgical capacity to reduce local waiting times and repatriate surgical patients who live closer to these facilities. At the same time, we undertook an outpatient mapping exercise to identify further opportunities to move patients' treatment closer to where they live and relieve pressure on the busy City Road hospital.

Moorfields Eye Hospital Dubai officially celebrated its fifth anniversary to coincide with World Sight Day in October 2012 five years, and also welcomed a new managing director and medical director. At the same time, we successfully completion negotiations to ensure our continuing presence in Dubai, alongside work to establish a surgical facility in Abu Dhabi.

Preliminary discussions also took place about a strategic partnership to deliver training and education in China, although this in the very early stages.

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

Priorities:

- Ensure that we are fully prepared to implement medical revalidation arrangements when agreed and use revalidation and our new clinical management structure to enhance our clinical quality management systems and culture
- Embed existing outcome measures into performance management, and further develop meaningful and relevant outcome measures
- Ensure we utilise the most effective and efficient clinical technologies by exploring, and where appropriate, trialling, developments including Femto-assisted phaco and flexible theatre solutions
- Further improve the patient experience
- Ensure that we are able to respond to the implications of the Health and Social Care Act in relation to its governance and regulatory requirements

Moorfields was rated green for readiness for medical revalidation in the national organisational readiness self-assessment (ORSA) audit in June, and submitted a complete list of doctors to be revalidated to the General Medical Council. Ten of our doctors were successfully revalidated by year-end.

Several initiatives contributed to an enhanced culture of patient safety. These included a strengthened system for investigating serious incidents, with greater consultant and senior trainee involvement, and the creation of a new quality and safety board report, which incorporates a consideration of clinical outcome measures and is being shared with the World Association of Eye Hospitals (WAEH) to provide true benchmarks with other specialist ophthalmic institutions.

Two patient reported outcome measures (PROMS) for ophthalmology are being piloted, and the development of a national squint audit is underway. Data are now being contributed to the national cataract database, allowing comparison with UK national benchmarks.

We further assessed the potential for two new technologies – Surgicube and Femtophaco – to expand our theatre capacity, and started to provide Femtophaco surgery for private patients only. All of our optical coherent tomography (OCT) machines were upgraded during the year to a common standard across the trust, and the project team who led this work were shortlisted for a national Building Better Healthcare award.

Waiting times continue to be a major cause of complaint from our patients and work went on throughout the year to improve these. As part of this work, we have re-profiled the majority of our medical retina and glaucoma outpatient clinics to ensure that the right staff are in clinic to meet the needs of the patients attending.

For surgical journey times, we introduced a succession of improvements to one test list for cataracts, which resulted in a reduction in the journey time for this list of two hours and 33 minutes. Work is now underway to expand these improvements to the rest of the cataract list, with pilots planned for two lists in the glaucoma service. Also in theatres, routine data are now collected and published as part of the productive operating theatre (T-POT) programme, which resulted in a 9% increase in the number of lists starting on time during quarter 3.

In December 2012, we launched a new integrated patient support service, bringing together our eye clinical liaison officer, nurse counsellors and Certificate of Visual Impairment (CVI) team into a coherent unit providing psychological and emotional support and professional counselling for patients at any stage as their sight worsens.

We also completed customer care training for managers and patient-facing staff and started a piece of work to improve our telecommunications systems and practices, following several problems with the existing network during 2012/13, which also identified a range of associated problems with current practice.

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

Priorities:

- Further raise our profile and ability to influence key decision-makers to build support for strategic developments and key projects, by developing effective two-way external communications with key individuals and organisations
- Develop and strengthen our overall brand identity to ensure quality and consistency across all our service locations
- Modernise our website by making it more relevant and accessible to patients, GPs and other stakeholders

A new external communications and engagement strategy was approved by trust board and is now being implemented. This includes work to raise our profile further, especially among audiences who are not easily reached by existing activity, to contribute to increased patient referrals and charitable donations and the recruitment and retention of high-calibre staff. It also covers the roll-out of a piece of work completed in the previous financial year to create a new visual identity and key messages, which are now in use across all publications and key corporate templates.

Our new website is now in the development phase, following agreement on new designs and wireframes earlier in the year, and is due to be launched in the first quarter of 2013/14. Content for the new site is being developed in tandem and will include a phased plan for further enhancements once the new site is live.

We ran several successful patient days throughout the year, bringing together patients, staff, healthcare professionals and charities to share experiences and learn from one another. This year, events covered retina, glaucoma, diabetic retinopathy and thyroid eye disease. In a similar vein, many of our experts were involved in conferences and seminars for various aspects of ophthalmology. These included an International Glaucoma Symposium, the UK Paediatric Glaucoma Society meeting and a Diabetic Retinopathy conference. In addition, several of our expert staff made important contributions to the first preventable sight loss indicator as part of the national public health outcomes framework.

5. Improving our estate and facilities

Priorities:

- Commence the next phase of planning for our future facilities requirements, following the appointment of an appropriately resourced project team
- Continue to progress the pre-campaign phase, ahead of initiating the private phase of the fundraising campaign to support the City Road redevelopment project
- Improve the environment and increase capacity for the new A&E clinical pathways
- Upgrade the patient and staff environment at our district hubs, focusing on Ealing and St George's
- Ensure that our City Road hospital can provide operational services safely until our new facilities are completed

The appointment of a project director and project manager for our new hospital programme, alongside specialist external advisors for clinical planning and cost, meant that we were able to complete an initial clinical service planning process for the new facility and identify realistic costs. At the same time, an outline case for support for fundraising for the new hospital was completed, and work is underway to identify potential major gift donors to finance part of the scheme.

We completed refurbishments to house our vitreo-retinal emergency and ultrasound services, co-locating these with other parts of the surgical pathway and freeing up space to expand the orthoptics department in the main hospital. We also completed a refurbishment of our ocular prosthetics department. Work is now underway to refurbish and expand our specialist A&E department, for which demand continues to rise. This expansion is possible following the completion of an upgrade in our private patient wing to accommodate a new observation bay for patients admitted to A&E who need to remain in hospital overnight.

In our satellite locations, we successfully refurbished our specialist eye unit at St Ann's Hospital in Tottenham, consolidating services in one area, and discussions continue with St George's Hospital NHS Trust to identify suitable new accommodation for our eye centre in the locality.

We have made steady progress against our backlog maintenance programme, although some works will need to be carried over to the new financial year.

On a lighter note, our new arts committee scored a major coup when they successfully negotiated the donation of an entire collection of tactile art to the main City Road hospital from charity BlindArt.

6. Increasing our productivity and efficiency

Priorities:

- Continue to deliver service and cost improvements
- Further assess and exploit the use of digital technology to improve quality, services, productivity or costs

At our large satellite facility in St George's Hospital in Tooting, we started a major transformation project, which is experimenting with radically different ways of providing services to improve them for patients. Confined initially to glaucoma outpatient services at St George's, we hope to expand it further in the new financial year.

We delivered cost improvements of £3 million for 2012/13, which included the full-year effect of savings programmes initiated in 2010/11 – this represents 3% of NHS clinical income.

We were unable to make any significant progress against our plans to further assess and exploit the use of digital technology due to limited technical capacity while our IT team focused on their main goal of sorting out our infrastructure. This is being addressed as part of a comprehensive upgrade plan, but digital technology will be considered as part of the 2013/14 IT business plan.

7. Developing our workforce

Priorities:

- Establish and implement revised staffing profiles in identified target areas to enhance the patient experience and provide an optimal service and cost balance
- Develop a strategy for nursing that extends and enhances their role and capacity in healthcare provision

We completed a workforce planning template to capture service-based plans and inform our wider workforce redesign project, and this has been piloted in several services.

In January 2013, we launched our new nursing strategy, to provide a clear vision for the profession. Called Focusing on the Future, the strategy sets out four strategic objectives to support our target of becoming a centre of excellence in the training and development of ophthalmic nurses, and of ensuring those nurses place patients at the heart of all they do: to develop a nursing workforce that is fit to deliver ophthalmic care in the 21st century; to educate nurses and support workers to deliver 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; and to deliver evidence-based, safe care with dignity and compassion.

8. Developing our leadership and organisational design

Priorities:

- Improve clinical engagement, connect responsibilities and authorities at service and satellite level, and integrate operational, nursing and clinical management by successfully embedding the new clinical management structure
- Improve the development, retention and progression of our high potential talent through the implementation of talent management processes
- Refresh our internal communications and engagement strategy to ensure that all staff can be fully involved in what we do

Our new clinical directors started in post on 1 April 2013, providing much-needed clinical leadership and focus and a clearer working relationship with the corporate management team. New clinical service director roles have also now been appointed to lead 11 ophthalmic sub-specialty areas as well as support services in anaesthetics and theatres. Corporate functions have been aligned to the new directorates, with designated finance, HR and performance and information personnel for each. We also created a new staff communications officer role to improve staff engagement and develop a more structured plan and communications tools.

9. Improving our IT and information

Priorities:

- Complete the development of OpenEyes, including a structured roll-out of the clinical system across all sub-specialties and locations
- Agree and commence implementation of plans to enable the operation of clinical and other areas without paper
- Identify and commence implementation of a system that provides unified and consistent access to ophthalmology medical images, irrespective of the user's location or equipment on which images were captured
- Develop and implement an ICT infrastructure that, for the foreseeable future, can support delivery of care at all required locations and meets the needs of all users
- Support the effective management of the organisation by delivering a new HR and payroll system and preparing for the implementation of a new finance system

We successfully launched version 1.0 of OpenEyes in September 2012, with further releases, including many enhancements and fixes in response to user feedback in subsequent months. Good progress has been made on the development of clinical modules for medical retina and glaucoma, and a prioritised plan for future clinical modules has been agreed. The development of a patient portal underway is well underway and due to go live in the first quarter of 2013/14.

Solid progress has also been made on the development of a new HR and payroll system, which is due to come into force in quarter 2 of 2013/14.

We also completed an IT and informatics strategy and have started the implementation of a plan to improve our IT infrastructure, which was identified as a priority as part of the strategy development process.

1.1.2 Performance against targets

Description of target	Target	Performance 2012/13
Infection control		
MRSA – meeting the MRSA objective	0	0
Clostridium difficile	0	0
Screening all elective inpatients for MRSA	100%	100%
Screening all emergency inpatients for MRSA	100%	100%
Waiting times		
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge	95%*	99.3%
Maximum time of 18 weeks from point of referral to treatment for admitted patients	90%	91.1%
Maximum time of 18 weeks from point of referral to treatment for non-admitted patients	95%	96.0%
Cancer waiting time targets		Not applicable *
Cancelled operations		
Total number of last-minute cancellations	<0.8%	0.70%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	100%	100%
Other		
Mixed Sex Accommodation breaches	0	0
Delayed transfers of care to be maintained at a minimal level.	(0.1% in 09/10, 0.03% in 10/11, 0.05% in 11/12)	0.17%

* The national cancer waiting times targets did not apply to Moorfields due to our very low numbers of cancer activity

1.2 Summary of financial performance

1.2.1 Summary of financial performance

A surplus of £4.2 million was generated for 2012/3 which was £0.2 million better than planned. This is principally due to higher income than planned which was partially offset by higher costs.

The surplus enabled the trust to achieve a financial risk rating of four by the end of the year. The table below presents a high-level comparison between the plan and actual performance for the year.

All figures in £million	**2012/13**		
	Plan	**Actual**	**Variance**
Income			
NHS Clinical income	109.6	110.9	1.3
Commercial Trading Unit Income	28.9	28.7	-0.2
Other Income	13.7	18.5	4.8
Total income	**152.2**	**158.1**	**5.9**
Expenditure			
Pay costs	73.0	77.3	-4.3
Non-pay costs	43.6	45.0	-1.4
Commercial Trading Unit Costs	23.8	23.6	0.2
Total expenditure	**140.4**	**145.9**	**-5.5**
Earnings before interest, tax, depreciation and amortisation	11.8	12.2	0.4
Depreciation, Interest and Dividends	7.8	8.0	-0.2
Net surplus	4.0	4.2	0.2

1.2.2 Income

1.2.2.1 NHS clinical income

NHS clinical income has stronger performance than originally planned at £1.3 million above expectations at the end of the year. Within this the increased use of Lucentis in the treatment of wet age-related macular degeneration (AMD) was £1.1 million over plan along with non-elective treatments and outpatient income which were £0.5 million and £0.4 million above plan respectively. These were offset principally elective income which was £0.9 million below plan.

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1.2.2.2 Commercial trading unit income

Our commercial trading units, Moorfields Private, Moorfields Pharmaceuticals and Moorfields Eye Hospital Dubai generated total income of £28.7 million, which was below expectations by £0.2 million.

1.2.2.3 Other income

A £4.8 million over-performance against plan is driven by income for VAT recovery which was above expected amounts primarily from in year partial exemption claims and recovery under contracted out services. In addition, R&D infrastructure funding was received during the final quarter of the year.

1.2.3 Expenditure

1.2.3.1 Pay costs

Pay costs were above planned amounts by £4.3 million at £77.3 million due to pay pressures and expenditure on temporary staff. Within this, medical staff costs of £25.9 million were over plan by £1.9 million, while nursing costs of £18.2 million were over plan by £0.2 million. Scientific, therapeutic and technical staff spend was over plan by £0.6 million at £11.9 million and administration staff was over plan by £1.6 million at £19.8 million. Finally, ancillary staff was above plan by £0.1 million at £1.4 million.

1.2.3.2 Non-pay costs

Overall, non-pay costs were £1.4 million over plan at the end of the year at £45.0 million. This is largely due to higher than planned activity and use of high cost drugs, alongside increased use of interims and advisory services and higher than planned IT expenditure.

Drug costs were £1.1 million over budget at £15.3 million, primarily due to increased use of Lucentis for age-related macular degeneration (AMD). Costs of clinical supplies were above plan by £0.5 million at £11.4 million. These were offset by underspends of £0.2 million in rents, insurance premiums and from other reserves that were not consumed or devolved.

1.2.3.3 Commercial trading unit costs

Overall costs were £0.2 million under planned amounts at £23.6 million. Where income under-performance was present in specific trading units, there was some cost reduction that compensated.

1.2.4 Cash flow

The operating surplus was partially offset by increased capital expenditure. Increases in debtor balances reflected were largely reflective of increased billing toward the end of the year, rather than an increased risk of non-collection. Offsetting increases in short-term creditor balances relate to trade creditors and deferred income. The net result is an increase in cash and cash equivalents from £18.5 million in 2011/12 to £20.6 million in 2012/13.

2 Future business plans

2.1 Overall vision

The 10-year strategy for Moorfields – '*Our Vision of Excellence*' was completed in 2010/11. This expresses our vision for the future - where we are going and what we want to be.

Our Vision of Excellence is that by 2020, we will be:

- Providing a more 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 delivering the highest standards of patient experience, outcome and safety across all sites
- At the forefront of international research with our partners
- Maintaining our leading role in the training and education of eye care clinicians

The strategy was developed during 2009/10-2010/11amidst the context of the Darzi next stage review, the World Class Commissioning agenda and the NHS London Healthcare for London strategic plan. As the strategy document was being published the new government published the White Paper – "Equality and excellence: Liberating the NHS".

Following the completion of the strategy there have been further changes in our environment, these include the:

- Second Francis inquiry, which had just been published at the time of finalising this annual plan, and the inquiry's report is being considered nationally and locally for its impact on improving patient care and services;
- Worsening economic outlook and the impact that this will have on the NHS;
- Transition to the new NHS structure and the introduction of Clinical Commissioning Groups;
- Growing importance of the Quality, Innovation, Productivity and Prevention (QIPP) programme coupled with the continuation of the care closer to home agenda leading to further shifts from secondary care into the community, particularly for long term conditions; and
- Health and Social Care Act – which received Royal Assent on 27th March 2012.

In late 2012, we started to review our strategy against our progress of the past three years and these external factors; whilst we believe that our vision and the strategy remains robust and continues to be aligned with that of our commissioners, we will need to reprioritise some of the key actions that underpin its implementation – this work was not completed as this annual plan was drafted, so we will need to review the annual plan early in 2013/14 to properly align it with the finalised strategy.

We have however identified the priorities to secure the delivery of the strategy in 2013/14, as they were envisaged in late 2012, and these are shown in section 2.2.4.

2.2 Strategic overview

2.2.1 National and local challenges

2013/14 will be a demanding year as the transition to the new NHS structure completes and the financial environment remains challenging.

We have made good progress towards the achievement of Our Vision of Excellence and the coming year sees the completion of significant workstreams, the on-going delivery of key quality and service improvement projects, and the roll-out of our transformational change programme.

Our good financial performance has given us some flexibility for the coming year, but we must deliver significant efficiencies if we are to continue to generate the surplus levels required to reinvest in services, and to afford our new hospital. We have therefore adopted a prudent series of assumptions, and are planning to deliver a £4m surplus and to achieve our planned Financial Risk Rating (FRR) in 2013/14.

The direction of travel set out originally in the White Paper, and now amended within the Health and Social Care Act, the emergent detail within the NHS Mandate and the NHS Commissioning Board's planning framework and commissioning intentions remains strongly aligned to our strategy.

We have taken steps to incorporate these within our plans and, in addition to the external environment, the plan detail our responses to the various factors driving change, alongside our internal service developments. Our strategic priorities are designed to meet these challenges.

NHS Reform

2013/14 will see clinical commissioning groups (CCGs) formally taking on responsibility for commissioning, alongside the National Commissioning Board's (NCB) regional and national processes for specialist commissioning.

These structural changes represent both a threat to Moorfields, in the fracturing of the contractual environment into a multiplicity of organisations with differing local priorities; and an opportunity, in a primary relationship with a larger commissioning support unit (CSU) that will now include 12 CCGs across central, north and east London.

NHS Mandate

The first Mandate between the Government and the NHS Commissioning Board, setting out the ambitions for the health service for the next two years, was published on 13th November 2012.

The Mandate reaffirms the Government's commitment to an NHS that remains comprehensive and universal – available to all, based on clinical need and not ability to pay – and that is able to meet patients' needs and expectations now and in the future.

The NHS Mandate is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements:

- preventing people from dying prematurely
- *enhancing quality of life for people with long-term conditions*
- helping people to recover from episodes of ill health or following injury

- *ensuring that people have a positive experience of care*
- treating and caring for people in a safe environment and protecting them from avoidable harm.

Through the Mandate, the NHS will be measured, for the first time, by how well it achieves the things that really matter to people.

The key objectives contained within the Mandate include:

- *improving standards of care and not just treatment, especially for the elderly*
- better diagnosis, treatment and care for people with dementia
- better care for women during pregnancy, including a named midwife responsible for ensuring personalised, one-to-one care throughout pregnancy, childbirth and the postnatal period
- *every patient will be able to give feedback on the quality of their care through the Friends and Family Test starting from next April – so patients will be able to tell which wards, A&E departments, maternity units and hospitals are providing the best care*
- by 2015 everyone will be able to book their GP appointments online, order a repeat prescription online and talk to their GP online
- putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment
- preventing premature deaths from the biggest killers
- *by 2015, everyone should be able to find out how well their local NHS is providing the care they need, with the publication of the results it achieves for all major services.*

The italicised text highlights the aspects of the Mandate that are likely to have the biggest impact on Moorfields.

NHS Commissioning Board planning framework – "Everyone Counts: Planning for Patients 2013/14"

The NHS Commissioning Board published its planning framework, "Everyone Counts: Planning for Patients 2013/14", in December. This outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

The guidance is published alongside financial allocations to clinical commissioning groups and is accompanied by other documents intended to help local clinicians deliver more responsive health services, focused on improving outcomes for patients, addressing local priorities and meeting the rights people have under the NHS Constitution.

The document then moves on to outline five offers from the Board to CCGs to provide the requisite "insights and evidence" to deliver improved outcomes:

- NHS Services, Seven Days a Week
- More Transparency, More Choice
- Listening to Patients and Increasing their Participation
- Better Data, Informed Commissioning, Driving Improved Outcomes
- Higher Standards, Safer Care

2.2.2 Safeguarding

As part of the on-going commitment to safeguarding, the trust will continue to work collaboratively with the local safeguarding boards both for adults and children. The trust, as an agency, is participating in the development and function of the safeguarding agenda and is providing the necessary resource to ensure that all staff have the knowledge and skills to protect vulnerable patients in their care and is ensuring that the requirements set out in the Monitor compliance framework, in relation to the criteria required to meet the needs of people with dementia or learning disability, continue to be met.

This will be achieved by:

- Attending, and contributing to the work of the local safeguarding boards, ensuring that the trust works towards the boards' priorities;
- Reviewing and implementing national policy;
- Auditing the trust's compliance with local policy; and
- Continuing with the appropriate provision of training and monitoring its effectiveness.

2.2.3 Quality

Quality forms a key area within our strategic priorities which are set out in detail later in this document. At the time of writing this plan, the second Francis inquiry has just been published and the inquiry's report is being considered nationally and locally for its impact on improving patient care and services.

The board has undertaken a first review and specific areas of quality performance will be reviewed as a result, as well as other aspects of the organisation. An example of this is set out under our 2013/14 strategic priorities (section 2.2.4.) quality theme - patient experience priority area. This refers to the need to consider the themes arising from complaints and other areas of patient feedback and to use this information and learning to create direct improvements in patient care and services. A full action plan is in the process of being developed.

Our quality report presents a detailed appraisal of our performance during 2012/13, and the priorities for 2013/14 – this is appended to this annual plan.

2.2.3.1 Performance-related payments linked to quality outcomes

The commissioning for quality and innovation (CQUIN) goals are made up of indicators from the national, London and North Central London (NCL) schemes for acute services. A number of these did not apply to us as a specialist eye hospital and following discussion with NCL, a range of appropriate quality measures has been developed for 2013/14. Achievement of these goals will result in an additional payment of 2.5% of the contract value, the same level as in 2012/13 in line with the continuing focus of payments linked to quality outcomes.

The CQUIN indicators are shown in the following table:

Type	Description of CQUIN goal	Indicator
National		
National		
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London		
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NCL / MEH		

[CQUINs ARE YET TO BE FINALISED]

2.2.4 Strategic Priorities

The 2010/11 Annual Plan expressed the trust's business plans through a series of strategic goals, objectives and top priorities. This approach was adopted due to the timing of the completion of the strategy, and the publishing of guidance late in the process.

The 2011/12 Annual Plan expressed the trust's business plans through a series of eight priorities. These set out the key objectives for the year in response to the external environment and further built on our achievements in delivering the strategy.

The 2012/13 Annual Plan expressed the trust's business plans through a series of priority areas and objectives that are more clearly linked to the strategic and enabling themes within Our Vision of Excellence, enabling the annual plan to become the implementation vehicle for the strategy.

The 2013/14 Annual Plan continues to utilise these strategic and enabling themes as the framework for the annual plan's strategic priorities, though the strategy refresh undertaken in late 2012/13 proposed the merger of the separate workforce and leadership / organisational development enabling themes into a single enabling theme around 'our people' – this results in 4 strategic and 4 enabling themes.

These priority areas do not include significant issues that have become well embedded in our day-to-day operational delivery and reporting, and therefore 'business as usual'; for example:

- the work to ensure that systems are in place to maintain on-going compliance with our recently awarded NHS Litigation Authority Level 3 status;
- the Medical Revalidation programme;
- our continuing organisational response to the Health & Social Care Act;
- the City Road backlog maintenance programme; and
- further development of the clinical management structure.

The priority areas and objectives are shown in the following table.

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
What we do: how Moorfields' portfolio will change	1. Business development	Deliver further growth in a sustainable manner: a) Manage the transition to clinical commissioning through the development of integrated services, working with patients, GPs and other social and voluntary agencies to develop the pathways which GP and patients want b) Increase market share by responding to patient and commissioner service concerns through a targeted GP engagement campaign, informed by a robust business intelligence capability c) Continue to generate opportunities for new sites and services through a strategic appraisal of acquisition prospects and tenders

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
	2. Commercial business development	Utilise the opportunities available with the changes to the private patient cap to exploit the brand and our expertise to generate new areas of business: a) Launch "MEH Commercial Ventures", the vehicle we will use for our commercial business activities, and develop a proactive commercial business development capability, initially focused on Open Eyes, to generate significant new revenue streams b) Maximise our returns from Moorfields Private through partnership working with our consultants, and by aligning demand and capacity at City Road and elsewhere. c) Maximise the value of Moorfields Pharmaceuticals by creating an organisation for specialist pharmaceuticals through collaboration with leading London hospitals.
	3. Research and development	Implement the joint R&D strategy to ensure that we maintain our world-leading status and maximise translational research opportunities and income generation: a) Implementation of Experimental Medicine Award through improving Early Phase Trials, increasing capacity/utilisation, developing new roles and work programmes within the clinical research facility. b) Focus on achieving all external research metrics by implementing new R&D processes, visual management, team re-alignment to improve process efficiency, increasing commercial research and reviewing and developing research management and governance. c) Setting up collaboration with UCL for the ACTIVE™ clinical trial unit to improve successes in high calibre grant awards; and full participation in UCLP Research Harmonisation Programme to speed up trials approvals and set-up, and improve industry engagement
	4. Education	We need to focus our efforts in developing the components of an education strategy that deliver the most impact in 2013/14, and then go on to shape the wider strategic issues: a) Establish Moorfields Education and Training as a (virtual) directorate that will give shape & focus to our aspiration that anyone, anywhere in the world who wants to learn about eyes looks to us first.

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Where we work: how our geographical reach will develop	1. NHS service development	We will respond to the requirements of our patients and commissioners, and "rebalance" NHS activity in line with our strategic direction - optimising our capacity and efficiency: a) Develop a strategic plan for where we intend to deliver sub-specialty services b) Repatriate clinical activity "closer to home" from City Road, expanding both the volume and variety of satellite-based capacity, where it is possible and financially prudent to do so c) Increase our utilisation of satellite facilities, providing further capacity if required, and in so doing to reduce local waiting lists, secure and expand market share and liberate capacity at City Road.
	2. International business	Continue to develop our international business through profitable expansion of our activities in the UAE and exploration of other opportunities as they arise: a) Secure our position as principal ophthalmic provider to ICLDC b) Establish a surgical presence in Abu Dhabi c) Evaluate new opportunities for profitable international activity, working with UKTI and other national agencies and/or independently International business development

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Our quality and reputation: how we will ensure quality is the defining characteristic of all we do	1. Quality	We will continue to maintain high standards of clinical quality, and demonstrate our excellence by providing our clinicians, patients, commissioners and other stakeholders with regular, up-to-date information on the success of most of our interventions: a) Following our response to the initial Francis inquiry, we will review our quality performance in light of the further report published in early 2013 b) Agreement of specifics of important outcomes or procedure results for each specialty and introduction of mandatory data fields in Open Eyes clinical modules which will allow routine measurement of outcomes c) Identifying standards for our outcomes from investigation of the medical literature and available results from other units, such as the National Ophthalmic Database. d) Publication of our outcomes against our standards on the new Moorfields website and in the Quality Report
	2. Patient experience	Moorfields is committed to continuously improving our patients' experience and we will focus on the areas that they tell us are important: a) Patients tell us that they are not kept informed about how long they have to wait in clinic or are kept informed about delays. We aim to improve this by ensuring that staff apply the learning from the customer care programme and make it their business to keep patients informed - we will monitor the effect of this by reducing the number of adverse comments about delays / keeping patients informed by 10% (data will be collected from the Moorfields minute cards). b) Patients tell us that they have difficulty in contacting the appropriate member of staff when trying to change an appointment. We aim to improve this by monitoring the numbers of formal complaints that make a specific adverse reference to appointments - we will reduce this by 20%. c) Patients tell us that they don't receive adequate discharge advice post-operatively or adequate explanation about side effects about medications. We will improve this 5% (composite score) on our 12/13 day care survey and set a local target thereafter.

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Our role and influence: the part we play as the market leader in eye care	1. Communications	Implement the external communications strategy to improve our specialist standing, public profile and brand recognition so that we are known for being the 'best': a) Identify new media opportunities and PR campaigns, in line with advice from specialist PR agency b) Improve the interface with R&D / BRC to develop an integrated proactive communications programme c) Complete the website modernisation project
	2. Influencing	Moorfields 'punches above its weight' but we need to enhance our ability to capture and track existing activity, and develop supportive new relationships in key areas: a) Identify three key areas where we could and should have an impact and develop plans to enhance engagement with the main stakeholders for these areas b) Refresh existing high-level stakeholder map to include R&D and Education and identify 'account managers' for each key group c) Implement new stakeholder management system, enabling us to track key relationships and report on progress d) Ensure that Moorfields is appropriately 'credited' when our staff influence (often with a BRC or Institute of Ophthalmology 'hat') through an internal awareness campaign.

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Improving our estate and facilities	1. New Hospital Project	We will continue the planning for the replacement of the City Road hospital, to provide an improved patient experience, by finalising the location for the new hospital and completing the business case for investment: a) Address the where are we going question, and confirm UCL's strategic and financial support to this, whilst securing a site should we decide to move and/or develop plans to maximise the income opportunities from redeveloping City Road b) Complete the business case for investment, including the capital and whole-life revenue consequences, for our requirements by developing the high level functional content for the new hospital, incorporating the Institute of Ophthalmology's needs c) Finalise fundraising planning with UCL and initiate the quiet phase of the campaign, once key decisions on location and costs have been addressed
	2. Satellites	We will further refine our networked model, and also ensure that our satellites are able to deliver our "rebalanced" clinical activities: a) Moorfields South – further develop our local SW London network and ensure that the St George's district hub continues to provide our specialist activity requiring critical care facilities b) Moorfields North – develop a NW London network based around Northwick Park, Ealing and Potters Bar

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Increasing our productivity and efficiency	1. Transformation	Changing the way we work to deliver the most effective and efficient services: a) Experiment with, and implement new ways of working, as part of the transformational change programme (including workforce redesign and operational productivity projects), in line with the skills required to offer optimum value to patients and understanding and realising the financial benefits of the programme. b) Commence the Open Eyes benefits realisation programme, initially focusing on starting to reduce our dependency on paper records in preparation for becoming fully "paper-lite", by developing electronic document management systems
	2. Technology	We need to lead the field in the translation of medical technology research into clinical practice, ensuring that we deliver services in the most efficient manner: a) Review all inter-related medical technology advances, initially focusing on imaging (e.g. binocular OCT, MIRA project, "biobank" glaucoma), and develop a coherent strategy b) Implement a telemedicine strategy to support the delivery of these technological advances
	3. Efficiencies	Deliver the financial efficiencies and income growth required to maintain our FRR and planned surplus levels: a) Maximise income from current clinical activity, expand services where appropriate (for example, the recent NICE approved treatment for Diabetic Macular Oedema), and grow market share b) Review all expenditure relating to our occupancy at satellite sites including negotiating service level agreements to ensure value for money and profitability appraisals of all sites and services c) Deliver key efficiency projects including appraising E-rostering systems, improving procurement and materials management cost-effectiveness, energy efficiency programmes, and reducing agency / overtime expenditure covering leave and sickness.

Our Vision of Excellence strategic / enabling theme	Priority area	Objectives
Our people: recruiting, retaining, developing and rewarding the best staff	1. Clinical leadership	Our people are our most valuable resource and are key to our continued success. We need to engage them fully in the delivery of our vision. We must support them, through development, through technology, and through clear incentives including reward, to provide the highest quality of care for our patients, and to be as productive as they can be: a) Talent management – develop a talent management process that will nurture the world-leading clinicians of the future, provide high quality leadership development for all those who lead teams, and ensure high quality objective setting and appraisal for staff at all levels.
	2. Staff Engagement	a) Staff engagement - develop and implement an internal, two-way communications strategy, and a well-being strategy, to deliver an engaged workforce, that hears consistent messages regarding efficiencies, our strategy, and our new hospital, and is sufficiently informed to contribute to the debate.
Improving our IT and information	1. OpenEyes	We will continue to develop and implement our bespoke electronic patient record (EPR) and maximise its impact internally and across the ophthalmic world: a) Complete the initial phases of all clinical modules b) Clearly articulate what Open Eyes can do for us, and the wider ophthalmic world, and develop an action plan to deliver this
	2. IT infrastructure	We need to modernise our IT systems and infrastructure to support the delivery of clinical services: a) Deliver the first phase of the approved IT infrastructure works to improve performance in key areas b) Prioritise the second phase to give the best return on investment

2.3 Summary of Financial Forecasts

2.3.1 Key financial assumptions

The financial plan for the year is presented in the section below.

The plan for 2013/14 has been formulated using published tariff pricing , draft financial assumptions yet to be agreed with the lead commissioner (subject to final contract sign-off) and detailed internal planning with managers and other budget holders.

The following table illustrates the key planning assumptions used for the next three years. In general, following 2013/14 it assumes higher inflation and slightly slower growth in outpatient and elective income.

The following table illustrates the key planning assumptions used for the next three years:

	12/13 to 13/14	13/14 to 14/15	14/15 to 15/16
Income			
Tariff decrease	-4.80%	-1.50%	-1.50%
MFF Decrease	0.00%	0.00%	0.00%
Elective Income Growth	2.00%	1.13%	1.13%
Outpatient Income Growth	2.00%	1.04%	1.04%
A&E Income Growth	3.00%	3.00%	3.00%
AMD Growth	2.00%	2.00%	2.00%
Commercial Unit Income Growth	Business Plan	2.00%	2.00%
Other Income Increase	0.00%	1.00%	1.00%

Costs			
Pay inflation factor (Incl Incr Drift)	1.50%	2.00%	3.00%
Inflation - Drug costs	2.50%	3.00%	3.00%
Inflation - Clinical supplies etc	2.50%	3.00%	3.00%
Inflation - Other costs	2.50%	3.00%	3.00%
Efficiency Programme	5.30%	5.00%	5.00%
Cost Pressures and Service developments	Calculated	2.00%	1.75%

- Tariff changes are a 4.8% decrease in 2013/14, and are assumed at a 1.5% decrease in 2014/15 and 2015/16.
- The market forces factor uplift that the trust will receive on tariff income next year has remained steady at 26.5% in 2013/14 and is assumed to remain at this level for the final two planning years.
- Other income is adjusted within the budget next year for known changes and at 1% thereafter.
- Pay inflation is assumed at 1% for 2013/14 increasing to 2.0% in 2014/15 and then to 3% in 2015/16.
- Non-pay is planned at between 2.5% and 3% in the planning term.
- Cost pressures are included for 2013/14 at agreed amounts and 2% and 1.75% respectively thereafter.

- Efficiency savings are included at 5.3% of NHS clinical income (£6.4 million) in 2013/14, at 5% in 2014/15 and 2015/16.
- 2013/14 assumes a 2% growth in elective and outpatient income and a 3% growth in A&E income and 2% growth in AMD treatments. Thereafter, growth is assumed at 1.1% for elective income, 1.04% for outpatient income, 3% for A&E income and 2% for AMD treatment income.
- Non-tariff income and local prices are budgeted at a 1.3% reduction in line with guidance.
- The acute contract negotiation is still in progress at the time of writing.
- Commercial trading unit figures based on latest planning assumptions.

2.3.2 Summary of the financial plan

The financial information presented below represents the forecast outturn for 2012/13, the 2013/14 budget and the overarching plan for the following financial years.

All figures in £million	2012/13			2013/14	2014/15	2015/16
	Plan	Actual	Variance	Plan	Plan	Plan
Income						
NHS Clinical income	109.6	110.9	1.3	113.9	113.4	113.0
Commercial Trading Unit Income	28.9	28.7	-0.2	33.7	34.3	35.0
Other Income	13.7	18.5	4.8	18.5	18.7	18.8
Total income	**152.2**	**158.1**	**5.9**	**166.1**	**166.4**	**166.8**
Expenditure						
Pay costs	73.0	77.3	-4.3	78.2	77.8	78.0
Non-pay costs	43.6	45.0	-1.4	48.7	48.9	49.0
Commercial Trading Unit Costs	23.8	23.6	0.2	26.9	27.0	27.2
Total expenditure	**140.4**	**145.9**	**-5.5**	**153.8**	**153.7**	**154.2**
Earnings before interest, tax, depreciation and amortisation	11.8	12.2	0.4	12.3	12.7	12.6
Depreciation, Interest and Dividends	7.8	8.0	-0.2	8.3	8.5	8.5
Net surplus	4.0	4.2	0.2	4.0	4.2	4.1

The three-year plan is for a £4 million surplus in 2013/14 moving to £4.2 million and then £4.1 million respectively in the following two years.

The following material movements reflecting the key financial assumptions should be noted:

- NHS clinical income: reduces steadily in line with tariff reductions, partially offset by income growth.
- Commercial trading unit income increases between 2012/13 and 2013/14 and for the other two planning years.
- Other income remains relatively static during the period with inflationary growth assumed.
- Pay costs inflate at 1% in 2012/13 and at 2% and 3% for the following two years.
- Non-pay inflates in line with assumptions, with planned reserves for 2012/13.
- Efficiencies are apportioned over pay and non-pay.
- Depreciation grows during the period in respect of additional capital investment.

2.3.1 Investment and disposal plans

The following table summarises the trust's capital investment plans:

Investment Plans (£m)

	2013/14	2014/15	2015/16
Capital Schemes Carried Forward from Prior Years	3.1	1.1	1.0
New Capital Schemes	6.0	6.4	5.5
Expected carry forward to future years	-1.1	-1.0	-1.0
Total	**8.0**	**6.5**	**5.5**

A prioritisation process has been undertaken and resulted in £3.1M of schemes to carry forward to 2013/14 and a £6.0M allocation for new schemes. It is anticipated that £1.1M of these schemes will move into the next financial year. All schemes are financed from internal cash. The principal large value schemes for 2013/14 are:

- £0.9M A&E refurbishment : To create additional space and capacity within A&E
- £2.3M backlog maintenance : Continuation of the programme
- £1.3M IT infrastructure and systems : Primarily the network upgrade
- £0.9M OpenEyes electronic patient record system
- £1.0M New Central London Building

Commercial capital schemes are sighted at £3.2M but are dependent on exploiting identified but uncertain opportunities and are subject to individual business case decisions and not included in the above totals.

2.3.2 Efficiency plans

The trust's efficiency plans are summarised as follows:

Efficiency Plans

	2012/13	2013/14	2014/15
Identified Schemes	5.4		
Unidentified Schemes	1.1	5.7	5.7
Total	**6.5**	**5.7**	**5.7**

£3.0 million of savings were delivered in 2012/13.

A major cash releasing efficiency saving programme has been agreed at £6.4 million for 2013/14, including the full-year effect of savings programmes initiated in 2012/13. This represents a 5.8% target against NHS clinical income.

Of the £6.4 million target a total of £1.1 million of schemes have yet to be identified or signed off as schemes that will proceed.

A 5% savings target has been assumed for 2014/15 and 5% assumed in 2015/16 to create cash surpluses to allow contribution towards a new building.

2.3.3 Sensitivity analysis

The following table illustrates the financial plan under a range of sensitivities where efficiencies vary by 1%, tariff income reduces by 1% and pay costs increase by 1%:

	4% Savings			5% Savings			6% Savings		
	Surplus / (Deficit)			Surplus / (Deficit)			Surplus / (Deficit)		
	Yr 1	Yr 2	Yr 3	Yr 1	Yr 2	Yr 3	Yr 1	Yr 2	Yr 3
Base Plan	2.9	3.1	3.0	4.0	4.2	4.1	5.1	5.3	5.2
1% NHS Income Fall p.a.	1.7	1.9	1.8	2.9	3.1	3.0	4.0	4.2	4.1
1% Increased Cost Inflation p.a.	1.3	1.5	1.4	2.5	2.7	2.6	3.6	3.8	3.7
Both Sensitivities	0.2	0.4	0.3	1.3	1.5	1.4	2.5	2.7	2.6

3 Risk Analysis

3.1 Governance Risk

3.1.1 Governance commentary

3.1.1.1 Constitution

The trust operates within a legal constitution in accordance with Schedule 7 of the NHS Act 2006.

3.1.1.2 Growing a representative membership

This is described in section 5.2.

3.1.1.3 Board role and structures

During 2012/13, the board has been composed of seven non-executive directors (including the chairman) and six executive directors. The board therefore has had a non-executive majority of one.

As 2012/13 draws to a close one of the non-executive directors has resigned their post to and will finish on 31 March 2013. A process has commenced to recruit an NED with major property development and/or construction experience to support the development of the hospital's rebuild.

During 2012/13 there have been four associate directors without voting rights who attend the board; these are the director of strategy and business development, the director of corporate governance, the director of human resources and the director of information technology.

The board believes therefore that it has the appropriate skills, knowledge and experience across the non-executive and executive directors to be able to fulfil the corporate and strategic objectives of the trust.

The range of experience of the non-executive directors includes marketing and communications, strategic and public sector management and commercial financing and corporate legal.

The board is held to account through the membership council but there is also extensive collaborative working. Governors are encouraged to attend trust board meetings which are held in public.

In 2012/13 there were 11 trust board meetings. The agendas of the membership council complement those of the board and the business cycle to ensure that governors are able to exercise their role in holding the Board to account and scrutinising the board's forward plans as well as their other duties.

In 2012/13 there were six board committees:

- Quality and safety: This committee provides overview and scrutiny of all aspects of quality and health and safety across the whole organisation. The committee is also responsible for reviewing the clinical and the quality and safety related non-clinical risks in the organisation. The committee met six times in 2012/13.
- Audit: The Audit Committee assists the board in fulfilling its oversight responsibilities relating to the integrity of the trust's accounts, the adequacy of the

Trust's board assurance framework, 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. The Audit Committee does not have direct oversight of risk management, as this forms part of an integrated board assurance system reviewed each quarter by the board. However, the Audit Committee contributes to this oversight with a particular focus to scrutinise risks relating to financial systems and controls. The committee meets at least four times per year.

- New Hospital Committee: This is a new committee which commenced in October 2012, which has an oversight role in supporting the development of plans for a new hospital to replace the aging hospital on the City Road site. The committee meets as necessary and in 2013 is expected to meet seven times.
- Strategy and investment: The strategy and investment committee conducts independent and objective reviews of the trust's strategic direction, large investments and other ventures. The committee is responsible for reviewing the risks in relation to the trust's strategy and the implementation of it. The committee meets frequently and in 2013 is expected to meet six times.
- Remuneration committee for executive directors: This committee is responsible for setting the pay and terms of employment of executive directors and other board-level posts. The committee is chaired by the trust's chairman and comprises all non-executive directors. The committee meets several times during the year.
- Nominations committee for the appointment of executive directors: This committee is responsible for the appointment of executive directors and meets when required.

The annual general meeting took place on 18th July 2012 and we continue to have very good attendance from our members.

3.1.1.4 Clinical management structure

The trust's clinical management structure was revised at the end of 2011/12 to strengthen clinical decision making at the core of the organisation, and to ensure that the management of the satellite sites is better aligned to the centre.

From 1st April 2012, the trust has had four clinical directorates:

- Outpatient and diagnostic services;
- Surgical services;
- Moorfields North (also containing Moorfields East); and
- Moorfields South.

Each directorate has a clinical director and is supported by the appropriate management arrangements.

In addition, a clinical director of quality and safety covers the whole trust.

3.1.1.5 Service performance

The trust has made strong progress in achieving compliance with its priority indicators and targets.

Key targets and indicators

The trust continues to perform well in relation to all its targets and has continued to receive a green governance rating from Monitor throughout the year.

NHSLA risk management standards assessment

The trust achieved NHS LA level 3 compliance in December 2011. The next assessment will take place in December 2014.

Registration with the Care Quality Commission

Moorfields was registered with the CQC in March 2010 without conditions. At that point, Moorfields declared itself non-compliant for the safety and suitability of its premises for Northwick Park, one of its satellite sites and CQC rated this as a minor concern. Moorfields completed a full refurbishment of this site in March 2012.

The trust had an unannounced inspection of its City Road site from the CQC in February 2012 and again in February 2013. One of the Trust's satellites, St Ann's was visited in August 2012. The CQC has had no regulatory concerns following any of its inspections and the trust has remained compliant against all the registration standards. A final written report for the second City Road inspection is expected in March or April 2013.

3.1.2 Risk management

The trust has a fully integrated system of managing risk with a risk strategy and risk registers. The trust has a corporate risk register that contains the high level risks. The register is divided into three sections, corporate, operational, and risks to delivering the trust's key priorities. The corporate risk register is reviewed by the board on a quarterly basis.

3.1.3 HCAI targets

The trust continues to achieve zero rates for both MRSA and C-difficile infection.

3.2 Mandatory services risk

3.2.1 Mandatory

[Heads of agreement has been signed with the lead commissioner for 2013/14contracts and the activity levels are incorporated into schedule 2 of the terms of authorisation. As is not unusual, finalisation of contract formalities will run into the new financial year.]

3.2.2 Significant risks

There are considered to be no significant risks to the provision of the trust's mandatory services.

3.3 Financial risk

3.3.1 Commentary on financial risk rating

The trust expects to achieve a financial risk rating of 4 as required.

The financial risks described in section 3.3.2 below are expected to be manageable within the contingencies included in the plan.

3.3.2 Significant risks

The principal financial risk is:

- An inability to maintain high standards within available financial resources (corporate risk register no. 14).

  Net magnitude: 12 (maximum 25)

  The source of this risk relates to:

  - Decreasing tariffs.
  - Increasing pressures due to challenging savings programmes.
  - Potential for cost growth unless efficiency programmes are well managed.
  - The need to maintain sufficient income.

  This risk is being mitigated through the implementation of further controls relating to:

  - Robust business and financial planning including contingency plans
  - Comprehensive savings programme for 2013/14 has been underway for several months.
  - Identification of improved ways of working and major efficiencies.
  - Longer term programme of transformational change is underway.
  - Review of marketing and offers to private patients
  - Staff engagement
  - Improved activity data capture and optimisation for billing purposes
  - Development of additional income opportunities
  - Monthly trust management board review of financial position and progress with savings plans
  - Monthly financial reporting to the board
  - Improved forecasting and modelling
  - Starting a project to implement patient level costing and improve geographic reporting

The risks around a potential lapse in financial governance/stewardship are considered low.

Other noteworthy risks and any mitigations, are set out below:

- Commissioning: The process of the current commissioning round and the changing commissioning landscape is creating uncertainty for the 2013/14 contract.
- Estate: The trust's main building is more than 110 years old. Because of its age there is a need for significant and on-going annual maintenance and the trust has risks in relation to its backlog maintenance programme in that unexpected/unplanned maintenance may be required. The Trust has sufficient contingencies and insurance to mitigate these risks. In addition the trust is preparing to replace its current main hospital building.
- IT: The trust has outdated IT systems that are in the process of being updated over a two year period. There are no patient safety risks associated from the current IT systems weakness.

3.4 Risk of any other non-compliance with the terms of authorisation

There are considered to be no significant risks to breaching the terms of authorisation.

4 Declarations and self-certification

4.1 Board statements and self-certification

Corporate Governance Statements
Quality
1. The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against Monitor's *Quality Governance Framework* (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of health care provided to its patients.
2. The board is satisfied that plans are in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.
3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.
Finance
4. The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months[1]
5. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

[1] using the FRR system at this stage, until the new ratios are introduced by the RAF on 1 October

Corporate Governance Statements
Governance
6. The board will ensure that the trust remains at all times compliant with its licence and has regard to the NHS Constitution.
7. All current key risks to compliance with the trust's licence have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.
8. The board has considered all likely future risks to compliance with its licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.
9. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.
10. An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).
11. The board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) and a commitment to comply with all known targets going forwards.*

Corporate Governance Statements
12. The board is satisfied that its NHS foundation trust can operate in an efficient, economic and effective manner.
13. The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.
14. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience, training and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.
15. The board is satisfied that: the management team has the capacity, capability, training and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.
16. For an NHS foundation trust engaging in a major Joint Venture, or Academic Health Science Centre (AHSC), the board is satisfied that the trust has fulfilled, or continues to fulfil, the criteria below.
17. The board is satisfied that plans are in place to ensure that the trust will at all times comply with its statutory requirements.
Joint Ventures & Academic Health Sciences Centres/ Networks
The board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;

Corporate Governance Statements
• have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • ensure that the Principles and Rules for Cooperation and Competition are considered and where appropriate the CCP is consulted; - maintain the register of interests and no residual material conflicts identified; - engage the governors of the trust in the development of plans and give them the opportunity to express a view of these plans

Corporate Governance Statements
In addition, before entering into an accredited AHSC or other major Joint Venture, boards of NHS foundation trusts are required to certify that they have received external advice from independent professional advisers with appropriate experience and qualifications and that they have taken into account the best practice advice in Risk Evaluation for Investment Decisions by NHS Foundation Trusts or comment by exception where this is not the case.

*In relation to statement 11: at the time of finalising the Annual Plan 2013/14, the Board was aware of one non-avoidable case of C.Difficile which would exceed the current threshold of zero. This has been discussed with Monitor. The Board is not aware of any other risks to its plans for on-going compliance with its existing targets or with any other targets going forwards.

5 Membership

5.1 Membership Report

5.1.1 Membership Council

The Membership Council met five times during 2012/13, its discussions during the year mirrored those of the Trust Board cycle. The Council has had input into the development of this Annual Plan and comments on the progress of the trust's strategy. The Council also reflects on the performance of the Board through a regular review of financial, operational performance and a focus on quality across the three areas of patient safety, clinical effectiveness and patient experience.

During 2012/13 the Council began the transition to introduce the new Membership Council and Governor responsibilities brought in as a result of Health and Social Care Act becoming law. These changes will continue to worked through and implemented in 2013/14.

Governors represent their members in the public, patient and staff constituencies and have participated in a range of activities such as membership engagement events and the annual membership week event in July at the City Road site and the satellites.

Governors lead the Membership Development Group and attend the Quality and Safety Committee and the Patient Experience Committee. Governors participate in appointment panels for senior managers and clinicians. Governors are invited to attend board meetings and regularly do so and trust directors regularly attend the Membership Council.

Governors are presented annually with a report about the trust's accounts and the trust's Quality Account from the external auditors about which they provide comments and feedback.

As per the trust's constitution, the trust has six public constituencies with 12 public governors; a patient constituency with 3 patient governors; a staff constituency with 4 staff governors and 6 nominated governors from our partner organisations. With the statutory removal of PCTs from 31 March 2013, in 2013/14 there will no longer be the 2 PCT nominated governors.

5.1.2 Membership data

Membership size and movement

Analysis of the membership data is shown in the tables below:

Public Constituency	2012/13	2013/14 (5% estimated)
At year start (April 1)	8,067	7,489
New members	317	
Members leaving	895	
At year end (March 31)	7,489	7,863

Staff Constituency	2012/13	2013/14 (2.5% estimated)
At year start (April 1)	1,620	1,720
New members	200[e]	
Members leaving	100[e]	
At year end (March 31)	1,720	1,763

e = estimates only. Better figures will be available in 2013/14 through the introduction of a new HR and payroll system.

Patient Constituency	2012/13	2013/14 (5% estimated)
At year start (April 1)	6,703	9,062
New members	2,955	
Members leaving	596	
At year end (March 31)	9,062	9,515

Current membership

Public Constituency		
Age (years)	Number of members	Eligible membership
0-16*	7	366,757
17-21	33	641,986
22+	7473**	7,727,584

* Members must by older than 14

**24 members did not have dates of birth recorded in the database

Public Constituency		
Ethnicity	Number of Members	Eligible membership
African	547 (7.3%)	341,914 (3.9%)
Any other Asian Background	324 (4.3%)	123,685 (1.1%)
Any other Black Background	41 (0.5%)	55,704 (0.6%)
Any other Mixed Background	75 (1.0%)	231,600 (2.7%)
Any other White Background	394 (5.3%)	622,503 (7.1%)
Bangladeshi	186 (2.6%)	143,153 (1.6%)
British	3782 (50.5%)	5,946,939 (68.1%)
Caribbean	371 (5%)	317,312 (3.6%)
Chinese and other ethnic group	378 (5%)	193,870 (2.2%)
Indian	943 (12.6%)	397,693 (4.6%)
Irish	253 (3.4%)	231,087 (2.7%)
Pakistani	195 (2.5%)	126,106 (1.5%)
Total	**7,489***	**8,731,566**

*Where there have been blanks because of an absence of data, numbers have been estimated on a prorata basis.

Public Constituency		
Gender	Numbers	Eligible Membership
Male	3,984 (53.2%)	4,442,110 (50.9%)
Female	3,505 (46.8%)	4,294,217 (49.2%)
Total	7,489	8,736,327

Patient Constituency		
Age (years)	Number of members	Eligible membership
0-16*	36 (4.0%)	366,757 (4.2%)
17-21	79 (8.7%)	641,986 (7.3%)
22+	8,918 (98.4%)**	7,727,584 (88.5%)
Total	9,033	8,736,327

*Members must by older than 14

**29 members did not have date of birth data available

5.1.2.1 About the Membership data

There are six public constituencies:

- Bedfordshire and Hertfordshire
- North Central London
- North East London and Essex
- North West London
- South East London
- South West London

This covers all the postcode areas in London, Essex, Bedfordshire and Hertfordshire.

Data has been gathered from the most reliable source for each heading.

Age & Gender

Age and Gender eligibility figures are the Office for National Statistics 2010 population age and gender estimates. The original data has been weighted to achieve the age splits required.

Ethnicity

Ethnicity estimates are based on the Census 2001 Ethnicity in the UK:Ethnic Group (GB). The original data has been weighted proportionately to estimate the population over 14 years.

Due to the constraints of the available data, all mixed-ethnicity data is aggregated and Chinese and other ethnic groups are aggregated.

Socio-economic group

Moorfields Eye Hospital NHS Foundation Trust does not currently collect data about the socio-economic category of members.

5.1.2.2 Membership Analysis

In age terms, both the public and patient constituencies are less well represented in the younger age groups compared to the 22+. This is likely to be because membership appeals more to those under 22 and indeed will certainly be much less appealing for children.

In terms of ethnicity, there is a generally good correlation between ethnicity within the public constituency and the eligible membership, the only notable exceptions being that the British category is under-represented and the Indian category is over represented.

For the gender category this is skewed towards men as we would expect about a 50:50 ratio.

More analysis on these categories will be undertaken during 2013/14.

5.1.2.3 Elections

A by-election was held in October 2012 for a new governor to represent members of the Bedfordshire and Hertfordshire constituency. This by-election was called as no one put themselves forward as a nominee for the previous ballot held in March 2012, which meant that this constituency was without a representative for the first part of 2012/13.

Further elections were held in March 2013 for four further public constituencies and three staff representatives, where governors had come to the end of their terms of office. The successful candidates started their terms of office from 1 April 2013.

All elections are held in accordance with the election rules as set out in the trust's constitution.

An analysis of the turnout for elections during 2012/13 is summarised below:

Date of Election	Constituency	Number of members	Number of seats contested	Number of contestants	Election turnout (%)
30 October 2012	Befordshire and Hertfordshire	563	1	5	29.2
21 March 2013	Befordshire and Hertfordshire	563	1	2	32.0
	North Central London	1,631	1	2	22.8
	North West London	N/A	1	1	Uncontested
	South West London	N/A	1	1	Uncontested
	Staff – City Road	N/A	2	2	Uncontested
	Staff – satellite	N/A	1	1	Uncontested

5.2 Membership Commentary

The Trust continues to grow its membership, with approximately 18,300 members at 1 April 2013, this represents a very healthy 11.6% growth in membership from the previous year. The profile of growth has been heavily centred on patient members and this is likely to be because members of the public identify most easily with the concept of being a patient and becoming a trust member, but are less clear about the concept of public constituencies and what the difference is between the two; this is a choice issue and there is no specific significance attached to this apart from the need to provide as much clear information as possible about the constituency types and to maintain health numbers across all constituencies which remains the case for Moorfields.

A new membership database is being developed in 2013/14 and during its commissioning a further data cleansing exercise will be performed for all membership types. This will rebase-line the trust's membership numbers and despite continued expected growth of the membership in year, may result in either no overall growth, or potentially a decrease in membership by the end of 2013/14.

Members receive information through the 'In Focus' magazine and via the website, and are invited to attend the Annual General Meeting (AGM) where they are informed about service and research developments, as well as the formal report from the Chief Executive. There is always good attendance of members at the AGM.

Membership engagement events will continue across all sites and there will be a membership event in July.

6 Glossary

A & E	Accident and Emergency
AMD	Age-related Macular Degeneration
AVRO	Association for Research in Vision & Ophthalmology.
BLT	St Bartholomew's and the London NHS Trust
BRC	Biomedical Research Centre
CAAC	Clinical Audit Assessment Committee.
CCG	Clinical Commissioning Groups
CCP	Cooperation and Competition Panel
C-diff	Clostridium Difficile
CIP	Cost Improvement Programme
CPI	Consumer Price Index
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
ENP	Emergency Nurse Practitioner
FRR	Financial Risk Rating
G.P	General Practitioner
HCAI	Healthcare Associated Infections
HR	Human Resources
ICT	Information and Communication Technology
IT	Information Technology
LPCB	London Project to Cure Blindness
MEH	Moorfields Eye Hospital
MDT	Moorfields Motion Displacement Test
MFF	Market Forces Factor
MGTT	Modified Global Trigger Tool
MONITOR	Independent Regulator of Foundation Trusts.
MRSA	Methicillin Resistant Staphylococcus Aureus
NCL	North Central London
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
Open Eyes	Ophthalmic Electronic Patient Record (web based)
ONS	Office for National Statistics
PAS	Patient Administration Services
PBR	Payment by Results
PCT	Primary Care Trust
PROM	Patient Reported Outcome Measure
QIPP	Quality Innovation Productivity and Prevention
RDCEC	Richard Desmond Children Eye Centre
R & D	Research and Development
RNIB	Royal National Institute for Blind People.
T-POT	The Productive Operating Theatre
UCL	University College London
UCLP	University College London Partnership
UKTI	UK Trade and Investment
VTE	Venous Thromboembolism
WCC	World Class Commissioning

Moorfields Eye Hospital NHS Foundation Trust
City Road
London
EC1V 2PD

Appendix 1

Quality Report 2012/13

1.0 Chief executive's statement on quality

The issue of quality across the NHS was brought into sharp focus this year with the publication of Sir Robert Francis QC's report into the poor standards of care at Stafford Hospital in February 2013. Although we are confident that failures on that scale could not happen here at Moorfields, we have robustly reviewed the findings of the report to identify areas where improvements could be made or where we might build on existing activity to ensure that patients are always truly at the centre of everything we do. Further details of our response to the Francis report can be found in section 2 of our annual report and accounts for 2012/13 and will form an important part of our strategic priorities for 2013/14.

Quality is central to our 10-year strategy, Our Vision of Excellence, where it is listed as one of four strategic themes. Specifically for 2012/13, we had four priorities as part of this strategic theme, covering medical revalidation arrangements, the embedding of outcome measures into performance management, the use of effective and efficient clinical technologies and improvements to the patient experience.

Progress against the specific quality themes of clinical effectiveness, patient safety and the patient experience are described in section two below. For 2013/14, we intend to build on this progress and on current initiatives to ensure that quality continues to underpin all of our activity.

National targets remain a helpful framework for delivering quality, and we are especially pleased that, once again, we successfully met or exceeded the national targets that matter most to patients. Specifically, we maintained our strong performance for the 18-week referral-to-treatment targets, the four-hour target in A&E and infection control measures. In addition, we are registered without conditions with the Care Quality Commission and received positive feedback from CQC inspections of our main hospital in London's City Road and to our satellite unit at St Ann's hospital in Tottenham.

We continue to work closely with our board and membership council, which includes patient representatives, in developing quality initiatives for the future. Increasingly, we are also interacting directly with patients through an enhanced programme of patient information days and via a wide range of feedback systems. We also introduced a new monthly board report specifically looking at quality and safety and incorporating clinical outcome measures.

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

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

2.0 Progress against priorities for improvement during 2012/13

For 2012/13, Moorfields identified six quality improvement priorities as set out below. These priorities were identified in consultation with patients, staff and governors and approved by the trust board.

2.1 Patient experience – improving outpatient waiting times

Objective: To ensure that improvements achieved to date in outpatient journey times (the time between the patient's appointment time and when they leave the hospital), are maintained, and that they apply to all glaucoma and medical retina clinics.

In addition, to develop and implement an operational plan to extend the remit of the outpatient improvement project to cover other ophthalmic specialties beyond glaucoma and medical retina.

The work of the outpatient improvement team will also be integrated into the trust's longer term plans and linked to the corporate priorities for the coming year i.e. the transformational change programme, workforce redesign and the relocation of service provision in line with geographical demand and financial sustainability.

Progress in 2012/13:

- The profiles of all clinics within the glaucoma and medical retina services were agreed with key clinicians, uploaded onto the patient administration system and implemented by the end of March 2013, with all the new profiles set to go live by the end of May.
- Approximately 20% of the re-profiled clinics demonstrated a significant reduction in the average patient journey time. The level of improvement is detailed in the table below:

Service / type of appointment		% of clinics demonstrating significant improvement	Benchmark average patient journey time	Average improvement	
				number of minutes	% of original journey time
Glaucoma	new	23%	2hrs 21mins	24 mins	13%
	follow up	39%	1hr 38mins	19 mins	17%
Medical retina	new	0%	1hr 59mins	Nil	N/A
	follow up	15%	1hr 43mins	17mins	15%

It is important to note that we did not achieve a significant reduction in the patient journey times in 80% of the re-profiled clinics. This is because having introduced the new profiles

we were unable to manage the clinics strictly in line with these schedules, and profiles continued to be overbooked in line with the level of demand on these two services. We believe that the transformational change programme referenced below and other initiatives focused on new ways of working and controlling demand, will be key to our ability to use the new profiles to deliver improved journey times and a better patient experience.

- A bespoke electronic rota solution designed to link doctors' leave to outpatient clinic capacity went live in the glaucoma service in February 2013.
- A new process for the requesting and authorisation of medical staff's leave was agreed with service directors and clinical directors and launched on 1st March 2013.
- During 2012/13, the trust completed the installation of 12 additional information screens across Moorfields' sites and services. These screens provide our patients with regular, high quality information about journey times, but they have also been used to reinforce health promotion campaigns such as flu vaccination and to advertise and facilitate service developments such as asking patients to express an interest in repatriating their care to a Moorfields site closer to home.
- During 2012/13 the trust employed Vanguard Consulting to help us to plan and implement a transformational change programme the core principle of which is to provide services that are designed to deliver only that which is of value to the patient. One of the key performance measures for the programme in the outpatient setting is the patient's journey time and the amount of non-value added time included in the outpatient journey. The programme has begun by focusing on the glaucoma pathway at St George's and to date some 1,500 patients have been involved in the experimental work. By recording the amount of time that patients spent waiting and undertaking value activities during the baseline and experiment clinics, the team at St George's was able to demonstrate the progress made by the experiments towards eliminating non-value time. In the baseline clinics, patients spent an average of 67% of their clinic visit in non-value activities, i.e. waiting. In the experiment clinics, patients spent an average of only 27% of their clinic visit on non-value activities. The team are working to improve these results further as the transformation programme progresses at St George's.

2.2 Patient experience – improving the cataract surgical pathway

Objective: To deliver the productive operating theatre programme (TPOT), and to ensure that further improvements in surgical journey times (the time between when the patient is asked to arrive at the hospital and when they are discharged home), are achieved via the completion of the service improvement work for the pilot areas. The work programme for 2012/13 will include the comprehensive introduction of staggered arrival times with a robust link to the order of theatre lists, pre-dispensing dilation drops and the provision of pre-packed post-operative medication. During the second half of the year the programme will move on to roll out this service improvement work to other cataract pathways.

Progress in 2012/13:

Productive operating theatre programme (TPOT)

- Initially TPOT focused on theatre list start times, theatre utilisation and cancellations on the day of surgery. Performance data on these indicators is now regularly published in theatres. Through the improvement work undertaken to date, the number of lists starting on time has increased from 40% in June 2012 to 59% in March 2013 and cancellations on the day of surgery have reduced from 12% to 7% as a result of this initiative.
- A review of all surgical capacity has been undertaken with a focus on repatriating surgical activity in line with care closer to home and the trust's strategic intention to optimise the use of its satellite locations.

Surgical journey times

- The average cataract journey time on pilot lists has reduced during 2012/13 from four hours and 56 minutes to four hours and two minutes, with an average journey time across the best of the pilot lists of three hours and 35 minutes.
- All cataract lists are now ordered in advance, which allows patient arrival times to be staggered where appropriate.
- Through the initial improvement work on the pilot lists it was found that pre-dispensing of dilation drops and pre-prescribing of post-operative medication, did reduce the patient's length of stay. Our original methodology however required significant administrative support from medical staff, which in turn led to inconsistency and variations in performance. In consultation with the clinical champion for this project a pre-operative dilation pellet was introduced which has subsequently been shown to improve the patient experience and to reduce both the patient preparation and nursing time. Pharmacists dispensing take home medicines on the wards, has also commenced, and we believe that this will have a positive impact on the post-operative length of stay.
- The improvements implemented on the pilot cataract pathways are now in the process of being rolled out to other services, and pilots have commenced in the adnexal, medical retina, cornea and glaucoma services.
- A clinical lead from theatres has also been appointed who is responsible for leading both of the programmes outlined above and securing the engagement of his clinical colleagues.

2.3 Patient experience – improving the environment

Objective: To continue to improve the quality of the patient environment in the outpatient setting, specifically through the delivery of the following key investment schemes:

- The City Road A&E refurbishment and expansion project (work to have commenced on site by the end of 2012/13)
- The redevelopment of Victoria Ward at City Road to accommodate the ultrasound service and the vitreo-retinal emergency clinic
- The refurbishment and expansion of the orthoptics department at City Road
- The refurbishment of the ocular prosthetics department at City Road
- The completion of the Moorfields at Ealing redevelopment project
- The completion of the design and planning phase for Moorfields at St George's hospital redevelopment project.

Progress in 2012/13:

- Work began on the City Road A&E refurbishment project on 18th February 2013. The observation bay will be relocated to increase the footprint of the A&E department and to provide dedicated space for the new emergency nurse practitioner (ENP) pathway. At the same time the department will be redecorated and the environment improved with new flooring, lighting and furnishings. Facilities will also be improved for children and patients who could possibly represent an infection control risk to others. This programme of work is expected to take approximately 32 weeks, with an anticipated completion date of quarter three 2013/14.
- The redevelopment of Victoria Ward at City Road to accommodate the ultrasound service and to create a new centre for retinal emergencies was successfully completed this year.
- Following the relocation of the ultrasound service to its new home on Victoria Ward, the refurbishment and expansion of the orthoptics department began at the end of February 2013, and is due for completion in the Spring.
- The refurbishment of the ocular prosthetics department at City Road was successfully completed this year.
- The Moorfields at Ealing redevelopment project and the Moorfields at St George's hospital redevelopment project have not made the progress anticipated this year. Relevant MEH staff including clinical and executive directors, have been actively engaged in negotiations with the respective host hospitals to develop and agree mutually acceptable plans for these developments, and both of these projects will remain priorities for the trust during 2013/14.

2.4 Clinical effectiveness – expansion of clinical outcome and performance indicator programme

Objective: To report routinely on at least two clinical outcome indicators for each major subspecialty service across the trust. To develop an array of meaningful clinical outcome indicators for two services with input from stakeholders, including users, and to develop a consistent outcomes and performance dashboard for all four clinical directorates.

Progress in 2012/13: All services have identified and agreed three key clinical outcome indicators ("core outcomes"), and 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. The trust's performance against these standards generally 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 of particular note are the following:

- The results for biometry predictability, which demonstrate how accurately and reliably we are able to achieve the planned postoperative spectacle prescription, both for all cataract surgery patients and also for those with high short sight where the outcomes are more difficult to predict.

- 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; 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.

The use of the WHO surgical safety checklist and the venous thromboembolism assessment are outcomes that measure process rather than the direct results of clinical care. We did not achieve 100% against these indicators during 2012/13, but it is hoped that the planned observational audit of practice in theatres will help to improve this performance.

The process of collecting outcome data remains time and labour intensive and as a result reporting is only possible annually for some outcomes.

Surveys have been undertaken in the glaucoma and adnexal services, with input received from patients and other stakeholders, including GPs, optometrists and commissioners. The results of these surveys have supported the key outcomes currently identified, with those deemed particularly important being the retention of vision, the ability to drive, and the outcome of surgical procedures.

2.5 Patient safety – site and service safety review: revision of patient safety walkabouts in combination with structured case note review procedure to cover all areas

Objective: To revitalise the patient safety walkabout process with a timetabled plan of walkabouts, and to combine this with a structured case note review procedure designed to spot the signs of things going wrong (the modified global trigger tool (mGTT)) to create a consistent safety review tool across all trust sites and services.

Progress in 2012/13: The trust has developed a revised, formalised and robust patient safety walkabout process and recently completed a pilot in which the four major district hubs were visited. Staff from the quality and safety team and one of the trust's executive directors met with local senior staff and presented and discussed a thorough review of all safety, patient experience and clinical effectiveness data including an analysis of both notable practice and areas of concern.

Each visit also included a physical tour of the department and where possible, visiting staff met with local staff and patients. Agreed and achievable remedial action plans were developed and the delivery of those plans monitored. A number of important actions have been completed including resolution of water supply issues in Ealing and the development of a process for prioritising case note provision from City Road to the satellite sites.

The process also allows major, longstanding issues, which the visits themselves could not realistically be expected to resolve, to be escalated appropriately within the organisation.

The trust also continued to use its locally developed mGTT to provide a structured case note review audit which measures risk and low-level adverse events and allows comparison of quality of care between sites. Changes implemented using the mGTT include the introduction of a combined children's vision clinic (orthoptic and optometric led) in Ealing, which has significantly improved patient journey times and efficiency. Not every site and service has completed an mGTT audit during the year and work continues to complete these.

2.6 Patient experience and clinical effectiveness – developing patient reported outcome measures (PROMS)

Objective: To create and pilot a PROM for ophthalmology.

Progress in 2012/13: The development of bespoke PROMs takes some time to allow for appropriate input and direction from patients and users, piloting and validation. During the year an easy to use PROM; the PRESS (patient reported eye symptom score), was developed for use in general ophthalmology clinics. Once developed, a successful pilot was run involving 50 patients who had attended a general ophthalmology clinic at City Road more than once. The pilot demonstrated that the tool was easy to use and the results showed that the majority of patients reported significantly better symptom scores at the second visit compared to the first. The pilot has been repeated at the trust's satellite service in Ealing Hospital, where it was combined with a clinician reported outcome score for the same patients. Work is now underway to analyse and compare results from patients and clinicians for the purposes of validating the tool. Several other PROMs projects are currently underway to identify which PROMs are practical and suitable for use in other areas of ophthalmology.

3.0 Performance against key indicators for 2012/13

Each of the indicators listed below was selected to provide comparable data over time to demonstrate compliance with those agreed corporate objectives for 2012/13 relating to the quality agenda. Some indicators were new for 2012/13 and the trust's rationale for changing or selecting new key indicators is as set out in its 2011/12 Quality Report.

The trust's achievement against each of the indicators in the table below has been assessed using a RAG (red, amber, green) 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	2012/13 target	2012/13
Patient experience				
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	73%*	81%	Results not yet available
% of patients who spent less than four hours waiting in A&E	Internal performance monitoring	99.1%	95% (national target)	99.3%
% of patients who spent less than three hours in A&E	Internal performance monitoring	New indicator	80%	81.7%
% reduction in average patient journey time for cataract surgery patients	Internal performance monitoring	4hrs 56 mins	30% reduction in average journey time on pilot lists (reduce from 4hrs 56mins to 3hrs 30mins)	18% reduction in average journey time on pilot lists (reduced from 4hrs 56mins to 4hrs and 4mins)
Complete the clinic re-profiling exercise in all medical retina and glaucoma clinics across all MEH sites.	Internal performance monitoring	Pilot clinics x5	99 additional clinics across the two relevant services on all sites	Clinic re-profiling exercise complete
Patient safety				
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	New indicator	90%	91.5%
% overall compliance with hand hygiene standards	Internal performance monitoring	96%	95% (increased from 90% in 2011/12	97%

Indicator	Source	2011/12	2012/13 target	2012/13
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0	0
Incidence of endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.48	<0.83	0.29
Incidence of endophthalmitis per 1,000 intra-vitreal injections for the treatment of AMD***	Internal performance monitoring	0.30**	<0.5	0.35
Site and service safety review: Patient safety walkabout and casenote review	Internal performance monitoring	N/A – new indicator	Combination walkabout and mGTT completed and reported to CG meeting in line with published programme	Walkabout process devised and completed in the four district hubs; mGTT audits regularly performed but not achieved in all major sites/services
Clinical effectiveness				
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%
Posterior capsule rupture rate for cataract surgery	Internal performance monitoring	1.34%	<1.8%	0.80%
The development of performance dashboards for the four new clinical directorates including all relevant clinical outcome indicators, and regular reporting via the	Internal performance monitoring	N/A – new indicator	As per indicator	Trustwide Clinical Quality and Safety performance report in use. Directorate dashboard in draft to be piloted.

Indicator	Source	2011/12	2012/13 target	2012/13
performance management framework.				
Comprehensive clinical outcome metrics in place for two specialty services	Internal performance monitoring	N/A – new indicator	As per indicator	Outcome surveys completed and outcome measures agreed for glaucoma and adnexal; awaiting the launch of relevant clinical modules in OpenEyes to start collecting results.

*2011/12 performance against this indicator was not included in the trust's 2011/12 Quality Report as the information was not available at the time of going to press.

**Last year 0.33 was reported as the rolling average as opposed to the overall figure for the year which would have been 0.30.

***AMD is Age-related macular degeneration which is a condition which usually affects older adults and results in a loss of vision in the center of the visual field (the macula) because of damage to the retina. It occurs in "dry" and "wet" forms. It is a major cause of blindness and visual impairment in older adults (>50 years). Macular degeneration can make it difficult or impossible to read or recognize faces, although enough peripheral vision remains to allow other activities of daily life.

4.0 Performance against national performance measures

Moorfields reports compliance with the requirements of the Monitor compliance framework, the NHS operating framework and the relevant indicators in the NHS outcomes framework to every meeting of the trust board as part of a monthly performance report. The report demonstrates progress against key quality indicators, as set out in the table below.

In relation to the Clostridium difficile data, the 28 readmissions indicators and the patient safety indicator which are the NHS Outcomes areas applicable to the trust, Moorfields Eye Hospital NHS Foundation Trust provides the following analysis with actions to improve the quality of its services:

- Clostridium difficile: there were no cases so no further comparison is required or actions are required.
- 28 day readmissions: there were 8 emergency readmissions within 28 days of discharge after inpatient admission. This equates to 1.3% of discharges following inpatient admissions. This is a significantly lower figure compared to the national average of 11.4% in 2010/11.
- Patient safety incidents: the benchmarking data for a specialist peer group indicates that Moorfields has good reporting rates for its overall numbers which have increased from 2011/12. A high number is an indicator that reporting rates are high with most incidents not leading to harm. The trust is below average for its rates per 100 admissions - within the range of the lowest and highest performers it compares at the lower end of the range (performance for 2012/13 was better than 2011/12). The trust believes that better comparative ophthalmic benchmarks need to found in order to obtain meaningful comparisons. The trust intends to continue to improve its overall reporting rate; part of supporting that will be by introducing electronic incident reporting, which will also help comparative analysis and learning from the themes that have arisen and any links to complaints, PALS and patient experience data. Under the current manual system this data is being used to improve aspects of care, treatment, service delivery or the patient experience as issues are determined – this action has been specifically confirmed in the trust's response to the Francis report.

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

Description of target	Performance 2011/12	Target 2012/13	Performance 2012/13	National average 2012/13	Highest performing trust 2012/13	Lowest performing trust 2012/13
Infection control						
MRSA – meeting the MRSA objective	0	0	0	NA	NA	NA
Clostridium difficile year-on-year reduction	0	0	0	NA	NA	NA
Screening all elective inpatients for MRSA	100%	100%	100%	NA	NA	NA
Screening all emergency inpatients for MRSA by 2011	100%	100%	100%	NA	NA	NA
Risk assessment of hospital-related venous thromboembolism (VTE)	100%	90%	96.1%	93.9%	100%	78%
Waiting times (1)						

Description of target	Performance 2011/12	Target 2012/13	Performance 2012/13	National average 2012/13	Highest performing trust 2012/13	Lowest performing trust 2012/13
Two week wait from urgent GP referral for suspected cancer to first outpatient appointment	100%	93%	100%	NA	NA	NA
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge	99.2%	95%	99.3% (3rd nationally for acute providers)	95.9%	100%	88.3%
18-week standard from point of referral to treatment for admitted patients	92%	90%	91.1%	92.2%	100%	78.5%
18-week standard from point of referral to treatment for non-admitted patients	97%	95%	96.0%	97.5%	100%	86.5%
18-week standard from point of referral to treatment for patients awaiting treatment	N/A – new measure for 2012/13	92%	92.0%	94.3%	99.6%	73.2%
6-week diagnostic test waiting time	N/A – new measure for 2012/13	99%	100%	98.9%	100%	82.4%
Cancelled operations						
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	100%	100%	100%	95.1% (full year)	100% (Q4)	25% (Q4)
Patient Safety Incidents (2)						
Numbers	826	N/A	1137	722	1720	36
Rate per 100 admissions	2.7	N/A	3.7	7.5	24.9	1.4

Description of target	Performance 2011/12	Target 2012/13	Performance 2012/13	National average 2012/13	Highest performing trust 2012/13	Lowest performing trust 2012/13
Numbers resulting in severe harm or death	7	N/A	8	3.4	0	26
Severe harm or death incidents as a % of total incidents	0.85%	N/A	0.7%	0.4%	0	1.8%
Other (3)						
Mixed sex accommodation breaches	0	0	0	0.2 per 1,000	NA	NA
28 day emergency readmission rate (over 16 years old)	N/A	N/A	1.3%	11.4% (2010/11)	NA	NA
28 day emergency readmission rate (0 to 15 years old)	N/A	N/A	0%	10.0% (2010/11)	NA	NA
Certification against compliance with the requirement regarding access to health care for people with learning disabilities	Full compliance	Full compli-ance	Full compliance	NA	NA	NA

(1) Only one of the new national cancer waiting times targets was relevant this year to Moorfields due to our low activity levels in this area.

(2) This year is the first time that this indicator has been required to be included within the Quality Report. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents, including those relating to severe harm or death are reported to the NRLS. The NRLS then report the serious incidents to the Care Quality Commission.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, trusts may apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting

in severe harm or death', often relies on clinical judgement. This judgement differs between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore the differences between the data reported by different trusts may not be comparable.

Specific things to note from this data are as follows:

- The benchmarking dataset is the acute specialist NRLS data.
- For 2012/13:
  - This is the first year of introduction of the patient safety indicator so no target has been set.
  - The rate per 100 admissions is calculated by dividing the total number of incidents by the total number of inpatient and outpatient admissions and deriving a rate per 100 admissions.
  - In relation to the number of incidents recorded as severe harm or death, following year end a limited number of clarifications are made which means this may not be the final figure.
- It should be noted that there is a huge variety in reporting between specialist acute organisations and that is unsurprising given the very different work that they do. More work is required to find a peer group that may provide better comparative data.

(3) An indicator relating to trusts' responsiveness to personal needs is not relevant to this organisation because it relates to the inpatient survey which this organisation does not participate in (because of its small number of inpatients and the nature of the ophthalmic care we offer).

5.0 Priorities for 2013/14

The development of the trust's quality report was led by the chief operating officer and co-ordinated 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 the three areas of patient safety, patient experience and clinical effectiveness. Development of the quality report was reviewed by the quality and safety committee half way through the year and was finalised as a balanced representation of the trust's priority areas across patient safety, patient experience and clinical effectiveness. The membership council has also scrutinised and fed its views into the development of the quality account which was agreed by the trust board on 23 May.

Progress against the trust's quality priorities has been overseen by the trust management board and scrutinised by the trust board, the quality and safety committee and the membership council.

The quality priorities for 2013/14 are consistent with the trust's agreed strategic priorities. A number of stakeholders have been consulted during the development of the quality priorities, including clinicians, governors (some of whom are patients), commissioners, the quality and safety committee, Healthwatch and Islington's Health and Wellbeing Scrutiny Committee. The quality priorities have been included in the annual plan and have been approved by the trust board.

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

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

Rationale for inclusion: As described in section 2.1 above, the results of the programme at St George's so far demonstrate that the systems thinking approach advocated by Vanguard Consulting makes tangible improvements to the value of outpatient visits. In order to see the full benefits of this approach, it needs in the first instance to be extended beyond outpatient clinics to encompass the referral and surgical stages of the Glaucoma pathway, prior to starting work in the other subspecialties at St George's.

How we will monitor, measure and report on progress:

A suite of measures will be developed to monitor the progress of the programme at St George's. These measures will be derived from the operating principles for the programme, which are listed below:

1. Only do work that is valuable to the patient
2. "Single piece flow" – minimise handovers between staff
3. "Set up clean" (i.e. with all staff and equipment ready on time) and "finish clean" (i.e. patients leave with all tests done and all the information they need and clinic staff leave a tidy clinical environment with all administrative tasks completed).
4. Patients see the right person with the right skills and additional expertise is available to be "pulled in" as and when necessary.
5. We will learn, make change and decisions based on data
6. Challenge existing rules, regulations and practices
7. Design against demand
8. Always have the right measures of capability

Progress against the agreed measures will be monitored and performance measured, by the multi-disciplinary team involved in the transformation programme at St George's and during monthly directorate performance review meetings. Performance against the measures will also be reported to the Trust Board as part of the new quality and safety report.

5.2 Patient experience

Objective:

- To improve how we communicate with our patients, specifically about waiting times and delays in the outpatient clinics.
- To make it easier for patients to contact the right person when they need to change or confirm appointments
- To improve the quality of the discharge information we give to patients, with an emphasis on medication side effects

Rationale for inclusion:

Patient feedback obtained from surveys, complaints and PALS enquiries tell us that we need to improve how we communicate with our patients. In particular, we need to concentrate on keeping them informed about delays during their visit and to make it easier for them to contact somebody who can help with enquires, such as appointment queries. Patients would also like to receive more robust information about how to manage their eye conditions following discharge after a surgical procedure.

How we will monitor, measure and report on progress

We will monitor improvement through monthly reviews of the number of complaints and PALS enquiries relevant to this objective, and this will be reported and reviewed at the Patient Experience Committee. We will also use the results from the day care survey to assess our performance on the quality and robustness of our discharge processes including information on medication side effects.

5.3 Patient experience – improving the surgical pathway

Objective:

- To complete year two of TPOT including participation in the Foundation Trust Network theatre benchmarking exercise and rolling out the programme beyond City Road to all MEH sites undertaking surgical activity.
- To roll out the surgical pathway improvements to all ophthalmic specialties.

- As part of the planning exercise for Moorfields' new Central London hub and in line with the trust's objective to provide care as close to the patient's home as possible and to optimise the use of our satellite network, operational management staff will work with patients and senior clinical colleagues to repatriate surgical work away from City Road, to existing and where appropriate new satellite locations.
- In line with the trust's transformational programme to review and redesign the current patient pathway for all ophthalmic services at City Road. This will involve process mapping the current pathway and working with clinicians, nursing staff and patients to develop the optimum patient pathway
- To develop and formalise a standard operating procedure for theatres

Rationale for inclusion:

We need to ensure that our surgical pathway at City Road is lean and patient focused in order to improve the patient experience and to ensure that we use resources efficiently and effectively in order to support the delivery of high-quality clinical care.

The development of a standard operating procedure will assist in supporting the delivery of this objective by providing clear and robust processes.

How we will monitor, measure and report on progress:

Progress on the delivery of these initiatives will be monitored via the regular monthly performance review meetings with the surgical services directorate.

We will also monitor improvement through monthly reviews of the number of complaints, PALS enquiries and patient feedback relevant to these objectives, for example the number of complaints mentioning unacceptably long surgical journey times.

5.4 Patient experience – improving the environment

Objective:

- The successful completion of the City Road A&E project as outlined above.
- The successful completion of the project to expand and refurbish the orthoptics department.
- The completion of the Moorfields at Ealing redevelopment project.
- Significant progress on the Moorfields at St George's hospital redevelopment project.

Rationale for inclusion:

We need to ensure that the environment in which patients are seen and treated is of a sufficiently high standard to support the delivery of high-quality clinical care. We face several challenges in achieving this objective, predominantly due to the age of the estate at the main hospital base in City Road and at some of our satellite facilities. We also need to ensure that, during the upgrade of any of our facilities, we can continue to deliver services with as little disruption and inconvenience as possible.

All projects listed under this objective are co-ordinated and managed by multidisciplinary steering groups, all of which include patient representatives.

How we will monitor, measure and report on progress:

The progress of these major capital projects is monitored by the trust's capital planning group and, in turn, by the trust board. The quality of the patient experience before, during and after project implementation is monitored using a variety of patient feedback mechanisms, including patient surveys, complaints, comment cards and Moorfields minute cards.

5.5 Clinical effectiveness – expansion of clinical outcome and performance indicator programme

Objective:

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

Rationale for inclusion:

The aim of developing a program of routine outcome measurement is to allow patients, commissioners, referrers and other professionals to see up-to-date, accurate information on the results of and safety of care provided by Moorfields. Outcomes must be relevant, and widely recognised as important and meaningful to clinicians, stakeholders and patients and should avoid excessive use of clinical staff time to generate the results. Ideally this information should be generated automatically from routine clinical data entry.

How we will monitor, measure and report on progress:

The trust will continue to collect information from patients, users, commissioners and clinical staff on which outcomes to measure in the remaining services, as well as incorporating information from the medical literature, major eye units internationally and bodies such as the Royal College of Ophthalmologists. Services will be asked to agree additional outcomes based on this information and the clinical modules in OpenEyes (the trust's new electronic patient record), will be created to allow these outcomes to be collected without the need for additional audit data fields or pages. Results will be published via the quality reporting systems below and on the new website.

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

Objective:

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

Rationale for inclusion:

Patient safety walkabouts and regular site visits, with reviews of local quality and safety data, are important in allowing two–way communication between very senior management staff, clinical staff, and patients, ensuring that safety and quality issues are highlighted and acted upon at the highest level in the organisation. Regular reviews of case notes are a proactive way of identifying and changing poor practice before it reaches the level of a serious patient safety incident. Both of these are particularly important for Moorfields with its many satellite locations.

The walkabout programme is extremely useful and now that the pilot has been successfully completed, the process will be reviewed to ensure optimum efficiency and effectiveness. Consideration will be given to including Non-executive directors and governors in this process alongside other senior trust staff.

How we will monitor, measure and report on progress:

The implementation of the patient safety walkabouts and mGTT audits programme will be monitored, and measured against the implementation plan via the new directorate

performance dashboards (see below). The dashboards will be reviewed at all directorate performance review meetings.

5.7 Patient experience and clinical effectiveness – developing PROMS tools

Objective:

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

Rationale for inclusion:

Information on clinical outcomes is important in an overall assessment of the quality of care provided, but the use of PROMs provides a key measure of whether the care that we deliver benefits the patients in relation to their quality of life. In the absence of nationally approved ophthalmic PROMs, and as a leader in ophthalmic care, Moorfields should take a lead in the development and use of these tools in ophthalmology.

How we will monitor, measure and report on progress:

The introduction of PROMs in general ophthalmology, cataract surgery, paediatric ophthalmology and glaucoma will be monitored via the quality and safety report to the Board. Patient scores will also be monitored in this way as well as via the directorate performance dashboards and the patient experience committee.

5.8 Patient safety and clinical effectiveness – developing regular quality reporting

Objective:

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

Rationale for inclusion:

The new clinical quality and safety performance report provides a complete overview and assurance mechanism for all aspects of clinical quality and safety across the three domains of patient safety, patient experience and clinical effectiveness. It does not however, provide some of the richer, detailed information on things such as patient complaints and the patient experience that is necessary to facilitate learning from such feedback.

The use of the new style report will therefore continue, but it will be supplemented by regular more detailed reports which will cover each of quality domains in turn. These supplementary reports will contain narrative and detail, and they will focus on learning, achieving actions for change and agreeing measurements which will demonstrate improvement. The development of the directorate performance and quality dashboards will continue to mirror the measures included in the trust-wide quality and safety report.

How we will monitor, measure and report on progress:

The clinical quality and safety performance report will be generated at least twice yearly with quarterly detailed reports on patient safety, clinical effectiveness and patient experience. The directorate performance and quality dashboards will be in use in all directorates and monitored via the routine performance review framework.

6.0 Key indicators for 2013/14

We have made some changes to our key indicators for 2013/14 as set out in the table below. These changes can be summarised as follows:

- The trust continues to receive adverse feedback from patients about how we communicate with them, whether it is keeping them informed about delays during their hospital visit, ease of access in contacting the correct person to assist with an enquiry, or the quality of discharge advice given after surgery. We have invested significantly in customer care training for all frontline staff in order to improve how we communicate with patients and we have also improved our telecommunications facility as well as improving the discharge advice that we give to patients. To evaluate the effectiveness of these interventions the trust has introduced a new indicator focused on the number of complaints received from patients about these issues throughout the year.
- The trust has performed consistently well against the national requirement for patients to spend four hours or less in the A&E from arrival to admission, transfer or discharge, with a performance of 99.3% in 2012/13 against a 95% target. At the beginning of the year we decided to set ourselves an additional internal performance target of a maximum journey time of three hours for A&E patients and this intention was included in our 2011/12 Quality Report. During 2012/13 we achieved this new standard for 81.7% of patients against our internal target of 80% and as a result our key indicator in relation to the emergency pathway for 2013/14

will be the three-hour standard. We will of course continue to report our performance against the national requirement in section 4.0 of the Quality Report.

- One of the trust's key quality improvement priorities for both 2012/13 and 2013/14 is to optimise the efficiency of our operating theatres via the implementation of the productive theatre programme (TPOT) and to continue the service improvement programme focused on the surgical pathway and designed to reduce patient journey times and improve the patient experience. In line with this objective we have introduced two new indicators for 2013/14; the first is focused on the percentage of operating lists on the City Road site that start on time, and the second requires the development of a standard operating procedure for Moorfields' theatres.
- The indicator focused on the completion of the clinic re-profiling exercise in the glaucoma and medical retina services has been removed as that piece of work was successfully completed during 2012/13. The emphasis on patient journey times in outpatients remains however, and is reflected in a new indicator that focuses on the progress of the transformational change programme described earlier in this report.
- The indicator focused on the development of clinical outcome measures in two specialty services has been removed as this piece of work was successfully completed during 2012/13. An indicator has however, been added to focus on the production of this information via OpenEyes, the trust's new bespoke electronic patient record.
- An indicator has been added which focuses on the trust's 2013/14 objective to develop patient reported outcome measures (PROMs) relevant to ophthalmology patients.

Indicator	Source	2011/12	2012/13	2013/14 target
Patient experience				
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	73%	Results not yet available	TBC in line with 2012/13 results
20% decrease in the number of complaints about communicating the reasons for delays, and / or accessing the most appropriate person to deal with appointments	Internal performance monitoring	N/A – new indicator	65 complaints	52 complaints
% of patients whose journey	Internal performance	N/A – new	81.7%	80%

time through the A&E department was three hours or less	monitoring	indicator		
% reduction in average patient journey time for all cataract surgery patients at City Road	Internal performance monitoring	4hrs 56 mins	18% reduction - 4hrs 4mins	30% reduction - 3hrs 30mins
% increase in all City Road theatre lists starting on time	Internal performance monitoring	N/A – new indicator	59%	90%
The development of a standard operating procedure for Moorfields' operating theatres	Internal performance monitoring	N/A – new indicator	N/A – new indicator	As per indicator
Progress on the transformation programme	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Staff in all subspecialty clinics at St George's to have been involved in a Systems Thinking intervention to improve their service. The focus in all clinics will be delivering increased value as defined by patients.
Patient safety				
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	N/A – new indicator	91.5%	90%

% overall compliance with hand hygiene standards	Internal performance monitoring	96%	97%	95%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0	0
Incidence of presumed infective endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.48	0.29	0.8
Incidence of presumed infective endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	0.30	0.35	0.5
Site and service safety review: Patient safety walkabout and use of mGTT	Internal performance monitoring	N/A – new indicator	N/A – new indicator	20 mGTT audits to be conducted during the year, the new walkabout process to be agreed and in regular use.
Clinical effectiveness				
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%
Posterior capsule rupture rate for cataract	Internal performance monitoring	1.34%	0.8%	<1.5% (reduced from 1.8% in 2012/13)

surgery				
Comprehensive clinical outcome indicators in place via OpenEyes	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Outcome metrics generated electronically for all clinical specialty modules in live use on OpenEyes
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 at least twice a year, supplemented with detailed reports on clinical effectiveness, patient safety, and the patient experience.
Developing PROMs	Internal performance monitoring	N/A – new indicator	N/A – new indicator	General ophthalmology PROM validated and in regular use in all relevant clinics

7.0 Statements of assurance

Review of Services

Moorfields Eye Hospital Foundation Trust provides ophthalmic NHS services covering a range of sub-specialties. We regularly review all healthcare services that we provide. During 2013/14, 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 2012/13.

Participation in clinical audits and national confidential inquiries

During 2012/13, one on-going national clinical audit was undertaken by Moorfields Eye Hospital NHS Foundation Trust, and two national confidential enquiry reports were reviewed.

Due to the single speciality nature of the hospital, most national audits are not relevant to the Trust. The trust therefore attempts to audit against standards and guidelines set by the Royal College of Ophthalmologists. During 12/13, 133 clinical audits were registered on the Trust's CLAW (clinical audit webtool) database, of which 18 audits were completed as a result of Royal College of Ophthalmology recommended standards.

With regards to National Confidential Enquiries (NCE's), two reports produced in 2012/13 were reviewed. Moorfields Eye Hospital NHS Foundation Trust participated in the development of and demonstrated compliance with one of these NCE's (cardiac arrest procedures). The second NCE reviewed was not relevant to the Trust and the trust was not able to participate in its development.

The national clinical audits, Royal College standards and NCE's that Moorfields Eye Hospital NHS Foundation Trust was eligible to participate in during 2012/13 were as follow:

National Audits

UK Ocular Tissue Transplant Audit - NHS Blood and Transplant

Fifth National Audit Project of the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland

Royal College of Ophthalmology Audits

- Modified Global Trigger Tool City Road/Glaucoma
- Modified Global Trigger Tool Ealing/Strabismus
- Modified Global Trigger Tool City Road/Medical Retina
- Retinopathy of prematurity Ealing
- Activity and outcomes in a Vitreoretinal Clinic
- Cataract Surgery Outcomes and Patient Satisfaction
- Modified Global Trigger Tool City Road/Paediatrics
- Cataract Surgery in Trainees
- Modified Global Trigger Tool Ealing/Paediatrics
- Intraoperative floppy iris syndrome in patients on oral doxazosin
- A Retrospective Evaluation of Optometrist Performed YAG and Argon pre-treated LASER Procedures
- Modified Global Trigger Tool Mile End/Primary Care
- Audit on Investigations for Retinal Vein Occlusions
- Prospective audit for screening of premature babies for Retinopathy of prematurity
- Outcomes of glaucoma referrals across Europe - The UK component
- Provision of eye services to children with sensorineural hearing impairment
- Activity and waiting times in a Day Case Cataract Service.

National Confidential Enquiries

Cardiac Arrest Procedures - Moorfields participated in the study and the Trust's processes and procedures comply with the recommendations.

Bariatric Surgery - Moorfields did not participate in the study and thus the recommendations are not applicable to the Trust.

Between April 2012 and March 2013, Moorfields Eye Hospital Foundation Trust clinical audit department have had 133 audits registered on CLAW (clinical audit web tool) of which 18 audits have demonstrated the implementation of the audit cycle. Audit reports and action plans have been submitted and approved by the clinical audit and assessment committee, ensuring that audit activity is adhered to as identified in the trust clinical audit annual report.

As part of the process for each completed audit report, action plans are generated to improve the quality of healthcare provided. Examples of some of the actions submitted include:

- Review all policies and ensure they are updated in line with current practice
- Ensure that all key findings from audit reports are disseminated and shared to all relevant staff for discussion at service meetings/nursing meetings encouraging best practice
- Ensure all audit criteria and standards used for audit are reviewed and discussed at the clinical audit and assessment committee meetings
- Summary of trust mandatory audit findings to be included in the trust intranet and communication brief
- Re-audit to be encouraged to ensure that we continuously monitor and evaluate clinical practice.

Action plans are monitored by the clinical audit department.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Moorfields Eye Hospital NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 4852.

Use of the commissioning for quality and innovation (CQUIN) framework

The CQUIN payment framework enables commissioners to reward provider by linking a proportion of the providers' 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 2012/13 the trust had eight CQUIN requirements. 2.5%, or £2.3M, of Moorfields Eye Hospital NHS Foundation Trust's income was conditional upon achieving quality improvement and innovation goals agreed between Moorfields Eye Hospital NHS Foundation Trust and NHS Islington through the CQUIN framework; the total for 2011/12 was 1.5% or £1.2M.

Registration with the Care Quality Commission

Moorfields Eye Hospital NHS foundation Trust is required to be registered with the Care Quality Commission (CQC) and is currently registered without conditions. The CQC has not taken any enforcement action against Moorfields Eye Hospital NHS Foundation Trust in 2012/13.

In August 2012, St Ann's, one of the trust's satellites received an unannounced inspect against six essential standards of quality and safety and was found to be compliant against all six of them. In February 2013, the trust's main City Road site received an unannounced inspection against six essential standards of quality and safety and was also found to be compliant against all of them.

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

Quality of data

Moorfields NHS Foundation Trust submitted records during 2012/13 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; 98.4% for admitted care; 98.0% for outpatient care and 92.7% for accident and emergency care. The percentages of valid data which included the patient's valid General Practitioner Registration Code were; 100% for admitted care; 100% for outpatient care and 100% for accident and emergency care.

The Information Governance assessment received a grading of level 2 with a "Satisfactory" score. The toolkit overall score was 75%.

Moorfields Eye Hospital NHS Foundation Trust was not subject to the Payment by Results Clinical Coding Audit during 2012/13.

Moorfields Eye Hospital NHS Foundation Trust will be taking the following actions to improve data quality during 2013/14:

- Complete a review of the data quality policy to ensure that responsibilities of staff, of all grades and disciplines, with regard to data quality are clearly defined.
- Launch the revised policy to ensure that staff are aware of their responsibilities.
- An external review of data quality will be undertaken.
- Raise awareness of data quality requirements and increase monitoring of frontline staff to ensure that they are checking and recording changes to patient information.
- Data quality procedures to be produced and made available to all staff involved in data entry on all trust systems.
- Review of data held within the Trust's data warehouse.
- Review PAS training currently available.

Executive leads have been nominated for each of the above action and the information governance committee will monitor progress against agreed timescales.

8.0 Statement of support from partner organisations

Our quality report for 2012/13 has been shared with our membership council as well as colleagues at our host CCG (NHS Islington), the London Borough of Islington's Health and Wellbeing Scrutiny Committee and Islington's Healthwatch.

NHS Islington CCG is responsible for the commissioning of health services from Whittington Health and Moorfields Eye Hospital acute/specialist trusts and Camden and Islington Foundation Trust for mental health services, on behalf of the population of Islington.

The CCG responded as follows about Moorfields' Quality Account:

NHS Islington CCG welcomes the opportunity to provide this statement about Moorfields' Quality Account. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for Moorfields and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

We have reviewed the content of the Accounts and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at Moorfields. We have discussed the development of this Quality Account with Moorfields over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within NHS Islington CCG and by colleagues in NHS North and East London Commissioning Support Unit.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with Moorfields to continually improve the quality of services provided to patients.

In thinking about next year there are three areas where the Trust might build on the accounts of this year:

- Making the presentation more exciting for the reader to convey the important messages about quality at Moorfields.
- Making it clearer how different staff groups have been involved.

- It would be really powerful if the accounts include patient anecdotes and case studies as Moorfields has some great stories to tell.

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

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 2010 to prepare Quality Accounts for each financial year.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- 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 2012 to May 2013
  - Papers relating to quality reported to the Board over the period April 2012 to May 2013
  - Feedback from the commissioners dated 28 May 2013
  - Feedback from governors provided in May 2013
  - Feedback from Islington Healthwatch dated 2 May 2013
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19 July 2012;
  - The national outpatient survey of November 2011 and A&E survey of September 2012
  - The 2012 national staff survey
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 31 March 2013
  - CQC quality and risk profile dated 31 March 2013

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which

incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report available at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

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

By order of the Board

.....Date.....Chairman

.....Date.....Chief Executive

10.0 Further information

Further information about this quality account can be obtained from the Director of Corporate Governance at Moorfields Eye Hospital NHS Foundation Trust. This report will be available on the NHS choices website from June 2013.

11.0 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 2013 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Moorfields Eye Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Moorfields Eye Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, 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 save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C. Difficile
- Emergency readmissions within 28 days of discharge from hospital

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 the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in the statement of directors' responsibilities in respect of the quality report; and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. 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 impact 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 thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

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

Deloitte LLP

Chartered Accountants

St. Albans

29 May 2013

Annex

Core Outcomes

Speciality	Metric		Standard	MEH performance 2012-13
Cataract	Posterior capsular rupture rate	% phaco operations complicated by PCR	<1.8%	0.80%
Cataract	Endophalmitis after cataract surgery	% phaco operations with postoperative endophalimitis	<0.08%	0.03%
Catarct	Biometry accuracy in cataract surgery	% postoperative refraction +/- 1D of that planned in those undergoing phaco	>85%	97.60%
Catarct	Biometry accuracy in high myopes having cataract surgery	% postoperative refraction +/- 1D of that planned in high myopes undergoing phaco	>50%	90.60%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	% failed trabeculectomies at 12 months postop	≤15%	8.20%
Glaucoma	PCR in glaucoma patients	% phaco surgery complicated by PCR in those with glaucoma	<NOD	2.15%
Glaucoma	Glaucoma tube drainage	% drainage tube failure after 1 year	<10%	5.20%
MR	Endophthalmitis after injections for macular degeneration	% suspected infective endophthalmitis after intravitreal lucentis for wet AMD	<0.05%	0.04%
MR	Visual improvement after injections for macular degeneration	VA improvement: % gaining ≥ 15 letters at 12 months.	>20%	30.50%

MR	Visual loss after injections for macular degeneration	VA loss: % losing <15 letters at 12 months	>80%	85.70%
MR	Time from referral to assessment of proliferative diabetic retinopathy	% patients referred from screening with R3 attending clinic within 4wks	80%	90.30%
VR	Success of primary retinal detachment surgery	% cases with attached retina 3 months after primary RD operation	>75%	80%
VR	Success of macular hole surgery	% cases with macular hole closed 3 months after primary macular hole surgery	>80%	81%
VR	PCR in cataract surgery in vitrectomised eyes	% phaco surgery complicated by PCR in those with previous vitrectomy	<NOD	4%
NSP	Serious complications strabismus surgery	% serious intraop or postop complications in strabismus surgery	<2.2%	0.30%
NSP	Premature baby eye (ROP) screening compliance	% adherence to ROP screening guidelines	99%	100%
NSP	Success of probing for congenital tear duct blockage	% success rate lacrimal probing in young children	>85%	85.70%
External Disease	DSAEK corneal graft failure rate	% failure DSAEK graft by 1 year	≤12%	11%

External Disease	PK corneal graft failure rate	% failure primary PK graft by 1 year	UKTS	16%
External Disease	DALK corneal graft failure rate	% failure DALK graft by 1 year	UKTS	11%
Refractive	Accuracy LASIK (laser for refractive error) in short sight	% +/- 0.5D planned after LASIK in myopia up to --6D	>85%	88.80%
Refractive	Loss of vision after LASIK	% losing 2 or more lines of vision after LASIK	<1%	0%
Refractive	Good vision without lenses after LASIK	% uncorrected visual acuity > 6/12 after LASIK	≥90%	97.80%
Adnexal	Ptosis surgery failure	% patients undergoing primary ptosis procedure requiring further ptosis procedure	<15%	3%
Adnexal	Entropion surgery success	% patients underoing primary entropion repair who require further procedure in 1 year	>95%	100%
Adnexal	Ectropion surgery success	% patients underoing primary ectropion repair who require further procedure in 1 year	>80%	100%
A&E	Unplanned reattendances	% Unplanned adult reattendance at A&E within 7 days	<5%	0.10%
A&E	Rate adherence to NICE transient ischaemic attach guidelines	% patients with TIA or "ministroke" attending A&E whose management complied with NICE guidance	100%	100%
A&E	Nurse led care in A&E	% pts attending adult A&E managed by nurse-led pathway	15%	21%

A&E	Treatment acute glaucoma	% patients with acute glaucoma whose management complied with protocol	98%	94.70%
A&E	Use of WHO surgical safety checklist	% pts undergoing theatre procedure in whom WHO checklist used appropriately	100%	94%
Anaesthetic	Venous thromboembolism prevention	% eligible pts undergoing theatre procedures who received correct VTE prophylaxis	100%	92%
Anaesthetic	Postop pain score completion	% pts in recovery who had postop pain score completed	75%	80%
Anaesthetic	On the day transfers	Patients unexpectedly transferred to another hospital	No std	0.97%