

Operational Plan Document for 2014-16
Moorfields Eye Hospital NHS Foundation trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute Moorfields Eye Hospital NHS Foundation trust's operational plan submission, which forms part of Monitor's 2014/15 Annual Plan Review (APR).

The operational plan commentary must cover the two-year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

APR 2014/15 guidance is available [here](#). Please note that the guidance is not prescriptive and foundation trusts are able to make their own judgement about the content of each section.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS trust Development Authority, which will enable strategic and operational plans to be reflected within each unit of planning before they are submitted.

Monitor expects that a good two-year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
 - a. The short-term challenge
 - b. Quality plans
 - c. Operational requirements and capacity
 - d. Productivity, efficiency and cost improvement programmes (CIPs)
 - e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, Monitor expects plans to be a maximum of 30 pages in length.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five-year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

Operational Plan for year ending 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

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The attached Operational Plan is intended to reflect the trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the trust Board.

In signing below, the trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision of the trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;
- The Operational Plan has been subject to at least the same level of trust Board scrutiny as any of the trust's other internal business and strategy plans;
- The Operational Plan is consistent with the trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Rudy Markham
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	John Pelly
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Charles Nall
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Signature



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1.0 Executive Summary

- 1.0.1 Moorfields Eye Hospital NHS Foundation Trust has prepared this Operational Plan in accordance with the relevant guidance; and has considered the external environment alongside the “short-term challenge” and the internal drivers for change in the production of its plans.
- 1.0.2 The overarching strategy is based on growth and improvements in productivity and efficiency; our core 5% growth assumption is supported by our historic performance and the NHS and commercial market opportunities that we plan to deliver.
- 1.0.3 The trust has developed its strategic priorities to ensure continued improvement in quality and operational service delivery, and this is evidenced through the inclusion of implementation plans.
- 1.0.4 The financial plan demonstrates a robust and sustainable position with a £5.0 million surplus (before impairments) in 2014/15 and 2015/16.

1.1 Background

- 1.1.1 Moorfields Eye Hospital NHS Foundation Trust (Moorfields, the trust) is the leading provider of eye health services in the UK and a world-class centre of excellence for ophthalmic research and education. Moorfields has a reputation developed over two centuries for providing the highest quality of ophthalmic care, and more than 1,800 staff who are committed to sustaining and building that reputation and ensuring we remain at the cutting edge of developments in ophthalmology.
- 1.1.2 Moorfields has a track record of strong operational and financial performance; and we have maintained a high standard against the majority of targets in 2013/14, though we did not achieve the 18 week referral to treatment target (RTT) in the last quarter. We will deliver a £10.5 million surplus in 2013/14.
- 1.1.3 Moorfields’ Care Quality Commission (CQC) and Monitor ratings have been consistently good. We have a reputation for high-quality clinical outcomes, particularly relating to our specialist services, and we continue to refine and develop our hospital and community based services.
- 1.1.4 We provide care in our main hospital in City Road and at 19 satellite sites in and around the capital. Although these centres were initially based in hospitals, their scope has increased in recent years to include more community-based locations. We run an ophthalmic service in London’s first purpose-built polyclinic in Loxford and deliver services in partnership with General Practitioners (GPs) in a Boots store in Watford. In Harrow, we have joined forces with a local group of GPs to provide more eye care in the community.

- 1.1.5 We continue to progress our networked satellite model to deliver planned care closer to home, and will be reviewing our portfolio to ensure it is aligned with this model and reaching local communities by encouraging patients to be treated in appropriate local services, rather than at the main central London hospital, and looking to create and develop satellite locations in response to patient and commissioner priorities.
- 1.1.6 Our network model is reflected in our complex contracts portfolio, which includes more than 75 clinical commissioning groups (CCGs); at the same time, the majority of individual service level agreements provide contracted income of less than £5 million. The London area represents about 70% of our overall income.
- 1.1.7 We continue to expand our clinical and commercial services as our strategy for growth enables us to reinvest in our facilities and equipment, and to improve and develop NHS services.

1.2 Overall vision

1.2.2 The trust launched a process in 2009 to develop its vision and strategy. The process involved periods of evidence gathering, analysis, synthesis and planning and involved a wide range of internal and external stakeholders. As a result, we were able to refresh our mission (which states why we exist and what we do), clarify our values (which express what we believe in and how we behave), articulate our vision (which sets out what we aspire to be by 2020).

This 10-year strategy was published in 2010 as *Our Vision of Excellence*; and was refreshed in 2013 to revalidate the core assumptions at the same time as refining and reprioritising the implementation programme (delivered through the annual plan).

1.2.3 The vision set out in our strategy 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 (rather than just responding to it)
- Known for delivering the highest standards of patient experience, outcomes and safety across all of our sites,
- At the forefront of international research with our partners
- Maintaining our leading role in the training and education of eye care clinicians

1.2.4 To achieve this, we concluded that Moorfields should seek to deliver services through a structured network of facilities across London and the south east, supported by a state-of-the-art specialist centre in London, which would be the focus for our most specialist and complex clinical services. This will be achieved by:

- Redefining our satellite model to include a central hospital supported by a highly distributed network of services, working within defined standard operating procedures and with a clear remit
- Aiming to increase our market share, initially focusing on parts of London where we do not provide a satellite service; and proactively engaging with partner organisations to seek out opportunities to attract new business in new locations or increase market share in existing facilities
- Seeking to play a greater role in service provision where we currently provide sub-specialty expertise
- Maximising opportunities to provide community-based services, prioritising the establishment of such services in areas where we currently have poor market penetration

1.2.5 We published our research and development strategy in 2013/14, have almost completed our education strategy, and are currently developing our international strategy. These interlinked strategies are vital components in the on-going delivery of *Our Vision of Excellence*.

1.3 Stakeholder engagement

- 1.3.1 Moorfields works with a wide range of groups and individuals, including patients, other healthcare organisations, academic partners, foundation trust members and charities. We engage with them in a variety of ways both face-to-face and in writing, whether via traditional publications or digital media.
- 1.3.2 A new external communications and engagement strategy was approved by the Trust Board in July 2012 and continues to be implemented. This includes work to raise our profile further, especially among audiences who are not reached by existing activity, in order to contribute to increased patient referrals and charitable donations, and to 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 documents. We are developing a stakeholder map identifying our key stakeholders and how we seek to engage with them.
- 1.3.3 Some of our initiatives to ensure stakeholders have been involved and informed of our strategic goals and priorities have included:-
- The relaunch of *In Focus*, our regular publication for foundation trust members, in the autumn of 2012. Using the new visual identity, the refreshed magazine contains more information and is additionally circulated to staff, patients and other key stakeholders
 - A complete overhaul of our website, informed by focus groups of staff and patients and an online survey to ensure that the new site is easy to navigate and that its structure reflects what users want and need
 - Support for better relationships with local GPs and the emerging CCGs, through the creation of a GP liaison manager post as part of our business development team. The new post-holder has developed and implemented a range of initiatives to support GP colleagues, including an ophthalmic education tool and a comprehensive referral guide, due for publication shortly
- 1.3.4 We attend meetings with the Islington health and wellbeing committee as required and liaise with Islington Healthwatch. In addition, Moorfields' director of nursing and allied health professions represents the trust on both the Islington Safeguarding Children Board and the Islington Safeguarding Adults Partnership to ensure that Moorfields protects these vulnerable groups as well as possible and in line with national guidance.
- 1.3.5 We are not part of a single 'unit of planning', owing to the complex nature of our relationships with many CCGs and our specialist contracts portfolio.

1.4 The national environment, the “short-term challenge” and affordability

1.4.1 Since the publication of our Annual Plan 2013/14, we have seen the formalisation of CCGs and the impact of their commissioning responsibilities with increased tendering of ophthalmic services. New specialised commissioning has also been introduced, but is still in its embryonic stages.

Other external factors influencing our future delivery of services and quality of care include:

- The publication of the Francis Report and subsequent Keogh Review and Berwick Report, which list many recommendations to address failures of care identified at Mid Staffordshire NHS Foundation Trust
- The introduction of a new CQC inspection regime for hospitals (although specialist hospitals are unlikely to be inspected until 2015)
- The changing role of Monitor as sector regulator
- Local Education and Training Boards (LETBs) are now in place, with a major influence on commissioning and funding of clinical education
- There are also new Clinical Research Network (CRN) arrangements that are challenging historic clinical research metrics

1.4.2 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. It is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements.

- 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

1.4.3 The NHS Commissioning Board published its planning framework, “Everyone Counts: Planning for Patients 2013/14”, which outlines the incentives and levers that will be used to improve services from April 2013. The guidance was published alongside financial allocations to CCGs and was 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.

- 1.4.4 Similarly, the national drive to improve and scrutinise performance, quality and safety will be strengthened with revisions to the NHS mandate, new hospital star ratings, levelling of clinical outcomes and further emphasis on recommendations of the Francis and other reports. The Friends and Family test will be extended to all hospital services and patients will be able to access their electronic records more freely than previously. Further opportunities are anticipated for patients to express their views about services.
- 1.4.5 An unprecedented affordability gap is forecast for the healthcare system (as highlighted in the Annual Plan Review guidance issued by Monitor, including rising demand and costs, and flat real-term funding, which could result in an estimated £30 billion shortfall by 2021) and this will impact most noticeably in 2015/16. This is likely to include increased tendering and competition, changes to the national tariff system and severe pay restraints, as well as the renegotiation of staff terms and conditions of employment.
- 1.4.6 London has a growing and ageing population, with increasing numbers of frail and older people and an ever greater incidence of chronic disease. At the same time, the public rightly expects ever higher standards of safety, quality and access to services coupled with greater expectations arising from medical innovations and future research and development. These factors will impact on the demand for our services,
- 1.4.7 Our core assumptions for 2014/15 and 2015/16 are based on an approximate 5% growth in activity; this is not unrealistic given our historic performance and reflects the increasing demand in line with demographic projections for London as a whole, and the incremental benefit we anticipate from delivering planned care closer to home from our satellite locations.
- 1.4.8 Our financial plan for 2014/15 has been formulated using published tariff pricing, draft financial assumptions yet to be fully agreed with the lead commissioner (subject to final contract sign-off), and detailed internal planning with managers and other budget holders.
- 1.4.9 We have considered the impact of the external environment, and the affordability challenge facing the NHS, alongside the various factors driving change internally in the development of our plans for 2014-16.

1.5 Strategic priorities

1.5.1 The annual plan is the delivery vehicle for *Our Vision of Excellence*; however our 2013/14 plan contained 18 priority areas grouped within the eight strategic and enabling themes. These priority areas include 48 subsidiary actions, many of which contained multiple workstreams. Whilst this approach has served us well for the last three years, we considered that we needed to refresh our approach to ensure that we were able to concentrate on the key issues and accelerate the implementation of critical workstreams. We therefore decided that our strategic priorities should only represent these core activities, and that the Trust Board and Trust Management Board would focus on monitoring these priorities.

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

1.5.3 Our priorities for 2014-16 are to:

- Improve the patient experience and our organisational efficiency by delivering an operational redesign programme across all sites to improve the way Moorfields delivers care, encompassing patient communications and administration, operational planning and performance, cost efficiency and investment, workforce planning, leadership and management;
- Deliver an electronic clinical record and a paper-light environment, through full implementation of OpenEyes as the clinical record across all sites and services (2014/15) with the minimum of day-to-day disruption and benefits realisation through cultural change (2015/16);
- Deliver our Quality Plan as quality and safety for our patients is paramount; the plan will be agreed by staff and patients with a focus on patient experience and outcomes, include intelligible and meaningful metrics and ensure that we deliver excellent care;
- Continue the development of our new joint facility with University College London (UCL) Institute of Ophthalmology (IoO), acquiring a site for the new facility, completing the design and supporting business cases, commencing fundraising and agreeing partnering arrangements with UCL; and
- Realise our vision of excellent education, through our education strategy, ensuring that Moorfields becomes a pro-active leader in this field.

1.5.4 We will communicate these priorities widely and include relevant personal actions with each staff member's annual objectives.

1.5.5 The Trust Board and Membership Council agreed that the annual planning process should be the mechanism by which we highlight those issues that the Membership Council would wish to scrutinise as significant transactions during the year.

The list below represents the agreed position (at 13th March 2014) in terms of the significant transactions that support the strategic priorities for 2014/15. A similar exercise will be undertaken as part of the planning for 2015/16 to develop and agree a list for 2015/16.

- Consolidation of the City Road site
- Land purchase business case for the new joint facility
- City Road site redevelopment business case
- Moorfields East strategy
- Moorfields Pharmaceuticals strategy
- International expansion proposals
- Any new mergers and acquisitions
- Any significant investments arising from the on-going development of OpenEyes / OpenEyes Foundation, the delivery of the research and development strategy, or the implementation of the education strategy

1.5.6 In line with the new guidance issued by Monitor, we also wish to assure ourselves that we have a strong and robust strategic planning process to deliver both our Operational Plan and Strategic Plan. Additionally, we will assess our capability and capacity to manage our strategic planning process and meet our responsibilities by using the assessment tool provided within the Monitor guidance; our assessment will be provided as an appendix to the Strategic Plan.

1.5.7 The following Operational Plan includes further detail on the implementation plans for the strategic priorities.

2.0 Operational Plan

2.1 Quality plans

National and local commissioning priorities

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

Quality, strategy and goals

2.1.2 Our Quality Report is published as part of our Annual Report, a statutory document for NHS foundation trusts. Quality is central to *Our Vision of Excellence* and continues to be a strategic priority:

“Deliver our Quality Plan as quality and safety for our patients is paramount: the plan will be agreed by staff and patients with a focus on patient experience and outcomes including intelligent and meaningful metrics and ensuring that we deliver excellent care”.

2.1.3 We recognise the importance of all our stakeholders in developing our quality initiatives for the future and our Quality Report has been developed with the support and engagement of our clinicians, governors, patients, commissioners, our Quality and Safety Committee, Healthwatch and Islington's Health Overview and Scrutiny Committee.

2.1.4 The plan covers all our sites and all the care and treatment that patients may receive, and is put together around a patient visit (or patient journey) to hospital. The patient journey has been separated into three parts:

- preparing for a visit to hospital;
- having care or treatment at Moorfields; and
- what happens after a visit.

2.1.5 In line with previous years, it remains based on the three simple and internationally accepted categories of quality of care:

- the patient experience,
- patient safety, and
- clinical effectiveness,

2.1.6 The following section details how we will deliver the quality agenda, aligning the quality actions to the individual strategic priorities as appropriate.

Impact across all three parts of the patient journey and the three quality categories

(a) Designing services of value to patients

In 2013/14, we introduced a suite of performance measures associated with the patient journey for the glaucoma pathway at St George's Hospital, based on work undertaken in 2012/13 to assist us with our transformational change programme, focusing on the core principle of designing services that deliver value to patients.

The initial pilot proved to be successful with unnecessary parts of the patient journey being removed and the development of a more integrated pathway. It also reconfigured some professional roles, assigning each patient individually to the team member best placed to deliver the care they required, together with a named key coordinator for the patient's overall journey..

This year, we will look to address some of the local site-related limitations and make improvements. We are also implementing several related initiatives to support the glaucoma pathway further, such as our enhanced practitioner role and technical support officer, and the development of virtual clinics (streamlined multi-disciplinary diagnostic and treatment clinics with remote clinical decision support).

(b) Improving patient communication and engagement

Keeping our patients informed and receiving their views and feedback on the services and care we provide is essential to ensuring we are delivering the highest possible quality of care and patient experience. We have a wealth of feedback routes including surveys, complaints and PALS enquiries to support communication and engagement with our patients.

Patients continue to report that they do not receive adequate or timely information about their care or our services and we must continue to review and improve. Customer awareness training has led to some improvements, but we will look at a more regular and sustained programme supporting customer care to reflect this ongoing need, particularly in service areas where staff turnover is higher to ensure that good customer awareness and communication is sustained.

Our refreshed Quality and Safety Plan proposes several actions to support patients preparing for a visit to Moorfields, including a new "Welcome to

Moorfields" information booklet and a dedicated section on our website. We also plan to publish information on clinical outcomes for specialty care, specialist expertise and detail around current waiting times on the website.

Further improvements are planned for the second stage of the patient journey around patient appointments, care and treatment, including consent procedures, suitable discharge information and translation and interpretation services. Equally, we want to improve feedback after a visit to Moorfields and have identified a range of actions to ensure we are appraised of the service that patients have received, and to enable patients and referrers to contact Moorfields with any follow-up requests.

We have identified key communication improvements to take forward following a detailed review of the patient experience in the glaucoma clinic; some are interlinked with the wider communication initiatives in the Quality and Safety Plan although some are specific to the glaucoma clinic.

(c) Improving the surgical patient journey

We highlighted earlier our approach to designing care pathways that deliver value to patients in clinics. We also began The Productive Operating Theatre Programme (TPOT) to improve surgical pathways and initially focused on the cataract pathway. Our aim was to improve patients' experiences of surgery by maximising our theatre productivity through lists starting on time, reducing cancellations from the list and optimising the ratio of City Road to satellite surgical activity. All patient information relating to admission is now in one place recorded sequentially throughout the patient's journey. We have initiated an extension of pre-assessment hours that has allowed for more same day pre-assessments to be undertaken and there has been development of telephone pre-assessment to save repeated visits by the patient. We have also introduced a new biometry protocol and training for staff to increase patient safety.

Patients are contacted 48 hours prior to surgery to try to reduce cancellations on the day of surgery. Mydrasert is now approved for dispensing on wards by nurses, removing the need for very frequent drop instillation for pre-operative pupil dilatation and a reduction in the number of observations needed has been agreed, which has greatly improved the patient experience and freed up time for nurses to support patients.

Our theatre efficiency and cancellation rates have begun to improve. A post-project review has been completed and priority areas for the next stage of the roll-out are to be agreed. Examples include the ongoing pilot for staggered arrivals for cataract surgery lists which we will assess later in the year, and a

review of post intra-ocular pressure (IOP)/slit lamp checks will become the exception not the norm to improve waiting time post-operatively.

Patient journey part 1 – improving patient experience

(d) Improving the environment

A pleasant environment in which to treat patients is important in enhancing the patient experience, as well as in assisting clinical staff to deliver the highest quality of clinical care.

This is recognised in the following strategic priority:

“Continue the development of our new joint facility with University College London (UCL) Institute of Ophthalmology (IoO), acquiring a site, completing the design and supporting business cases, commencing fundraising and agreeing partnering arrangements with UCL”.

Our existing main hospital at City Road is ageing and does not enable the development of new care pathways or improved clinical adjacencies. We made a strategic decision to develop a new joint facility with IoO and work will continue towards achieving this goal. The key actions we will deliver in 2014-16 include:

- Complete the design brief for the new build to enable us to articulate our functional space requirements. As part of the design brief, we will need to develop operational policies, an accommodation schedule and design and quality standards;
- Frontline operational and clinical staff will inform the development of this design brief, to ensure that it delivers the service redesign anticipated from new clinical pathways and clinical adjacencies that will enable us to deliver optimal care;
- The design brief will also be informed by whole system activity profiling of both the main hospital and the satellite sites, as well as by the future capital development programme for the satellites to ensure that we provide the appropriate capacity across our network;
- We will articulate the benefits of close working and the integration of some facilities with IoO to ensure we continue to lead the world in ophthalmic research;
- The 60-year financial model that demonstrates the affordability and sustainability of our proposals will be further refined, and will become our primary financial planning tool;
- Once we have agreed our design brief, we will procure a design team who will design our functional requirements in line with the Royal Institute of British Architects (RIBA) Stage E – Technical Design;

- We will develop the outline business case for the project, based on the Treasury 5-case model;
- We will also seek to consolidate the land ownership of the City Road site, and to commence marketing for the sale of the site, whilst looking to complete the acquisition of a new site for our proposed new build;
- At the end of 2013, we initiated an engagement process with a wide array of stakeholders and will continue to engage with patients, the public and other stakeholders. We are also creating an independent patient reference group to allow further patient input to the design of the new facility;
- The project includes a joint fundraising campaign with UCL and we have already commenced the 'quiet' phase;
- We will develop a suite of agreements with UCL that will govern the relationships between the two organisations within the new facility.

Current estate and physical capacity

Our current estate presents us with several operational constraints in delivering our services as effectively as possible. The existing infrastructure at the City Road hospital is our key constraint and some of our satellite locations have limited space availability. We will further develop our estate strategy to reconcile our networked model of satellite care, to address existing estate constraints and to improve the environmental concerns set out within the quality section.

Each year as part of the annual planning process, we identify capital projects that are monitored by the trust's Capital Planning Group. As the new facility will be sized with reference to further shifts of activity from the main hospital site to satellites across the network, we will be ensuring that the appropriate capacity will be in place before the new hospital. During 2014-16 we will:

- Commence and complete the re-provision and expansion of all of our services at St George's Hospital in Tooting;
- Complete the expansion of our outpatient services at Ealing Hospital, and work with the local health economy to support the long-term planning for this hospital site;
- Complete the Moorfields East strategy and seek to develop a new surgical hub in the east of London.

Patient journey part 2 – improving patient safety

(e) Improving processes and reporting

Several systems have been put in place recently to improve patient safety and quality. We have introduced a plan of patient safety walkabouts, quality

reviews and safety visits that enable an analysis of notable practices, to assess areas of concern and to ensure that staff and patients have the chance to tell us their concerns and highlight any safety issues. Following analysis of quality and safety data, visits to service delivery areas and meetings with local staff and patients, remedial action plans are developed and regularly monitored to ensure improvement is being made. Important findings which cannot be resolved at a local level are escalated in quality and safety reports received by the Trust Board.

Incidents are captured on the Ulysses risk management system (Safeguard) that has been in use at the trust for some years, but used a paper-based method to report incident details, which was less efficient and effective than an integrated electronic process would have been. As a result, Safeguard was upgraded in September 2013 and an electronic incident report form (e-form) and supporting processes were established. This method of reporting has been piloted in several key areas and has been very well received by staff. It is leading to improved reporting of incidents and near misses and will be rolled out to all areas. It is important to note that while the number of incidents reported is rising, the severity of these incidents remains either minor or no harm, and the number of serious incidents (SI) and never events (NE) are not rising. In addition, the lack of a significant increase in complaints and claims supports our belief that the rise in incidents is due to a better reporting culture and not an indicator of decreasing safety.

We also have our own locally developed modified global trigger tool (mGTT) – a structured case note review procedure designed to spot any points of concern and to measure risk and low-level adverse events. Regular reviews of case notes are a proactive way to identify and change poor practice before it triggers a serious patient safety incident. Many have been completed through the year and several recommendations are being implemented.

Patient journey part 3 – improving clinical effectiveness

(f) Expansion of clinical outcome and performance indicators

Moorfields' core clinical outcomes programme examines performance across all services. It benchmarks our performance with other providers, or from published literature, and with standards set by the Royal College of Ophthalmologists or other similar organisations, in line with the aspirations of the Health and Social Care Act 2012. Previously we have identified at least three clinical outcome indicators for each of our major sub-specialty services.

Our outcome measures have been developed to ensure we are collecting relevant, current and purposeful information for our stakeholders to assess

routinely the quality and safety of the services we deliver. However it must be noted that, due to the need for many of these outcomes to be collected by hand by busy clinicians, with time allowed for completed follow-up to ensure we see the final results of treatment, some outcomes are measured by examining a representative small cohort. Until OpenEyes is fully functional it will be impossible to audit all cases for all outcomes, including identifying accurately our “routine” cases – those with no other serious eye disease or high risk cases – which is the ideal and our aim. The quality team are working closely with OpenEyes and individual services to ensure the ability to generate important outcomes is embedded in the clinical modules of OpenEyes as they go live. This work has already been completed for the cataract, glaucoma and medical retina modules and continues for vitreoretinal and paediatrics and strabismus. The aim is to generate a range of automated outcomes for these services.

The cataract service has performed a large OpenEyes audit on cataract outcomes, demonstrating that it is possible easily to audit large numbers of cases electronically. The findings were presented at the November 2013 Clinical Governance half day, where it was noted that the audit demonstrated that results were limited by the accessibility of computers for Electronic Patient Records (EPR) in some sites and a lack of full use of the EPR by all clinicians. This issue is being addressed.

Patient and commissioner surveys on outcome topics are complete for glaucoma, adnexal, medical retina and vitreoretinal ophthalmology and are underway for paediatrics, strabismus and cornea. These surveys ensure that patients and stakeholders are influencing which outcomes are chosen for regular use.

While the assessment of outcomes assessed by clinicians is very important, the most important result is that reported by the patient. In 2013/14 we piloted bespoke patient reported outcome measures (PROMS) across our ophthalmology services; considerable time is required to develop appropriate PROMS as they include input and direction from patients and users as well as trial and validation. The availability and application of PROMS enables us to assess if the services and care that we provide to our patients is delivering benefits to their quality of life and improving their well-being. However, there are currently no mandated ophthalmic PROMs and the development of validated PROMs is a lengthy, resource-intensive process.

Clinicians and research staff from the IoO are starting to work to develop PROMs useful both for research and clinical care, while the trust has two main projects examining PROMs for regular use in clinics. The general ophthalmology PROM, Patient Reported Eye Symptom Scorecard (PRESS),

has been piloted in City Road and Ealing and compared against the Clinician Reported Eye Symptom Scorecard (CRESS). A new team of trainee ophthalmologists have taken this on as a Quality, Innovation, Productivity and Prevention (QIPP) scheme and will now complete a final revision of the format of the scorecard in conjunction with patient views, before submitting the tool for publication and promoting its regular use in general ophthalmology clinics; they will also start to develop a similar tool for paediatric ophthalmic patients.

The trust is undertaking a comparison study of four different cataract PROMs at Ealing. Patients are completing questionnaires pre-operatively, and at two weeks and three months post-surgery. So far, 49 patients have completed the study, with one of the four PROMs showing the greatest sensitivity in detecting improvement after cataract surgery and another showing poor sensitivity for monitoring the effect on quality of life of cataract surgery. The trust is continuing the project to include more patients. We plan to share findings at ophthalmic conferences and hope to publish the findings in mid-2014.

External quality review

- 2.1.7 Moorfields has been registered without conditions with the CQC since 2012. Two unannounced inspection visits, against six essential standards of quality and safety, took place in 2012/13; one visit was to one of our satellite units and one to our main hospital. Both locations were found to be fully compliant.

The NHSLA and CQC require certain clinical audits to be completed by the trust. An audit of audits, assessing whether the trust complied with its own clinical audit policy, a consent audit and a clinical records (documentation) audit were all completed for 2013/14.

Our quality of data included in the Hospital Episode Statistics is consistently high, with many records of published data achieving 100%. Our Information Governance toolkit score overall was 75%.

We share our annual Quality Report as prescribed by Monitor to demonstrate that we are complying with the responsibilities under the Health Act 2009 and the NHS Quality Accounts Regulations 2010. Previously it has been commented that presentation could be enhanced by providing more personal patient accounts and in a more appealing format along with more clarity on the staff groups/stakeholders involved. An Independent Report to our Council of Governors on our Quality Report was undertaken in 2013 and our Q2 2013/14 Monitor evaluation highlighted a possible risk of failing the Clostridium Difficile target, but this did not materialise.

Quality risk management

- 2.1.8 The trust is committed to implementing the principles of governance and to supporting those principles by an effective risk management system designed to deliver improvements in patient safety and care, as well as ensuring the safety of its staff, patients and visitors. Risk management includes identifying and assessing risks, and then responding to them.

As with all public bodies, the trust has an approved risk management strategy and policy that identifies accountability arrangements, resources available and guidance on what may be regarded as acceptable risk within the organisation. Our risk management policy provides a structured approach to the management of risks, with detailed processes and procedures for staff to follow. We continue to raise awareness and develop a culture where all risks are identified, understood and managed (via the Ulysses risk management system). We have an integrated approach to the management of risk and integrate risk into the overall arrangements for clinical and corporate governance from the development of our robust arrangements in all areas for managing risk. We have an appropriate system and organisational structure in place for the identification and control of key risks, and we continuously identify and undertake risk assessments and record the result in our local and corporate trust risk registers, as appropriate.

The trust's strategic risks are included in the corporate risk register and each year, targets to meet strategic objectives are included in the annual planning review to ensure annual planning priorities provide a single unified set of targets for the organisation. Our corporate risk register contains the assessed risks against the operational plan priorities and as a consequence is able to assess the impact and links to strategic priorities.

We have several risks identified on the risk register that could affect the deliverability of the Quality and Safety Plan, with associated risk mitigation:

<u>Risk</u>	<u>Mitigation</u>
Failure to identify and/or address existence of poor clinical standards due to inconsistent implementation of good clinical practice across the trust that could lead to an undesirably wide range of outcomes	Existing controls generally enable the existence of good standards, and improvements to enhance closer supervision to create better consistency are being addressed along with continuous review and update of clinical guidelines, scheduled clinical governance workshops and developing wider

	learning from the global trigger tool
Failure to address significant patient experience concerns resulting in little or no improvement to patient waiting times, motivating patients to seek alternative care and rising complaints	More floor walkers to ensure patient experience concerns are addressed in clinic and improvements to our pathways that have been implemented and their further expansion and development initiatives to improve capacity and service availability
Failure to have in place adequate systems to ensure good quality data impacting on quality of patient care, performance and income	We have a Data Assurance framework in place and are currently populating this for day-to-day use; individual data sets are subject to differing levels of scrutiny and some are subject to detailed audit within the scheduled Quality Audit Plan
Inability to maintain high standards and functions within available resources due to affordability impact	We have robust financial planning and modelling within the trust and are looking at sustainable productivity and cost improvement programmes
Major IT systems failure from poor IT infrastructure	Significant improvements are being made to trust IT infrastructure and business continuity plan is reviewed and up-to-date. Open Eyes releases are being reviewed to identify and implement improvements with further modular functionality being specified from wider clinical base and more succinct programme management

Equally, each clinical directorate and the individual departments within them are responsible for maintaining a local risk register, which feeds into the corporate risk register via local annual plans. The quality plans and risks for clinical directorates reflect both locally identified quality initiatives and risks specific to their services, as well as the wider corporate quality priorities and associated risk linked to the corporate risk register.

Quarterly reports about the corporate risk register are issued to the Trust Board in addition to the quality and safety reports for clinical effectiveness and performance respectively.

We also have a comprehensive risk awareness training package to educate staff at all levels about the principles of risk management and to equip them with the appropriate skills to undertake risk management activities effectively in their local work areas.

We intend to enhance our training/risk management support this year. As highlighted previously, we have moved from a paper-based incident reporting system to our e-system Ulysses risk management system; we aim to implement it fully by early summer 2014 and to provide basic IT training on using and accessing the system.

We also plan to develop staff awareness and skills on the need for risk reporting and its application, which will help us to develop a culture of openness to identify risks and to provide better understanding and management of risk.

Alongside this training, we will offer staff the opportunity to learn basic skills around Root Cause Analysis (RCA), again helping to analyse and interpret serious incidents and never event reporting. For staff that are already familiar in the application of RCA, we will introduce more advanced training support to enable them to investigate more fully and identify mitigating action.

Francis Report

- 2.1.9 In February 2013, the second Francis Report into events at Mid Staffordshire NHS Foundation Trust was published, and listed 290 recommendations.

Our Trust Board considered a detailed response to this report in March 2013 and identified an action plan to address the recommendations. In November 2013, the Government responded in detail to the report, and our action plan may be refreshed to take account of that response.

The Trust Board regularly reviews the action plan to monitor progress and identify any risks to its implementation. Our action plan lists many themes which correspond with our Quality Plan and those actions have been reconciled to our quality priorities.

Similarly, our risk management processes and systems for capturing, managing and reporting on our Quality and Safety Plan will incorporate recommendations and associated actions in response to the Francis Report.

Quality and our workforce

2.1.10 Our nursing and education and training strategies highlight our approach to developing a workforce that can deliver optimal ophthalmic care in the 21st century – more detail of these strategies is provided in the sections covering operational capacity and workforce. Correspondingly, we highlight our research and development strategy due to the intrinsic link with high quality specialist care at Moorfields.

Quality assurance and governance framework

2.1.11 The trust has developed a wide range of quality indicators aligned to the three key categories outlined above – patient experience, patient safety and clinical effectiveness. National targets remain a helpful framework for delivering quality and 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 our Trust Board as part of the monthly performance review.

2.2 Operational requirements and capacity

Activity and demand

- 2.2.1 Referral demand to new outpatient clinic appointments continues to rise from the previous year's activity across the majority of our commissioners. Our glaucoma and external disease subspecialties show the most significant increase, with the lowest growth in general ophthalmology. Within our Moorfields North directorate, 57% of outpatient activity is either general ophthalmology or glaucoma – much of this activity forms the core of both our and commissioners' plans to shift activity from hospital to community settings.
- 2.2.2 Urgent care demand has also grown, with attendances in the final quarter of 2013/14 higher compared to the same period last year. Outpatient clinic referrals through A&E also continue to rise. Performance against the national four-hour waiting time standard remains consistently high and our internal three-hour waiting time for A&E attendance continues to improve.
- 2.2.3 Admissions have increased compared with the previous year, with significant growth seen particularly in our North West London satellites. Long waiters both for first outpatient appointments and admissions peaked in December, recording the highest level in the last two years. Short-term additional capacity, including weekend working, is planned on a continuous basis, while further demand and capacity modelling is assessed. Additionally, we continue to improve our processes for tracking and targeting patients for treatment and are looking at bringing forward and treating some of the long waiting patients to reduce numbers booked into long waiting slots in the future.
- 2.2.4 The requirement for diabetic macular oedema (DMO) and age-related macular degeneration (AMD) injections for patients in line with recent NICE guidance has also added significantly to demand for services and corresponding increased activity.

Operational Capacity

- 2.2.5 Moorfields' patient services are sub-divided into four clinical directorates, following a restructure which came formally into force on 1 April 2012. The restructure aimed to ensure that senior clinicians had greater involvement in the running of the hospital and more responsibility to make decisions about the management of patient care.

The four directorates responsible for patient care are as follows:

Outpatient and diagnostic services

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

Surgical services

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

Moorfields South

Moorfields South treats patients at our district hub that is co-located at St George's Hospital, Tooting (SGH) with services provided from other locations across the locality. Our local surgical centre (providing more general ophthalmology for outpatients and day-case surgery) is at Queen Mary's Hospital (QMH), Roehampton. Community-based outpatient clinics are provided from Bridge Lane Health Centre, Battersea and Teddington Memorial Hospital. The network will soon include eye services currently provided by Croydon Health Services NHS Trust.

Moorfields North

This directorate has four distinct geographical networks: Moorfields at Bedford, Moorfields North West (comprising Northwick Park, Potters Bar, Watford, Watford Boots and Harrow), Moorfields at Ealing, and Moorfields East (comprising St Ann's, Mile End, Barking, Loxford, Harlow, and Homerton).

- 2.2.6 Towards the end of 2013/14, several operational issues and capacity constraints have become apparent in elective/day case activity, again associated with increased demand and long waits both at the main hospital in City Road and at many of the satellite sites. A similar pattern is also emerging for outpatient activity, with some services experiencing issues with slot availability on Choose and Book (CAB), which affects our ability to achieve RTT standards. There is also significant follow-up capacity issues, with clinics regularly overbooked.
- 2.2.7 We will address these issues through delivering the following actions in support of the strategic priority:

“Improve the patient experience and our organisational efficiency by delivering an operational redesign programme across all sites to improve the way Moorfields delivers care, encompassing patient communications and administration, operational planning and performance, cost efficiency and investment, workforce planning, leadership and management”.

2.2.8 We aim to improve the patient experience and our organisational efficiency through the following programmes of work, which will be phased over the two-year period, with prioritisation agreed within each specialty and service to ensure that the work is able to be properly managed:

- Patient communications and administration
- Clinic and theatre redesign
- Operational planning and performance
- Cost efficiency and investment
- Workforce planning
- Structure, leadership and management

2.2.9 Based on a lean/systems-thinking approach, the work will focus on matching capacity to demand, the establishment of effective flow mechanisms and visual management, the identification of key improvement measures and a process to assess the quality impact of the changes.

Patient communications and administration

2.2.10 Previously, we highlighted planned improvements to patient communication and administration as integral to improving the three-part patient journey as set out in our Quality Plan

- i) Implement the recommendations of the patient communications project which will provide:-
 - a) Improved capacity in specialty administrative teams to ensure that phone calls are picked up promptly and queries answered
 - b) Expansion of our nurse-led telephone advice line to increase our capacity to deal with clinical queries from across the patch
- ii) Implement the administrative and clerical programme of work already started in 2013/14 which will:-
 - a) Increase our administrative staff establishment
 - b) Establish standard operating procedures across the patient pathway processes that support clinics and theatres

- c) Provide training and development at all levels, including supervision and leadership, customer care and adherence to the standard operating procedures
- iii) During 2014/15, commence redesign work in the booking centre and admissions office to achieve better processes and communications with patients
- iv) Carry through the work already started on the tracking of RTT 18 pathways, including communications with patients and GPs and training of clinical and non-clinical staff

Clinic and theatre redesign

2.2.11 Similarly, improving patient pathways is highlighted in our Quality Plan, but is also aimed at improving efficiency and productivity. In all specialties and at all sites, we will review the organisation of clinics and theatres to achieve consistently shorter waiting times:

- i) Review of the clinical pathway and processes/flow within each clinic to address the individual flow and waiting issues so that patients' time in clinic is reduced
- ii) Review of clinic templates and booking processes to achieve the 'perfect' clinic at all sites and in all specialties based on some key principles, but not necessarily 'one size fits all'
- iii) Clarity on the theatre arrangements at all sites, including the appropriateness of increasing general anaesthetic (GA)/more complex surgical procedures at certain sites and consideration of six or seven-day working
- iv) Process changes to achieve the 'perfect' theatre pathway at each site and in each theatre based on some key principles but not necessarily 'one size fits all'
- v) In all specialties, identify ways to reduce hospital visits and/or the need to see a consultant at every visit whilst ensuring that at key points in the progression of the patient's condition, the appropriate review and treatment will take place. Use of technology will be key to this work.

Operational planning and performance

2.2.12 We aim to improve our approach to operational planning and performance:-

- i) Reducing and equalising waiting times across all sites. This will entail:
 - a) In early 2014/15, establishing the capacity required to reduce the backlog of long-waiting patients and return to 18 week compliance

- b) Completing a demand and capacity exercise by specialty and by site to determine future capacity requirements
- c) Ensuring that business planning is directly linked to demand and capacity planning
- ii) Refinement of the performance reporting system, streamlining reports and dashboards, making them more accessible to managers and staff
- iii) Development of processes better to monitor performance on a daily, weekly, monthly and quarterly basis, based on real-time tracking and reporting
- iv) Undertake a comprehensive review of operational data quality and a training programme to address gaps in practice, supported by a schedule of regular audits

Cost efficiency and investment

2.2.13 Improving our cost efficiency and the need for investment will enable us to address the affordability challenge facing us in the future, and is described in the efficiency, productivity and cost improvement programme section:-

- i) Establish through benchmarking and statistical analysis the organisation's ability to reduce its operating costs through the identification of key cost drivers and ways to reduce these
- ii) Capture the financial impact of redesign in respect of both investment requirements and cost reduction opportunities

Workforce planning

2.2.14 Each of the directorates has identified the workforce priorities to drive forward their operational requirements in 2014-2016 within their respective operational plans. It is evident that many of these workforce priorities are trust wide and that a corporate approach would be of benefit. For example, recruitment and retention, skill mix and job redesign, education, training and development, and research and development opportunities are common priorities across all directorates.

The cumulative impact of additional clinical, nursing and support staff required to support our increasing demand for services such as the DMO/AMD injection service, to meet the six-day working model, and increasing subspecialty at satellites to deliver planned care closer to home and to staff new satellite development, needs to be addressed at a corporate level.

First, we must fill existing vacancies and address the vacancy factor. We are aware that London as a whole has issues in meeting staffing establishments. More importantly, we need to look at skill mix and role changes to meet the shortfall. We have already identified expanding optometrist/ophthalmic technicians' roles within the patient pathway. Linked to the broader redesign

work described above, we will identify the immediate and future workforce requirements as follows:

- i) For ophthalmic nurses, emergency nurse practitioners and technicians, we will commission external support for a design and modelling exercise to determine the requirement by staff group, including the continued development of expanded roles (linked to the nursing strategy)
- ii) Develop full competency framework for the ophthalmic technician role, in liaison with the practice development team
- iii) For specialist nurses, undertake a review of all roles and job plan structure (linked to the nursing strategy)
- iv) For optometrists and orthoptists, based on continued redesign, explore the opportunities for expanded roles
- v) For administrative and clerical staff, continue the job design, recruitment and training programme commenced in 2013/14
- vi) For medical staff, undertake a job planning exercise linked to the demand and capacity work and requirement for further posts
- vii) Implement e-rostering to support us in understanding our staffing requirements and scheduling

Nursing strategy

2.2.15 Our nursing strategy sets out four high-level strategic priorities for the profession. Moorfields will aim to help nurses reach their full potential and to develop ophthalmic nurses for the future.

The strategy addresses the challenges facing the nursing workforce over the next operational period, including those already highlighted around the greater demand for nursing to meet increased activity and deliver RTT targets, realising our quality intentions and the Francis Report recommendations. We need to develop new care pathways that will result in changes to professional roles. Several initiatives have been implemented since the strategy was first launched, including enhanced roles for advanced practitioners and emergency nurse practitioners, and the development of technical support workers. We have also introduced a postgraduate qualification programme, introduced paid study leave and implemented our new leadership programme for nurses on Agenda for Change bands 7 and 6 respectively. Further progress is planned for 2014-2016 in line with the priorities set out in the strategy:-

- A skill mix review will be completed during the year to support the development of enhanced nurse practitioners supplemented by healthcare assistants/optometry technicians to enable the development of clinical pathways across the services and across the different sites

- Other service developments are also being considered, such as a nurse-led post-operative assessment service, collagen and corneal service cross-linking and AMD clinics and adnexal extended role nurse practitioners, particularly around the development of virtual clinics
- Our nursing bank is being extended to other professions and we hope to develop our bank by attracting staff from other locations – this will be part of a high visibility recruitment campaign

Structure, leadership and management

2.2.16 Several leadership initiatives have been implemented to support the introduction of our directorate structure and individual professional development.

- i) Review spans of control and role requirements across all sites, taking particular account of the site expansion that has taken place over the last two years and that which may be planned over the next two years
- ii) Clarify and enhance the role of leadership and management (including 'on the floor' visibility as occurs in the Aravind Eye Hospital in India) through the LETB-funded leadership programme, supported by a coaching and development programme
- iii) Ensure there is sufficient capacity and flexibility to enable short-term support/interventions can be undertaken as required

Programme management capability

2.2.17 To enable us to deliver planned changes around our operational redesign programme we also need to consider more structured programme management and increased programme management capacity. This will enable us to coordinate work, share learning and deliver a robust reporting system. The shape and structure of this support will be determined during the first quarter of 2014/15.

Education and training strategy

2.2.18 Development of our workforce is inextricably linked to other strategies such as our education and training strategy, due for publication shortly, and the recently approved research and development strategy.

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

The key actions that we will deliver in 2014-16 are shown in the following section:

Education and training strategy actions 2014-15

Leadership and operational excellence

- Develop a specification for and appoint to the role of director of education (Q1,2)
- Consult upon and agree an organisation structure and funding for an integrated education directorate (Q2)
- Agree a governance structure for oversight of all education activities and develop shared standard operating procedures (Q3)
- Agree the education infrastructure required for the new building and requirements for the interim period (Q1,2)
- Agree interim arrangements for use of existing education facilities (Q3)
- Agree and execute an annual education operating plan including budget arrangements (Q4)

Sustainability

- Identify and prioritise where the needs of key learner populations and stakeholders are not being fully met, and develop plans to close significant gaps (Q2)
- Establish a mechanism to publicise and celebrate education successes in conjunction with the communications team (Q3)
- Develop and implement a set of universal metrics for learner experience (Q3)

Product innovation

- Implement an annual review of the product mix (all functions, including patient requirements) (Q4)
- Agree a position on investment in digital learning (scope, scale, timeline, budget) (Q4)

Strategic partnerships

- Develop a formal and strategic partnership with the IoO and UCL (Q1)
- Review other key partnerships and the extent of formality that exists, and formalise as necessary (Q2)
- Agree joint structures to engage educators, clinicians and clinical scientists to enhance understanding and implementation of knowledge translation (Q3)

Education and training strategy actions 2015-16

Leadership and operational excellence

- Complete implementation of new organisational and governance structures

- Create a central repository for shared education resources
- Undertake first annual review of strategic plan

Sustainability

- Increase our understanding of existing and potential markets and customers and their current and future needs
- Develop a promotion and marketing plan that addresses the needs of existing and prospective learner populations
- Develop a capacity and capability plan to meet education and training demand both current and future
- Develop structures for sharing and evaluating best teaching practice across all educator groups and increasing education publications

Product innovation

- Strengthen and grow Moorfields' education offer by aligning the learning on offer to the needs and aspirations for all staff groups
- Agree a range of delivery mechanisms including digital, face-to-face and blended learning products
- Agree an annual investment and supply plan
- Develop criteria for product development, cost and pricing and begin to develop a pipeline of new commercially focused products

Strategic partnerships

- Agree a joint development plan for creating eye health specific education content and tools
- Develop and implement plans to build joint capacity for education scholarship and knowledge translation capability

Research and development strategy

2.2.19 Moorfields and IoO together form the largest and one of the most successful eye and vision research partnerships in the world. Most recently, we were named as one of 11 expert institutions from across the Commonwealth who have come together for the first time as the Commonwealth Eye Health Consortium, thanks to a £7.1 million grant from the Queen Elizabeth Diamond Jubilee trust. Co-ordinated by the International Centre for Eye Health at the London School of Hygiene and Tropical Medicine, the consortium will pursue vital research into conditions such as diabetic retinopathy, which leave millions without sight, and will build capacity across the Commonwealth to tackle avoidable blindness and provide quality care to those affected or at risk.

We published our R&D strategy in 2013 to give us a clear direction for joint future research activity and to enable us to respond quickly and more ably to

new developments and opportunities. The strategy will shape how we prevent visual impairment in the future and change the lives of patients around the world. To deliver this purpose we have identified four strategic themes and are prioritising actions to deliver against the corresponding strategic goals:-

- Focusing on a number of world-leading, high-patient impact research programmes, whilst also strengthening our fundamental research base
- Attracting, training and developing premier research talent to drive research discovery and innovation
- Developing an integrated culture to foster an inspirational environment for collaborative research to boost innovation
- Heading world-leading partnerships with other institutions and organisations, including charities and industry, to bring complementary skills to bear on some of the most challenging research questions

At the same time we have identified key enablers to help us achieve our strategic goals:

- Attracting resources by delivering outstanding value for funders; we aim to increase funding from government and industry, as well as from charitable / philanthropic donations
- Integrating healthcare, research and education to drive synergies between all three areas of activity
- Providing sustained investment in research
- Embracing the challenge
- Growing in international excellence
- Establishing world-class infrastructure that includes state-of-the-art research facilities, techniques and equipment and a comprehensive informatics network (linked with our implementation plans for Project Oriel and OpenEyes)

Key risks to operational delivery

2.2.20 The most significant risk to our operational capacity will be the availability of the additional staff needed to reinstate our 18 week RTT performance, at the same time as continuing to address increased demand for our services – in particular our injection services. The preceding sections on workforce and education demonstrate how we will mitigate this risk.

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

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

As highlighted in our quality section around risk management, our operational risks and corresponding risk mitigation plans are overseen by our corporate governance team and regularly monitored by the Management Executive and Trust Board.

2.3 Information management

2.3.1 OpenEyes, our innovative open source web-based electronic patient records system created by an internal development team, is a key enabler and essential to the trust in delivering our strategic priorities and operational objectives.

“Deliver an electronic clinical record and a paper-light environment, through full implementation of OpenEyes as the clinical record across all sites and services (2014/15) with the minimum of day-to-day disruption and benefits realisation through cultural change (2015/16)”.

2.3.2 The first phase of OpenEyes went live in 2012 and covers all activity relating to surgical bookings, theatre diaries and surgical waiting lists both at our main hospital and in our satellite locations. It also handles routine reporting. The initial focus was to implement OpenEyes in a small number of subspecialties – cataract, glaucoma and medical retina as these are high volume areas. It was subsequently recognised that investment and urgent action was necessary to stabilise and improve our information technology infrastructure to support the operationalisation and full roll-out of the clinical recording information system. Significant progress has been made in developing the infrastructure to an acceptable standard at City Road and at the vast majority of satellite sites, but further investment is planned this year to roll-out improvements to all sites. Additionally many of our satellite locations are running stand-alone imaging databases that are over capacity and slow, while IT infrastructure in some is managed by the host organisation. We now ensure IT infrastructure requirements are clearly defined for any new satellite developments so that we can eventually electronically link our sites together.

2.3.3 Against this backdrop and with agreed work plans to deliver the OpenEyes project, several key actions have been identified within the programme plan for delivery in the operational period:-

- Post project evaluation of current functionality to identify enhanced functionality improvements for the next stage of the roll-out planned for cataract, glaucoma and MR subspecialties (next phase development for these subspecialties)
- Short-term proposal to implement improved links with the current patient administration system (PAS) and waiting list management to ensure better information is available for scheduling patients to achieve RTT performance
- Complete an option appraisal to review PAS functionality in the long-term alongside the integration of OpenEyes
- Develop OpenEyes functionality modules for vitreo-retinal, strabismus / paediatrics and corneal subspecialties

- Build functional requirements for these subspecialties
- Deliver training support to users
- Identify parallel pilots and proof of concepts – model community testing before rolling out
- Roll-out the new subspecialty functionality to the main hospital and satellites
- Assess with clinical colleagues the data management and analytical capability arising from the new OpenEyes functionality and align this with quality reporting, quality audit and research projects
- Identify and agree links with other systems and information management systems – the next priority would be to consider links with the clinical reporting system and ophthalmology scanning and imaging systems; there is no national solution, but we are considering proposals to provide a short-term solution whereby OpenEyes could “wrap around” to support seamless integrated information for our users and enable all patient-specific images to be seen at all sites. This proposal will not only improve the capacity at satellites where there are slow-running databases but help to support patient pathways for virtual clinics and overall time management
- We are assessing proposals for e-rostering, which should be beneficial in improving patient pathways
- The mobile technology and telehealth strategy will be aligned with our remote working and virtual clinic development to identify key actions to support their implementation
- A pilot to scan A&E attendance cards with an external company has started to support and contribute to the implementation of a paper-light system; an evaluation will be undertaken once an appropriate period of implementation has been established and will include any impact on OpenEyes deliverability

2.3.4 Estimated costs have been prepared and will be reassessed once more of the detailed implementation is defined.

2.4 Financial plan

2.4.1 The plan for 2014/15 has been formulated using published tariff pricing , draft financial assumptions yet to be fully agreed with the lead commissioner (subject to final contract sign-off) and detailed internal planning with managers and other budget holders.

Productivity, efficiency and cost improvement plans

2.4.2 Within the national tariff-setting process, there is an expectation that further efficiency gains will close the affordability gap. In broad terms, 2014/15 sees tariff deflation at levels consistent with recent years, while the tougher financial climate in 2015/16 is expected to lead to a larger real-terms reduction in the tariff, requiring higher efficiency levels.

2.4.3 In the table below, we have included our efficiency savings target which is calculated at 3.0% of NHS expenditure (£4.4 million) in 2014/15, and at 4.26% in 2015/16 (£6.3 million). It is planned that £2.2 million will be delivered from cost reductions in 2014/15 and £3.2 million from cost reductions in 2015/16, with the remainder delivered by revenue generation schemes in both years.

Efficiencies are apportioned over pay, non-pay and against income.

Efficiency Plans

	2013/14	2014/15	2015/16
Identified Schemes	6.4	3.1	1.5
Unidentified Schemes		1.3	4.8
Total	6.4	4.4	6.3

For 2014/15, a total of £3.1 million has been identified or signed off as schemes that will proceed against the £4.4 million target. For 2015/16, we have identified schemes totalling £1.5 million. Work continues to identify schemes to close the remaining gap.

2.4.4 Key productivity schemes include:

- Service redesign projects, initially focused on glaucoma pathways that will deliver radically different ways of providing services to improve them for patients
- We have invested heavily in improving our IT infrastructure in 2013/14, and our IT strategy will now enable us to deliver efficiencies and improve productivity
- The productive operating theatre programme was highlighted in our quality section as a means of improving surgical pathways; it initially focused on the cataract pathways and aimed to improve patients' experience of surgery and maximise our theatre productivity

2.4.5 Over recent years, Moorfields has successfully identified new market opportunities and anticipates future growth in this area. Our ability to attract

additional income is key to helping us meet the future affordability challenge and will be further explored in our marketing management within the Strategic Plan.

2.4.6 Several new satellite services will become operational this year, in both our Moorfields South and Moorfields North directorates. These new developments are in line with commissioning intentions to deliver planned care closer to home and support our networked model. In addition, plans to increase intra-vitreous injections for new NICE approved indications are included. The main service developments and transactions are included in the financial plan along with the full-year effect of 2013/14 revenue generation schemes. NHS clinical income is also reduced by the tariff deflator.

2.4.7 Our three commercial divisions forecast growth of a further £1.3 million net in 2014/15, with partial recovery of non-recurrent reductions seen the previous year combined with targeted growth in certain activities. A fuller recovery and increase is seen in 2015/16 with a net growth of £1.7 million.

Key financial plan assumptions

2.4.8 The following table illustrates the key planning assumptions used for the next two years. In general, following 2014/15 it assumes higher tariff deflation of NHS income and higher inflationary pressures on costs. In addition to this, the provision of funding for service redesign projects is increased in 2015/16.

	13/14 to 14/15	14/15 to 15/16
Income		
Tariff deflator	-1.50%	-2.60%
Education and Training Increase	0.00%	0.00%
R&D Increase	0.00%	0.00%
Income Generic Growth	1.40%	1.40%
Other Income Growth	0.00%	0.00%
Costs		
Pay inflation factor (Incl Incr Drift)	1.56%	2.90%
Inflation - Drug costs	2.00%	2.90%
Inflation - Clinical supplies etc	2.00%	2.90%
Inflation - Other costs	2.00%	2.90%
Efficiency Programme	3.00%	4.26%
Contingency	1.00%	0.86%
Service Redesign	2.00%	-
Cost Pressures and developments	1.00%	0.86%

- Tariff changes are a 1.5% decrease in 2014/15 in line with published tariff, and are assumed at a 2.6% decrease in 2015/16
- The market forces factor uplift that the trust will receive on tariff income next year has remained steady at 26.5% in 2014/15 and is assumed to remain at this level for 2015/16
- Education income has been adjusted with known changes as notified by Health Education England
- R&D income is based on planning assumptions on a project by project basis with no generic percentage change applied
- Other income is adjusted with known changes across both years with no generic percentage change applied
- Pay inflation and incremental drift is assumed at 1.56% for 2014/15 increasing to 2.9% in 2015/16 in line with issued guidance
- Non-pay is planned at between 2.0% overall average increase for 2014/15 and 2.9% increase for 2015/16 as per issued guidance
- Cost pressures already notified for 2014/15 have been included. An additional 1% cost pressure reserve has also been built in to the plan for 2014/15 and 0.86% for 2015/16 along with a 1% contingency reserve in 2014/15 and 0.86% in 2015/16.
- For 2014/15 a service redesign reserve has been included at 2%
- An efficiency savings target is included at 3.0% of NHS expenditure (£4.4 million) in 2014/15 and at 4.26% in 2015/16 (£6.3 million). It is planned that £2.2 million will be delivered from cost reductions in 2014/15 and £3.2 million from cost reductions in 2015/16, with the remainder delivered by revenue generation schemes in both years
- 2014/15 and 2015/16 assume a 1.4% growth in all areas of NHS income; cost budgets and growth cost reserves have been set in line with activity change assumptions
- Non-tariff income and local prices are deflated at the notified deflation factors
- Commercial trading unit figures are based on latest planning assumptions

Summary of the financial plan

2.4.9 The financial information presented below represents the forecast outturn for 2013/14 and the budget for 2014/15 and 2015/16. The plan for 2014/15 and 2015/16 is to make a surplus before impairments of £5.0 million. The reduction from the full year forecast surplus in 2013/14 of £10.5 million is due to planned investments and developments, removal of non-recurrent items and cost pressures and reserves.

In broad terms, 2014/15 sees tariff deflation at consistent levels with recent years, while we expect a tougher financial climate in 2015/16 to lead to a larger real-term reduction in the tariff requiring higher efficiency levels.

All figures in £million	2013/14			2014/15	2015/16
	Plan	Actual	Variance	Plan	Plan
Income					
NHS Clinical income	114.7	119.1	4.4	134.7	137.4
Commercial Trading Unit Income	33.6	30.9	-2.7	34.8	36.5
Other Income	20.3	24.1	3.8	20.6	20.9
Total income	168.6	174.0	5.4	190.1	194.8
Expenditure					
Pay costs	79.7	78.9	0.8	89.4	90.7
Non-pay costs	49.7	50.8	-1.1	58.4	60.8
Commercial Trading Unit Costs	26.9	25.5	1.4	27.9	28.0
Total expenditure	156.3	155.2	1.0	175.7	179.5
Earnings before interest, tax, depreciation and amortisation	12.3	18.8	6.5	14.4	15.3
Depreciation, Interest and Dividends	8.3	8.2	0.1	9.4	10.3
Net surplus	4.0	10.5	6.5	5.0	5.0
Impairments	0.0	0.0	0.0	8.5	2.6
Net Surplus after Impairments	4.0	10.5	6.5	-3.5	2.4

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

2014/15

- NHS clinical income: increases due to directorate developments, satellite expansion and general income growth offset by tariff reductions, with appropriate reserves accounted for
- NHS clinical income has over-performed in 2013/14 against plan by about 5%, and although we do not anticipate over-performance in 2014/15 at this stage, where this does occur we are confident that any contractual terms we agree will not restrict payment
- Commercial trading unit income increased between 2012/13 and 2013/14 by £2.7 million (9%) but still fell behind plan in 2013/14, partly due to non-recurrent factors; the planned growth for 2014/15 is therefore reasonable and achievable, with a partial recovery of those non-recurrent factors
- The directorate development pressures and satellite service developments included in the plan for 2014/15 increase NHS clinical income by £15.6 million and expenditure by £13.0 million. NHS clinical income is also reduced by the tariff deflator
- Other income decreases by £3.5 million in 2014/15 due to reductions in non-recurrent income received in 2013/14
- Pay costs inflate at 1.56% in 2014/15; costs increase to deliver developments offset by efficiencies
- Non-pay inflates at 2% in 2014/15; costs also increase to deliver new developments offset by efficiencies

- Efficiencies are apportioned over pay, non-pay and against income
- Depreciation and interest charges show an increase during the period in respect of additional capital investments and their associated financing costs
- Commercial activities: our commercial divisions plan to grow a further £1.3 million net in 2014/15 with partial recovery of non-recurrent reductions seen the previous year combined with targeted growth in certain activities
- The trust has a substantial capital programme of new buildings across its network; a prudent view has been taken of the likely stance of the valuer's approach to both finished stock and work in progress, and this is likely to result in an impairment in 2014/15 which is shown within the plan for the year

2015/16

- NHS clinical income: increases due to developments, efficiencies and general income growth offset by tariff reductions
- Other income increases by £0.3 million in 2015/16 due to increases in rent.
- Pay costs inflate at 2.9% in 2015/16; non-pay inflates at 2.9% in 2015/16
- Efficiencies are apportioned over pay, non-pay and against income
- Depreciation and interest charges show an increase during the period in respect of additional capital investments and their associated financing costs
- Commercial activities: our commercial divisions plan to increase income with targeted growth in certain activities.
- Further impairments are forecast in 2015/16 in line with the likely stance of the valuer's approach to both finished stock and work in progress.

Financial risks

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

<u>Risk</u>		<u>Mitigation</u>
Changes to tariff structures for CCG and specialist commissioned activity detrimental to our financial position	Tariff structures for CCG and Specialist commissioned activity change to the detriment of our financial position.	Moorfields has limited contingency reserves (1% of NHS costs) for this eventuality. We would need to seek to generate additional savings and revenues in order to maintain contingency

		reserves for other uncertainties, such as commissioner intentions.
Anticipated growth for our commercial businesses may not materialise with consequent impact on profitability	Commercial businesses experience volatility as against anticipated growth rates with a consequent impact on profitability.	Formal submitted plans only address activities known to be going ahead. New opportunities are likely to crystallise to some degree. Residual risk is accepted in line with past practice at Moorfields.
Inflation is above expectations, leading to pay and non-pay pressures that are not fully funded	Inflation is above expectations, leading to pay and non-pay pressures that are not fully funded.	Moorfields has limited contingency reserves (1% of NHS income) for this eventuality. We would need to seek to generate additional savings and revenues.
Capital costs increase substantially to address service capacity improvements	Capital cost steps in service capacity improvements turn out to be substantial. A consistent theme at satellites is that existing and recent additional space is constrained.	Current good working knowledge of the resource requirements of patient pathways is being formalised alongside data environment improvements. This should allow Moorfields to seek opportunities to further optimise the utilisation of its infrastructure and to ensure that new infrastructure is closely targeted to patient requirement.
Cash balances adversely impacted from an array of poor practices and processes	Cash balances are hit by continued weak commissioner operational and planning performance alongside Moorfields' continued heavy investment in new capital projects. Commissioners continue to	Moorfields has existing cash resources and will seek debt finance for its current pipeline of major incremental projects, e.g. St George's Hospital building and site acquisitions.

	under commission and to be poor at processing invoices. NIHR have moved from payment in advance to payment in arrears.	
Broader health system planning changes adversely impact on our operational and financial position	Broader health system planning changes. Moorfields is atypical in its range (many) and scale of commissioners (few more than £25 million p.a.). There is a risk that there will be unforeseen effects from a more general health system approach on Moorfields' operational and financial position.	Engagement, where offered, in the relevant consultation processes.
Short-term planning cycles do not represent or afford us to illustrate strategic financial performance based on our significant growth opportunities	Moorfields is committed to change and growth. Perhaps unusually for an NHS hospital, we have significant growth opportunities and these may involve decisions to invest to grow or improve, weakening historically planned financial performance in the short term. The relatively fixed nature of the planning cycle set out by Monitor therefore represents a risk to a fair interpretation of our reported performance.	Discussions with Monitor over flexibility to change planning assumptions and resulting plans and metrics over time, e.g. opening a new satellite where care is currently poor would diminish short term financial results whilst improving patient care and, potentially, Moorfields' medium-term financial performance. Residual risk: potentially substantial depending on Monitor's attitude.

Capital requirements

Investment and disposal plans

2.4.11 Our capital investment plans for 2014/15 and 2015/16 are as follows:

	2014/15 £M	2015/16 £M
Prior Year Carry Forward	2.1	1.2
Estates	1.9	2.0
Information Technology	2.5	1.5
Medical Equipment	1.6	1.5
Injection Facilities Upgrade	2.1	-
Anticipated carry forward to following year	-1.2	-1.0
Operational Capital Expenditure	9.0	5.2
Confirmed Satellite Expansion	1.5	-
St Georges Site New Build	6.5	7.7
Project Oriel Capital Costs	17.0	40.0
Projects Capital Expenditure	25.0	47.7
Total Capital Expenditure	34.0	52.9

Operational capital expenditure.

2.4.12 This section shows our regular capital expenditure on the current estate, IT schemes and medical equipment replacement and purchasing. The major items for 2014/15 to note are as follows:

- £2.1 million carry forward from 2013/14, principally estates schemes for backlog maintenance, expansion of our satellite at Ealing Hospital and works to expand our ocular prosthetics department. An estimate of carry-forward from 2014/15 to 2015/16 is included
- £1.9 million for new estates schemes: the primary scheme is the continuation of the City Road backlog maintenance programme, with smaller schemes included for a chiller replacement and security upgrades. Backlog maintenance and an estimate of other schemes are included for 2015/16
- £2.5 million for information technology - continued development and roll-out of OpenEyes plus imaging systems to ensure availability of medical images throughout our network of sites as well as smaller schemes for licence purchases and network upgrades. Continued investment in OpenEyes and other IT programmes are anticipated in 2015/16
- £1.6 million for medical equipment derived from our prioritisation and risk assessment. Major items include theatre microscopes, surgical equipment, and upgrade of our intra-ocular lens (IOL) master machine stock, tomography imaging equipment, sterilisation washers and a range of other items. An estimate is included for 2015/16

- £2.1 million for injection facilities in line with the increased demand as outlined in the operational capacity section

Projects capital expenditure

2.4.13 £1.5million is included for satellite expansion confirmed at the point of setting the plan. This is primarily to purchase medical equipment for the new site. There is potentially a further £1.9 million for other satellite expansion projects which are not yet confirmed and as such not included in capital or revenue plans at this stage.

- £6.5 million St George's new build. The Trust Board recently agreed an investment in a new standalone building at our satellite in Tooting which will combine an outpatient and theatre service in one location on the site. A further £7.7 million is anticipated in 2015/16 to complete the build.
- Building infrastructure schemes: this project is a major capital scheme to re-provide our facilities in central London by moving our City Road hospital to a new site. Amounts are provisional at this stage, but include enabling capital in 2014/15 and new site acquisition in 2015/16.

Cash-flow and Financing

2.4.14 The trust plans to finance its 2014/15 capital programme with a combination of retained cash reserves, in-year generated cash from surpluses and loan financing. The high level cash-flow for the next two years is shown below:

	2014/15 £M	2015/16 £M
Projected opening cash reserves	23.9	23.5
Working capital movements	(0.9)	(3.6)
In-year surplus	5.0	5.0
Add depreciation	6.5	6.8
Operational capital expenditure	(9.0)	(5.2)
Projects capital expenditure	(25.0)	(47.7)
Planned loan financing	23.0	47.7
Projected closing cash reserves	23.5	26.5
Potential Additional Building Infrastructure Projects Expenditure and Resultant Borrowing*	20.0	-

2.4.15 Moorfields comprises a network of sites across London and the South East of England. The network is experiencing both a growth in demand and an urgent need to replace obsolete building stock. The trust has several investments authorised or in preparation; these will ultimately increase and replace capacity and have a number of dependencies including negotiations with counter parties (e.g. host hospital sites etc.).

2.4.16 For 2014/15 the trust plans to submit business cases to the Foundation Trust Financing Facility (FTFF) to the value of £30.7 million, and draw on £23 million of this loan financing in 2014/15 with the remaining drawing of £7.7 million taking place the following year. It should also be noted that there is the potential for the trust to apply to the FTFF for a further £20 million of loan financing in 2014/15 to support building infrastructure, which would bring the total loan financing agreed to £50.7 million, with £43 million drawn in 2014/15. This requirement for this second tranche of borrowing is still under review. For 2015/16, it is planned that a further £40 million will need to be agreed with the FTFF as part of building infrastructure development.

Glossary

A & E	Accident and Emergency
AHSC	Academic Health Science Centre
AMD	Age-related Macular Degeneration
CAB	Choose and Book
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme
CQC	Care Quality Commission
CRESS	Clinician Reported Eye Symptom Scorecard
CRN	Clinical Research Network
DMO	Diabetic Macular Oedema
ENP	Emergency Nurse Practitioner
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record
FTFF	Foundation Trust Financing Facility
GP	General Practitioner
HCAI	Healthcare Associated Infections
HMT	Her Majesty's Treasury
HR	Human Resources
IoO	Institute of Ophthalmology
IT	Information Technology
LETB	Local Education and Training Boards
LINK	Local Involvement Network
MGTT	Modified Global Trigger Tool
Monitor	Independent Regulator of Foundation Trusts
NE	Never Event
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
OJEU	Official Journal of European Union
OpenEyes	Ophthalmic Electronic Patient Record (web based)
PALS	Patient Advice and Liaison Service
PAS	Patient Administration Services
PROM	Patient Reported Outcome Measure
PRESS	Patient Reported Eye Symptom Scorecard
QIPP	Quality Innovation Productivity and Prevention
QMH	Queen Mary's Hospital
RDCEC	Richard Desmond Children's Eye Centre
R & D	Research and Development
RCA	Root Cause Analysis
RCO	Royal College of Ophthalmologists
RIBA	Royal Institute of British Architects
RTT	Referral To Treatment
SGH	St. George's Hospital
SI	Serious Incident
T-POT	The Productive Operating Theatre
UCL	University College London