Moorfields Eye Hospital NHS
NHS Foundation Trust

Strategic Plan Summary for 2014-19

Moorfields Eye Hospital NHS Foundation Trust

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1. Declaration of Sustainability

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.

Our strategy – "Our Vision of Excellence" was written in 2009 and was refreshed in 2013. It remains aligned with commissioner strategies and is based on providing care in the most appropriate setting (ideally closer to patients' homes). The strategy is also based on growth and improvements in productivity and efficiency; our core growth assumptions are supported by our historic performance, and the NHS and commercial market opportunities that we plan to deliver.

We developed a joint research and development strategy with our partners at the UCL Institute of Ophthalmology (IoO) in 2012/13. The vision for this strategy is to continue to be a world leader in eye-disorder prevention and treatment by conducting fundamental research. Our Operational Plan 2014-16 detailed the implementation of this strategy which is focused on bringing the latest advanced treatments into clinical care, whilst delivering the commercial benefits of our intellectual property around expertise and data.

We have also developed an education strategy, published in April 2014, which will place Moorfields as one of the top ophthalmic training centres in the world. We will appoint an education lead in 2014 who will prioritise and implement our education strategy as detailed in our Operational Plan 2014-16.

Moorfields has a track record of strong operational and financial performance and we maintained a high standard against the majority of targets in 2013/14, although we did not achieve the 18-week referral-to-treatment target (RTT) in the last quarter. We delivered a £9.3 million surplus in 2013/14.

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.

Since 2004, the Department of Health has been trying to encourage the delivery of more routine and minor emergency eyecare outside hospital. In addition, there have been significant advances in treatments of previously untreatable conditions, such as intra-vitreal injections for wet age-related macular degeneration (AMD). It is widely acknowledged that changes in strategic direction will occur, and are likely to be impacted by technologies allowing improved remote diagnosis and assessment – for a significant number of routine follow-up appointments, attendance at hospital is likely to be unnecessary and the introduction of new community-based eye health pathways, including those supported by local optometrists, is likely to increase in response. We have seen the beginnings of activity shifts into community settings, particularly in general ophthalmology, and our strategy includes consideration of how we will respond to further shifts, especially in the management of long-term conditions such as glaucoma and AMD.

Given the rising number of older people who will be living with eye health problems, the overall demand for ophthalmology will continue to increase. Our growth opportunities are further improved by our strong competitive position, particularly within London.

Over the last five years, we have extended our geographic reach, increasing our satellite locations from 13 in 2009 to 21 in 2014. These have been through acquisition (Moorfields at Croydon), success in tenders (Moorfields Richmond services at a variety of locations), collaborative working with commissioners (Moorfields at Barking Hospital and at Bridge Lane Wandsworth) and partnerships (Moorfields at Watford - Boots). This strategic plan includes further expansion in our satellite locations.

We have also seen a shift in our centre of gravity, with approximately 50% of new referrals now being seen in satellite locations away from our City Road hospital, and we have been increasing the range of sub-specialties available at key locations and repatriating activity closer to patients' homes.

Our planning for the replacement of the existing City Road hospital is well underway, and we decided to move to the King's Cross / Euston area in 2013 – this will improve the accessibility of our services and foster greater integration with the UCL Institute of Ophthalmology. The new facility, which we hope to open in 2020, will sit at the centre of our network and this strategic plan includes consideration of our capacity requirements across the network.

The strategic plan is therefore primarily focused on our NHS services and balances the continuing shift of activity from hospital settings, and our need to transform service delivery, with the opportunities for growth arising from demographic factors and our market position. The plan includes a gap analysis for the capacity arising from our demand model and details how the gap will be met. These are aligned with our commissioners' strategies.

Our financial modelling over the period is based on robust growth projections which would be strengthened if we seize the marketing opportunities that present themselves from the market assessment detailed within the strategic plan. The financial position also includes our commercial operations and summarises how we intend to grow further this aspect of the organisation.

The delivery of the strategic plan will ensure our continued sustainability in terms of the quality of services we provide and our financial performance.

The strategic plan covers a five-year period with inherent uncertainties as to the opportunities and threats facing Moorfields. The assurances given as to financial and operational sustainability are therefore made on the basis of currently known information about the political, economic, strategic, regulatory, technological and operational priorities for the NHS and ophthalmology services in particular. Significant change in this understanding through, for instance, a change in government, a change in government spending priorities or financial position, changes in the payment by results regime, a major clinical technology breakthrough etc., could invalidate the planning assumptions on which this five-year strategy is built and could threaten Moorfields' financial and operational viability.

This summary document includes the key components of the Strategic Plan.

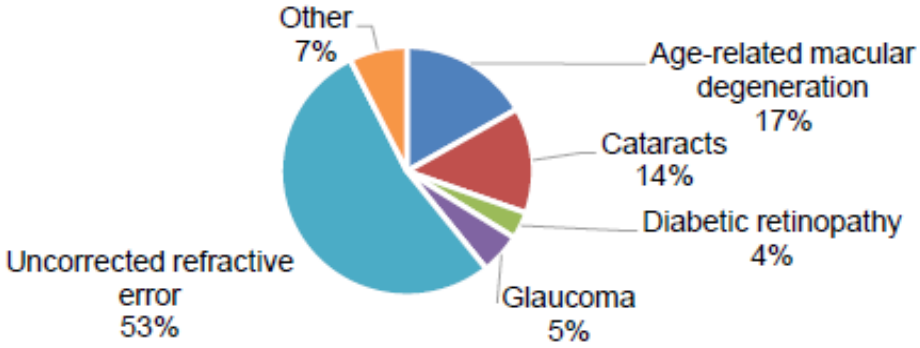
2. Market Analysis and Context

1. Healthcare Needs Assessment

Visual impairment and blindness is a significant national and global issue and its prevalence is projected to rise, partially as a consequence of an ageing population. At the same time, research and technologies are transforming ophthalmic services meaning that some diseases that historically have caused sight impairment and blindness are now potentially treatable.

There are five major causes of sight impairment in the UK which account for 93% of sight loss in the UK. Sight loss is one of the major health challenges facing the NHS and addressing its causes is a national health priority.

Major Causes of Sight Loss in the UK (Access Economics, 2009)



Uncorrected refractive error relates to sight impairment due to a corrective test not being undertaken and / or a corrective measure not being complied with – for example, no eye test done to discover a sight loss issue and / or prescription glasses not worn.

Age-related macular degeneration remains the largest cause of sight loss, despite the introduction of new drugs to treat the condition.

The above data relates to sight loss (in the entire population) rather than blindness. Work undertaken by staff at Moorfields, published in BMJ Open in February 2014, has shown that diabetic retinopathy is no longer the leading cause of certifiable blindness among the working age population in England and Wales. Instead, hereditary retinal disorders, including Stargardt's disease and retinitis pigmentosa, now account for the largest number of Certificates of Vision Impairment (CVI), comprising 20.2% of the total number of cases for this age group.

For the first time in 50 years, diabetic retinopathy / maculopathy was found to be the second largest cause of certifiable blindness, at 14.4%, followed by optic atrophy (14.1%) in this age group. Together, these three leading causes accounted for almost half of all blindness certifications in the working age group. Glaucoma was responsible for 5.9% of certifications, followed by congenital abnormalities of the eye, which include congenital cataracts and retinopathy of prematurity, at 5.1%.

The change may be related to many factors, including the introduction of nationwide diabetic retinopathy screening programmes in England and Wales and improved glycaemic control. However, the fact that inherited retinal disease now represents the commonest cause of certification in the working age population has significant clinical and research implications, particularly in relation to the provision of care and resources in the NHS and the allocation of research funding.

Key summary facts in relation to sight issues

1	Global placement for Moorfields Eye Hospital NHS Foundation Trust and Institute of Ophthalmology for scientific productivity and impact of ophthalmic research activity (source: Boston Consulting 2012)
17	Average number of years taken to translate just 14% of original research to the benefit of global care (source: Annual Review of Public Health, 2009)
8.5%	Percentage of global population who are visually impaired, have low vision or are blind (source: WHO, 2010)
50%	Percentage of sight loss which is believed to be preventable (source: UK Vision Strategy)
1in 9	The number of people in the UK aged over 60 who live with sight loss (source: Fight for Sight)
4 million	By 2050, the number of people in the UK who will suffer significant sight loss i.e. impaired vision in both eyes (Source: RNIB)
100	Number of people in the UK every day who start to lose their sight (source: RNIB website)
£2 bn	Amount of NHS money spent annually on eye care in England (source: DoH, 2012)
£8 bn	The cost each year of sight loss and eye health to the UK economy (RNIB, 2013)
86%	Percentage of working age adults in the UK who state vision is their most valued sense (source: College of Optometrists, 2011)

2. Demographic projections

Over the 10-year period to mid-2022, the UK population is projected to increase by 4.3 million to 68.0 million, equivalent to an annual growth rate of 0.6 per cent each year (source: Office for National Statistics (ONS) 2012). Of the 4.3 million projected increase, some 2.6 million (61 per cent) is a result of projected natural increase (more births than deaths) while the remaining 1.7 million (39 per cent) is the projected net number of migrants.

The population of England is projected to increase by 7 per cent by mid-2022; the population of the other UK countries is also projected to increase, but at a slower rate – Northern Ireland is projected to increase by 5 per cent over the same period, while Scotland and Wales are projected to increase by 4 per cent by mid-2022.

The population is projected to continue ageing, with the average age rising from 39.7 years in 2012 to 40.6 years in mid-2022. However, the increase is not consistent across all age groups; the number of children aged under 16 is projected to increase from 12 million to 13 million, and then stay at around this level for the next 15 years. There were 3.21 people of working age for every person of state pension age in mid-2012. By mid-2022, allowing for the change in state pension age, this 'old age support ratio' is projected to rise slightly to 3.39.

The increase for 65+ age banding is expected to rise by the most significant proportion, by 16% at 2022, with the number of people aged 80 and above projected to more than double and people aged over 90 to more than triple.

Estimated and projected population of the United Kingdom, mid-2012 to mid-2022

	2012	2017	2022
United Kingdom	63.7	65.8	68.0
England	53.5	55.4	57.3
Wales	3.1	3.1	3.2
Scotland	5.3	5.4	5.5
Northern Ireland	1.8	1.9	1.9

Whilst Moorfields receives referrals from across the UK, the majority of activity is provided in the South East of England so population projections for London are more relevant. These are presented overleaf and show a slightly different picture; whilst the 65+ age banding is expected to rise approximately in line with national population projections, the working age adult banding and 0-15 age banding are expected to rise by 1.1% and 1.7% respectively in the same time period. Overall, London will see an average 1.2% increase in its population between 2012 and 2022.

The 10-year compound annual growth rates are also presented overleaf and show a consistent 1.5% compound annual growth rate in the 65+ age group, whilst the overall London population's compound annual growth rate falls from 1.3% from 2010-2020 to 1.2% for 2012-2022.

London population, 000s

Age Band	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
0-15	1600	1634	1670	1706	1743	1780	1811	1837	1861	1882	1901
16-64	5658	5729	5799	5868	5932	5991	6052	6113	6174	6232	6287
65>	934	953	968	981	993	1006	1018	1032	1048	1065	1085
All	8192	8315	8437	8555	8668	8776	8881	8983	9083	9179	9272

London population – 10-year compound annual growth rates

Age Band	2010-2020	2011-2021	2012-2022
0-15	1.9%	1.9%	1.7%
16-64	1.1%	1.1%	1.1%
65>	1.5%	1.5%	1.5%
All	1.3%	1.3%	1.2%

3. Epidemiological Impact

In addition to the basic demographic modelling, consideration was given to the inclusion of more detailed epidemiological estimates. The main authoritative source for these is provided by the RNIB in its study into the projected incidence of eye disease in the UK: Future Sight Loss UK (2009). It provides age-related and ethnicity-specific projections of eye disease to 2020 on a national basis, covering medical retina, glaucoma, and cataract. This, however, does not cover all the activity undertaken by Moorfields, and nor does it allow the actual Moorfields population to be projected forwards with any specificity as it does not provide visibility at local authority level.

The RNIB kindly provided the trust with their Sight Loss Tool, which provides a means of assessing sight loss and was provided on a borough-by borough basis, albeit not on a condition-by-condition basis. However, it did allow for an assessment of the change in incidence of sight loss across the London boroughs, which suggested an overall compound annual growth rate of 2.4% for inner and outer London (crudely, the Moorfields catchment). The RNIB caveat to the model is important and is reiterated here: “The tool is a national-level prevalence model that has been applied locally as a guide/estimate in the absence of any other data.”

4. Moorfields specific demographic and epidemiological growth

Moorfields developed a strategic demand and capacity model, the outputs of which are presented in the following section of this plan. Utilising outturn patient-level data for 2012/13 (this is currently being refreshed), the model applied ONS population projections by age and local authority, enabling the Moorfields-specific projected demographic growth to be calculated – this is substantially greater than the average London-wide projection (for example, for outpatients, Moorfields’ growth is 1.64% per annum, against 1.2% average population growth).

The available data therefore suggests using either a 1.64% (Moorfields-specific demography) or a 2.4% (RNIB national epidemiological tool) annual growth factor. The trust has taken a view that an appropriate modelling assumption, at this stage of the process, would be to take the midpoint of these two factors and use a 2% annual growth factor for demographic and epidemiological growth.

5. Strategic Demand and Capacity Modelling

The demand and capacity model is a core planning tool for the sizing of our new hospital, and the recently approved land purchase business case included the model's outputs in support of our future space requirement at our central site. This strategic plan presents this data alongside the capacity requirements across the network, as the new central site sizing is predicated on the wider network's capabilities to cater for growth and repatriation.

The strategic demand and capacity model uses the following assumptions:

- 2% per year growth to reflect demography and epidemiological factors across our activity base – this is a composite measure based on the ONS and RNIB datasets; and
- 2% per year growth to reflect service developments and market share gains across our activity base, with the demand delivered at satellite sites – this is a realistic measure based on historic growth, the impact of new treatments and the market opportunities.

The impact of these assumptions is demonstrated below:

	City Road	All other sites	**Total**
Base demand (e.g. outpatient attendances)	**50**	**50**	**100**
Demographic & epidemiological growth - %	2%	2%	**2%**
Demographic growth – attendances	1	1	**2**
Service development & market share growth - %	0	2%	**2%**
Service and market share growth - attendances	0	2	**2**
Revised demand – attendances	**51**	**53**	**104**

A detailed assessment of the potential activity that could be repatriated from City Road to Moorfields' satellite sites has also been undertaken, and suggests that there is the potential to repatriate up to 50% of City Road activity closer to patients' homes. This percentage is considered a maximum and is based on the assumptions that present service configuration continues unchanged, capacity is available at satellite sites and workforce plans allow for the dispersed delivery repatriation. Our assessment of potential repatriation includes consideration of the following issues:

- Timetabling: the extent to which capacity is driven by scheduling assumptions
- Attendance avoidance: the extent to which activity may not need to be seen within a hospital setting
- Clinic organisation and design, including increased number of sessions per week
- Distribution of activity across the network in line with the policy of care closer to home and the trust strategy
- Patient choice: some patients may prefer to be seen in central London and may not wish to have their care transferred to a local site

We have therefore concluded that we can realistically redistribute approximately 20% of activity from City Road. This is an average across sub-specialties, with glaucoma, medical-retinal and general ophthalmology assumed at a higher percentage shift.

We have also considered the impact of commissioning intentions on our workload with respect to the impact of:

- Competition on high volume straightforward elective surgery;
- Referral refinement for suspected glaucoma patients; and
- Out-of-hospital solutions for general ophthalmology, stable glaucoma and stable MR patients.

We have modelled a variety of scenarios to gain an appreciation of how these shifts would affect our capacity requirements at each site, and are undertaking further work to refine both the commissioning intentions and our response to them with respect to different service models and pathway partnerships. For prudence, the demand and capacity model presented within this plan does not include the impact of these commissioning intentions to ensure that we are not under-sizing our satellite requirements at this early planning stage.

The demand modelling has been undertaken by site and sub-specialty from 2013/14 to 2023/24 although the summary below presents the outputs for the five-year strategic plan only.

Outpatients	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	**455,212**	**473,420**	**492,357**	**512,052**	**532,534**	**553,835**
City Road	285,093	231,628	236,260	240,985	245,805	250,721
Satellite sites	170,119	241,793	256,097	271,066	286,729	303,114
Satellite as % of total	37% *	51% **	52%	53%	54%	55%

Admissions	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	**30,788**	**32,019**	**33,299**	**34,631**	**36,016**	**37,457**
City Road	18,307	15,129	15,432	15,741	16,055	16,377
Satellite sites	12,481	16,889	17,867	18,891	19,961	21,081
Satellite as % of total	41%	53%	54%	55%	55%	56%

* Includes orthoptic and optometry attendances, these are primarily delivered at City Road – we deliver approximately 50% of our outpatient work at satellite sites if this activity is excluded.
** The repatriation of patients will be a gradual process delivered over the coming years, but the demand model presents this as a step-change event in 2014/15 for simplicity.

The net impact of the model over the plan period is a 22% increase in activity with:

- Outpatients increasing by 98,623 attendances to 553,835:
    - City Road outpatient attendances decreasing by 12%
    - Satellite site outpatient attendances increasing by 78%
- Admissions (surgical activity) increasing by 6,669 to 37,457
    - City Road admissions decreasing by 11%
    - Satellite site admissions increasing by 69%

The demand and capacity model includes sites where Moorfields holds commissioner contracts, and therefore excludes: all partnerships (as we are not responsible for these facilities), our Bedford service (as it is excluded from the repatriation analysis and we are a sub-contractor) and the new Croydon service (the business case included an initial analysis, but this is currently being refreshed and brought into the overall model).

Transformation

We intend to redesign our patient pathways to streamline and modernise how we deliver and organise care on a whole-systems approach, ensuring we are maximising our efficiency and effectiveness whilst designing future services that are fit for purpose, meet the needs of the local population and create an environment in which staff feel valued and actively contribute. Much of the detail about the service redesign programme was contained in our Operational Plan 2014-16. In summary, the improved patient pathway will focus on and will be incorporated into the planning of future capacity requirements:

- Delivering a consistently high quality patient experience
- Reducing or eliminating waiting throughout all aspects of the patient pathway
- Reducing, where it is appropriate to do so, the need for patients to attend hospital
- Reducing reliance on the central London tertiary hub
- Taking full advantage of technology and new job roles in both clinical and operational areas
- Optimising organisational clinical and operational efficiency and cost effectiveness
- Training of staff in new ways of working as well as involving them directly in redesigning services

It is intended that the transformation process will cover all satellite sites, and will include a review of the service portfolio that is appropriate at each site. The development of these new services will not be done in isolation, but with the involvement of patients and commissioners, which will provide assurance that Moorfields is meeting external expectations and that the organisation understands customer and commissioner needs. The implementation of changes will be supported by a robust workforce plan.

Gap Analysis

The business case for the new hospital will be completed in 2014/15, although we will retest the capacity requirements presented in the land purchase business case. Having developed our capacity requirement at the central site, we have assessed our current satellite facilities, in terms of both utilisation and physical capacity, to assess our ability to respond to the future capacity needs across our network.

The capacity requirement and gap have been calculated for 2018/19 – the end of the five-year plan and the point by which we need to have delivered our network capacity requirements to support the new hospital; and 2021/22 to ensure that we have considered the period after its opening. The available capacity represents a modelled requirement based on demand and the capacity assumptions detailed previously.

The outpatient analysis is expressed in terms of outpatient clinic functional areas, i.e. the base outpatient planning unit for the new hospital, consisting of 10 clinic rooms and associated supporting accommodation.

This demonstrated that we will require, in aggregate, an additional 3.3 outpatient functional areas across the network to deliver the demand requirements and to support the new hospital in 2018/19, with a further 1.0 required by 2021/22.

The surgical analysis demonstrated that we will require, in aggregate, an additional 3.0 theatres across the network to deliver the demand requirements and to support the new hospital in 2018/19, with a further 1.0 required by 2021/22.

We have already introduced more capacity in our satellite clinics and theatres to meet our existing demand requirements and to support the delivery of operational performance, and the new hospital business case will reflect these recent changes.

We have concluded that the impact of commissioner intentions, extra sessions, and a shift in routine monitoring to other locations would in themselves be unlikely to be sufficient, even with improved utilisation resulting from process re-engineering, to meet the predicted demand.

Also, many of our satellites are located within hosted accommodation that presents some difficulties when assessing future capacity solutions, expansion or accommodation redesign to support clinical adjacencies and patient pathways as host hospitals may have their own capacity issues.

Our plans for closing the gap in our capacity requirements are therefore presented in the following sections.

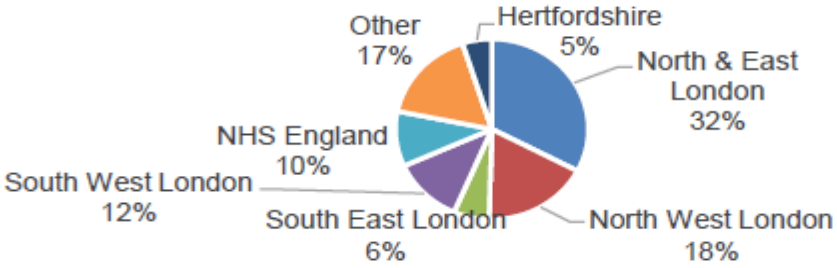
6. Market Analysis

Moorfields has a significant reputation for the delivery of ophthalmic care. We provide a wide spectrum of clinical services from high-volume activity to highly specialist services.

Moorfields activity is commissioned through NHS England for specialist work (approximately 10% of our activity) and commissioning support unit clusters for non-specialist work as shown in the figure below.

The trust's largest contracts are with London commissioners, which make up approximately 70% of activity, with other commissioners representing over 70 separate CCGs.

Contract Activity (%) 2013/14 by Commissioning Area



The market assessment considered commissioning intentions, market share shifts and the competitor landscape to inform our strategic options. This includes establishing where we want to have a presence, the nature of the service, if there is existing capacity or where we need to develop the basis of our strategic model.

Our strategy for growth outside of London and the South East is most likely to be in partnership with other providers rather than through direct service provision. This component of our strategy is still under development although we have engaged with several potential partners to assist in shaping our initial thoughts.

7. Commissioner Intentions

The macro health environment in which Moorfields operates has evolved significantly over recent years, and has seen the emergence of an increasing number of community-based providers, and the emergence of private providers, delivering largely high-volume, less complex work – for example, the routine monitoring of more stable long-term conditions such as glaucoma.

Moorfields' ophthalmic provision covers the spectrum of care from high volume work, to complex and specialist work. Moorfields has, as part of our strategic planning approach, introduced new long-term planning modelling and processes to test different potential scenarios based on anticipated commissioning shifts and the effects of other providers in the market. This review is being undertaken for both outpatient and elective activity and by sub-specialty.

The high level emerging outputs of the review are:

- Vitreo retinal. This is a complex, often emergency service, and there is not considered to be any likely material impact on this service by commissioning intentions. There may be future drugs that would shift activity away from a surgical setting to an outpatient setting, but at present these are not available and no timeline, evidence or information is available to support a shift away from an acute setting.
- Adnexal. There is a potential in the medium term for some simpler surgery to be commissioned in a community setting rather than acute hospital, although no firm plans have been developed.
- Cataract. There is a potential that competition from the private sector and other NHS providers will reduce the current levels of cataract activity that Moorfields undertakes. This shift will affect surgery less so than outpatient activity.
- External and Corneal. There is not likely to be any material impact on this service by commissioning changes; however, some less complex activity could be appropriate for shifting to a community-based setting.
- Glaucoma. Surgical activity is unlikely to be affected by commissioning changes due to the complexity of this type of surgery. A significant proportion of outpatients will be further refined / retested in community settings, reducing the volume of work referred to Moorfields, whilst many 'stable' patients will be monitored in a community setting. An element of first attendance and follow-up outpatient activity may be shifted to a community-based setting.
- Medical retina. Different assumptions were made to the different areas of treatment within medical retina, as they are considered to be subject to distinct market forces:
    - AMD injections: The monitoring of 'stable' patients (post-injection phase) may be undertaken in community settings, whilst injections will be delivered across the satellite network.
    - Diabetic retinopathy screening service (DRSS): This activity is likely to be affected by known commissioning changes in diabetic screening and in particular by the planned introduction of surveillance clinics, which could reduce the need for care to be undertaken in a hospital eye service.
    - Other MR activity. There is not considered to be any likely significant shift for other MR activity as the numbers are small in activity terms and usually highly complex in clinical terms.
- Paediatric and Strabismus. It is not considered likely that either outpatients or surgery will be materially affected by commissioning shifts.
- General ophthalmology. Different assumptions were made to the different areas of treatment within general ophthalmology, as they are considered to be subject to distinct market forces:
    - General Ophthalmology traditional activity. It is thought likely that the location of this activity will be materially changed by future commissioning changes, with a significant proportion being transferred out of the acute setting.
    - General Ophthalmology with sub-specialty input. A proportion of this work is likely to be shifted into a community setting.
    - A&E follow-up general ophthalmology. This activity is normally a single attendance and may be undertaken in a community setting.

8. Tender Opportunities

Aligned with the need to consider the CCG commissioning intentions, we have also assessed and identified the possible tender opportunities that may arise between 2014 and 2019. As well as hoping to influence our market share and future sustainability from market analysis, we hope also to be prepared to react to tender opportunities on a more strategic basis, rather than an ad-hoc agenda.

In summary, 94 CCGs were identified that have advertised or tendered an element of the ophthalmology pathway in 2013 or will be retendering before the end of 2016, including secondary elective treatment centres. Of these, 38 CCGs were shifting into primary care settings (optometrists) – outside London, mainly optometrist focused – but these relate to 2013 to date and do not include pre-2011 contracts awarded; 10 DRSS programmes across 21 CCG localities are currently being tendered or intention identified.

9. Future Changes in Eye Care

There have been significant shifts in the patterns of service delivery for eye disease and disorders in recent years. For example, day-case treatment is now the norm as opposed to overnight stays, and much more treatment is being provided outside an acute setting. Since 2004, the Department of Health has been trying to encourage the delivery of more routine and minor emergency eye care outside hospital. In addition, there have been significant advancements in treatments of previously untreatable conditions, such as intra-vitreal injections for wet AMD.

It is extremely difficult accurately to predict or quantify specific future trends in eye care, and the likely changes in location and type of eye treatments. However, it is widely acknowledged that changes in strategic direction will occur, and are likely to be impacted by:

- Technology e.g. technologies allowing improved remote diagnosis and assessment. For a significant number of routine follow-up appointments, attendance at hospital is likely to be unnecessary.
- Locations e.g. there is likely to be a shift away from tertiary hubs.
- New treatments available, either under NHS provision or private. The trust is shortly to commence an NHS trial for femto-phako laser surgery. This technology may greatly improve the productivity of cataract surgery and may improve the quality and efficiency for less experienced surgeons.
- Community eye health pathways supported by local optometrists and dispensing opticians/ establishment of primary eye care companies.

3. Strategic Direction

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), and articulate our vision (which sets out what we aspire to be by 2020).

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

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, working with primary care professionals (e.g. GPs and opticians), prioritising the establishment of such services in areas where we currently have poor market penetration

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).

As highlighted in our Operational Plan 2014- 2016, Moorfields and the wider NHS have seen much change since we started on our journey towards 2020 so we re-examined our strategy to ensure that it remains relevant, robust and deliverable in light of both the changes to our external environment and our own progress internally towards its achievement.

We did this by looking at our overarching vision, the underpinning strategic direction and the actions we said that we would take to deliver the strategy. Furthermore, the external environment we operate in has changed and this brings fresh challenges and opportunities that require consideration:-

- The Francis inquiry and the Keogh review, and subsequent reports, presents further opportunities for us to review our strategy to ensure that it is focused on what is important – the quality of what we do.
- The structural changes within the NHS have caused some disruption, and the landscape post-2013 will be difficult for us as approximately 80% of our clinical work is non-specialist, though conversely our specialist work, the remaining 20%, is often not fully recognised and this activity forms a very small component of the responsibilities for clinical commissioning groups.
- We have seen far more competition from other NHS providers and the private sector than we anticipated, and this has highlighted issues with how we respond to these opportunities, and the pricing for the full range of our services.
- We have performed well financially, though the most recent funding round has highlighted our hyper-sensitivity to changes in a single tariff for our NHS work, whilst the changes to the private patient cap enabled by the Health & Social Care Act presents us with unparalleled opportunities for non-NHS growth – our brand, expertise and market position all work to our advantage in this arena.

We concluded that the strategy remained robust and relevant, and that the Operational Plan was an appropriate mechanism by which to implement the strategy and monitor our progress towards achieving its aims.

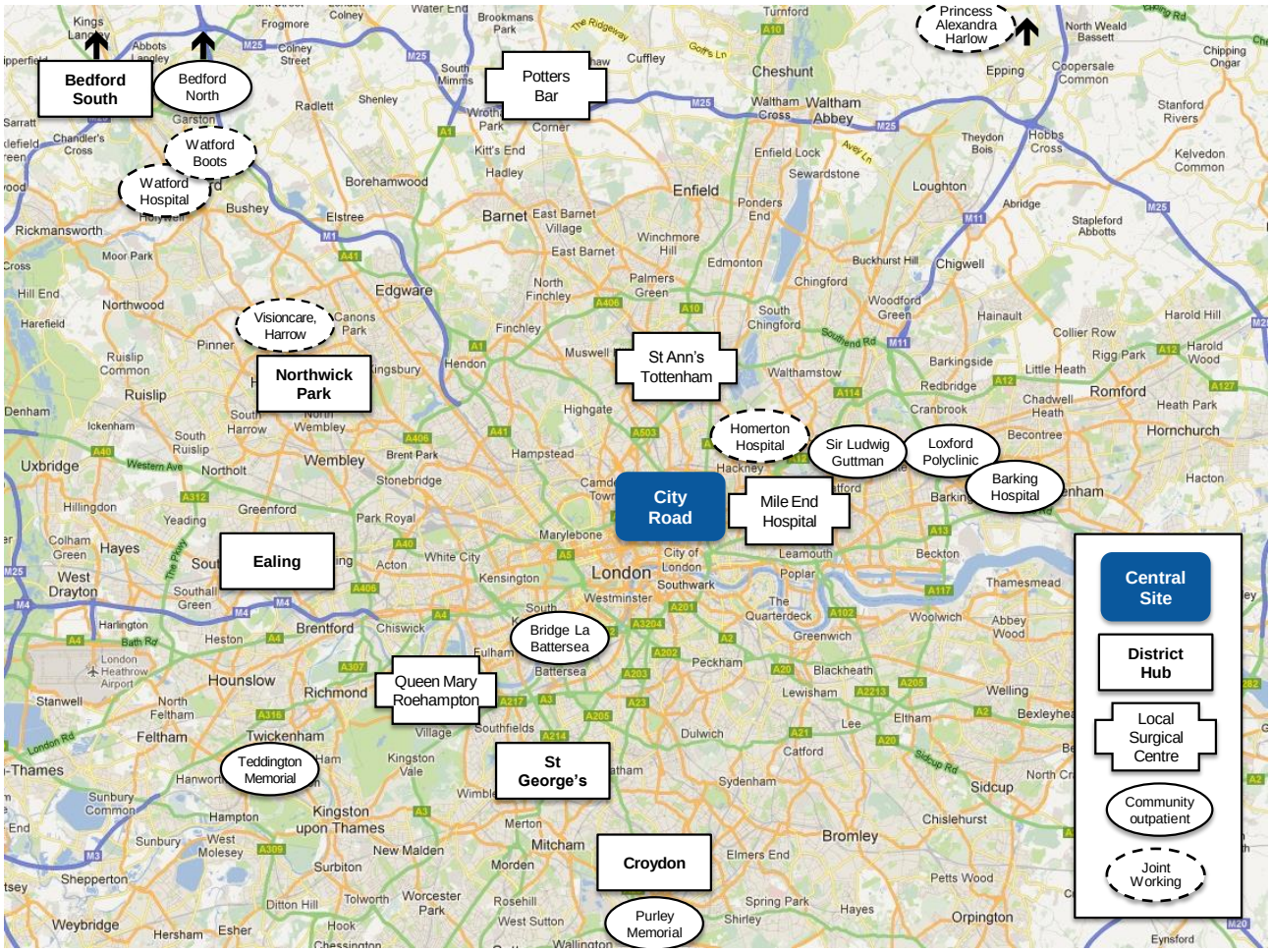
We published our research and development strategy in 2013/14, our education strategy in April 2014, and are currently developing our international strategy. These interlinked strategies are vital components in the delivery of *Our Vision of Excellence*.

4. Strategic Options

In this section, we reconcile the demand growth with the gap analysis, market assessment and commissioning intentions to quantify opportunities and respond to our network capacity requirements.

The map below illustrates our existing network, including the newly acquired Croydon satellites and the Sir Ludwig Guttman health centre satellite (due to open in July 2014).

Moorfields Network



Coupled with other business and market intelligence, we have reviewed the risks to the sustainability of the existing network to explore the potential to expand our strategic model.

As part of our strategic options, we continously look at respective CCG commissioning intentions for ophthalmic care for their local populations and consider the fit with our strategic model and how best we could support any future changes to ophthalmic provision.

Where possible, we have aimed to establish more general strategic options that incorporate the strategic option at each satellite and also reflect on the market opportunities that exist.
We have therefore considered a range of solutions to meet the capacity gap and further develop our services.

1. Do nothing – no change to existing service provision, i.e. do not deliver service redesign and transformation, including throughput and productivity improvements.

   This will not be viable as we would be unable to meet existing demand for services; nor would we be able to deliver the required productivity and financial efficiency improvements.

2. Do minimum – deliver service redesign and transformation only, i.e. no significant increases in physical capacity.

   This will not be viable as we would not be able to meet the increased demand for ophthalmic services across our network, nor would we have the physical capacity within our satellites to support the new hospital.

3. Capacity developments (in addition to service redesign and transformation across the network):
   a. Deliver the St George's project – provide new and expanded accommodation (due to complete in 2016).
   b. Complete the Moorfields East strategy (currently under development).
   c. Reconfigure our satellites in the North West – develop the North West to include increased community provision and further extend joint working across Ealing and Northwick Park.

<u>Moorfields South & St George's</u>

The gap analysis presented earlier in this paper highlights a potential shortfall in projected capacity of 1.3 outpatient functional areas and 2.0 theatres across Moorfields South by 2021/22.

We have approved a £14m investment on the St George's site and are about to enter the design phase of the project. This will deliver a new larger building, enabling the continued repatriation of City Road patients and the further development of the local network.

- We plan to meet the outpatient capacity requirement through the St George's expansion, the development of the Croydon network and further shifts into local community facilities (some new).
- The St George's expansion will provide an additional theatre resulting in an apparent unmet gap of 1 theatre; however both the St George's and Croydon business cases included repatriation of a significant quantum of Croydon residents from St George's to Croydon. As the strategic demand and capacity model excluded the new Croydon service, these patients form a sizeable part of the unmet gap. Additionally, the new Croydon unit has scope to increase its theatre capacity. We have therefore concluded that the gap can be met, but are updating the model to include Croydon, and undertaking a validation exercise to ascertain whether we need to increase the number of theatres within the St George's new build to respond both to our capacity requirements and strategic aspirations around St George's as our 'second' site.

Moorfields East strategy

The gap analysis presented earlier in this paper highlights a potential shortfall in projected capacity of 1.4 outpatient functional areas and 1.0 theatres across Moorfields East by 2021/22.

We are currently developing our Moorfields East strategy in response to this gap, and to address the fact that our existing six sites in the east (Mile End, Barking, Loxford, St Ann's, Homerton and Harlow) were not set up in a planned way, but have simply evolved organically as various opportunities arose, which means that there is now a need to plan more comprehensively and cohesively for the future.

We will therefore seek to maximise the use of the existing sites, particularly at Mile End and St Ann's, in the short-term to meet the increased demand and help meet the capacity gap, and also to provide more of the sub-specialist activity, in particular corneal, medical retina and paediatrics wherever possible. We will be opening a service at the Sir Ludwig Guttmann health centre in Stratford (part of the Olympic legacy) in July 2014.

In the longer term, we will work with commissioners to develop further community-based solutions and develop a district hub for the East.

North West

The gap analysis presented earlier in this paper highlights a potential shortfall in projected capacity of 1.6 outpatient functional areas and 1.0 theatres across our satellites in the North West by 2021/22.

We manage the ophthalmology service at North West London Hospital's (NWLH) site at Northwick Park Hospital, as well as the ophthalmology service at Ealing Hospital. As part of Shaping A Healthier Future, NWLH and Ealing will merge. Brent CCG tendered community ophthalmology services in 2012 and the service was awarded to BMI, who are currently mobilising for a contract commencement in 2014.

We are already increasing the use of our theatres at Northwick Park and Potters Bar, and building an outpatient extension at Ealing (due to complete in 2014) to meet the capacity required in the gap analysis.

Bedford

We have a district hub and community clinics in Bedford and have been working with commissioners around the future of local services.

Monitor are currently assessing the provision of services at the hospitals in Bedford and Milton Keynes to ensure that they meet the needs of their local population and are financially sustainable.

We therefore intend to develop a strategy for services in Bedfordshire that respond to the Monitor review and the wider market opportunities.

5. Strategic Plans

As highlighted in the previous section, we have incorporated, where appropriate, respective strategic options for satellites and wider market influences in order to create a coherent list of strategic options. However, as there is considerable complexity and operational detail associated with these strategic options, we have also applied a prioritisation framework to ensure we can establish an implementation approach that maximises our effort and corresponds with the market timing of opportunities.

The aim of a prioritisation framework is to provide a simple approach to identifying which strategic options should be initiated and is based on a Boston Consulting Box method, capturing the benefits versus effort and ease of implementation of each of the options.

Clearly, where there is high benefit and low implementation effort to deliver a strategic option, it should be prioritised as a next key stage of the strategic plan; conversely, those activities that offer low benefit but high effort should be considered at later date in the strategic schedule. Those strategic options that offer high benefit but also high effort will need further review to establish the extent of effort necessary and timing for implementation.

Our immediate priorities will be to:

- Progress the St. George's expansion.
- Commence service provision at the Sir Ludwig Guttman health centre as a precursor to the Moorfields East strategy.

In the short term we will also:

- Develop our strategy for Bedford services.
- Respond to tendered market opportunities.

Each of these plans will include robust implementation and monitoring processes, and detailed milestone planning.

We have also recently developed a decision-making tool to support us in assessing the appropriateness and viability of future business development opportunities which will incorporate alignment with our strategic priorities.

Risk Mitigation

The trust has in place a robust risk management process. The strategic risks of the trust are included within the corporate risk register and will incorporate any associated with strategic options. This risk register is regularly reviewed by the trust executive team and the trust board.

Our main perceived strategic risk is that we do not increase our capacity to maintain performance targets for waiting times and to meet the projected increased demand. This additional capacity will be delivered through our service transformation at satellites highlighted in our summary strategic options and will require co-ordination of a complex programme of workstreams (refer to our Operational Plan 2014-16) to ensure we design patient-centred pathways with appropriate skilled professionals in a quality environment and can respond proactively to commissioner intentions for community-based ophthalmic services.

6. Financial model

The plan for 2014/15 has been formulated using published tariff pricing, draft financial assumptions yet to be fully agreed with all commissioners, and detailed internal planning with managers and other budget holders.

10. Productivity, efficiency and cost improvement plans

Within the national tariff-setting process, there is an expectation that further efficiency gains will close the affordability gap. The five-year plan adopts an assumption for tariff deflation at input inflation less a 4% provider efficiency requirement in all years, in line with the guidance published by Monitor in January 2014.

Efficiency Plans

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Identified Schemes	6.4	3.1	1.5	-	-	-
Unidentified Schemes		1.3	4.3	6.1	6.3	6.5
Total	**6.4**	**4.4**	**5.8**	**6.1**	**6.3**	**6.5**
% of NHS Costs	4.9%	3.4%	4.0%	4.0%	4.0%	4.0%

11. Commercial Activities

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

During 2013/14, work has been completed to develop MEH Ventures LLP, the partnership vehicle we will use in future to develop our commercial business activities. Further expansion of these activities will continue over the five-year period.

12. Summary of the financial plan

All figures in £million	**2013/14**			**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
	Plan	**Actual**	**Variance**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
Income								
NHS Clinical income	114.7	120.5	5.8	134.7	139.1	145.2	150.1	155.1
Commercial Trading Unit Income	33.6	30.8	-2.8	34.8	36.5	39.1	41.9	44.0
Other Income	20.3	22.5	2.3	20.6	20.9	21.1	21.3	21.4
Total income	**168.6**	**173.8**	**5.3**	**190.1**	**196.5**	**205.4**	**213.3**	**220.5**
Expenditure								
Pay costs	79.8	80.8	-1.1	89.4	90.5	94.6	98.0	101.4
Non-pay costs	49.3	49.9	-0.6	58.4	62.7	64.5	66.6	68.9
Commercial Trading Unit Costs	26.9	25.5	1.4	27.9	27.9	28.7	29.5	30.2
Total expenditure	**155.9**	**156.2**	**-0.3**	**175.7**	**181.2**	**187.9**	**194.1**	**200.5**
Earnings before interest, tax, depreciation and amortisation	12.6	17.6	5.0	14.4	15.4	17.5	19.2	20.0
Depreciation, Interest and Dividends	8.6	8.3	0.3	9.4	10.4	11.1	12.4	13.9
Net surplus	**4.0**	**9.3**	**5.3**	**5.0**	**5.0**	**6.4**	**6.8**	**6.1**
Impairments	*0.0*	*0.0*	*0.0*	*8.5*	*2.6*	*0.0*	*0.0*	*0.0*
Donations	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*9.4*	*9.4*	*9.4*
Net Surplus after Impairments and Donations	***4.0***	***9.3***	***5.3***	***-3.5***	***2.4***	***15.7***	***16.2***	***15.5***