Moorfields Eye Hospital NHS Foundation Trust

NHS

Quality Account 2025/26

(includes quality priorities for 2026/27)

Our commitment to quality excellence

Version 1.0

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Part 1: Statement on quality

1.1. Statement on quality from the chief executive

This Quality Account describes the quality of care we delivered between 1 April 2025 and 31 March 2026, highlighting both what we have delivered well and, importantly, where we know, we must continue to improve.

Throughout the year, our focus has been on ensuring that Moorfields continues to provide safe, effective and compassionate care, while responding openly and honestly to the challenges facing the NHS. Across the Trust, I have consistently seen a strong commitment from staff to our shared values of excellence, equity and kindness, which guide our approach to quality improvement and patient care.

One of the most significant service achievements during the year was the accreditation of Moorfields at Stratford as a GIRFT surgical hub, recognising the delivery of high-quality, efficient elective care, and supporting improved access for patients.

The clinical outcomes detailed in this Quality Account demonstrate continued strong performance across our services. In September 2025, NHS England published national league tables for the first time under the NHS Oversight Framework, comparing trusts across performance, safety, finance and workforce measures. In this assessment, Moorfields was rated highest nationally among acute and specialist trusts in Quarter 1 of 2025/26. While I welcome this independent assurance, I remain clear that our focus must be on understanding variation, sustaining improvement and ensuring consistently high standards of care across all services.

Research and innovation continue to play a vital role in improving care at Moorfields. During 2025/26, we made further progress in AI-enabled diagnostics, the management of complex and rare eye conditions, and research that contributed to national clinical guidance, helping to translate innovation into safer and more effective patient care.

Improving access to care has been a key priority. In November 2025, our Single Point of Access service was renamed SPARC, reflecting its development into a broader digital platform supporting referral, triage and pathway coordination across eye care services. SPARC enables direct referrals from optometrists, improves the speed and accuracy of clinical triage, embeds patient choice and reduces delays between referral and treatment, contributing to improved patient safety and experience. The service has also been used as a national case study, demonstrating how digitally enabled pathways can improve access, reduce unnecessary hospital attendances and maintain high standards of care.

MoorConnect (our EPR system) remains a critical programme for the Trust and is scheduled to be fully implemented later in 2026. Over recent years, the organisation has

made this programme a central commitment, focusing on the preparation required to ensure a safe and effective transition. This has included building digital readiness, strengthened clinical and operational engagement and supporting our teams through change. As implementation approaches, our focus remains firmly on patient safety, clinical leadership and ensuring the system supports high-quality, joined-up care.

We also continued to make progress on the Oriel Centre development in Camden, with construction continuing throughout 2025 following completion of the concrete frame in late 2024. Oriel remains on track for opening in 2027 and will bring together clinical services, research and education in a purpose-built environment that supports long-term sustainability and innovation.

Patient safety and experience remain firmly central to my priorities as Chief Executive. During the year, we continued embedding our Patient Experience Principles and embedding the Patient Safety Incident Response Framework (PSIRF). This represents a continued shift towards a learning-focused, compassionate and system-based approach to managing patient safety incidents, and PSIRF improvement work is also strengthening how we learn from and respond to safety events.

The year has also required honest reflection. Results from the 2025 NHS Staff Survey highlighted the pride our colleagues take in the care they provide. At the same time, the survey made clear that we must do more to rebuild trust, improve communication, strengthen leadership visibility and better support staff wellbeing. I take this feedback seriously, and the Board and Executive Team are committed to sustained action to address these concerns.

Looking ahead, strengthening clinical and professional leadership remains a priority. I am pleased that Simmi Naidu joined us in March 2026 as Chief Nurse, and is already bringing valuable expertise at a time when nursing leadership, patient experience and workforce wellbeing are central to our quality and safety ambitions.

This Quality Account reflects the progress we have made between April 2025 and March 2026, while recognising that there is more to do. I remain committed to an open learning culture, continuous improvement and working with our staff, patients and partners to ensure Moorfields continues to deliver safe, effective and compassionate care.

Peter Ridley
Chief executive

Our values

Excellence is at the heart of our purpose and history. It is also fundamental to our future as we innovate at the forefront of eye care, delivering the best care and experience for our patients.

Equity means everyone can expect that we will do our best for them – our patients, staff, and system partners, providing appropriate, accessible, excellent, and sustainable care based on clinical need. Everyone can be confident their voice is listened to in decisions about their care.

Kindness means we are friendly and considerate – treating everyone with respect and going out of our way to reassure and give confidence.

1.2. Introduction to the Quality Account 2025/26

At Moorfields Eye Hospital NHS Foundation Trust, quality is integral to every aspect of our decision making and service delivery. Our trust strategy, developed in partnership with patients, carers and staff, sets clear priorities for improving the quality, safety and effectiveness of the care we provide.

This quality account is a statutory annual report, required under the Health Act 2009 and the Quality Accounts Regulations, through which NHS trusts account to patients, the public and other stakeholders for the quality of the services they deliver. It provides an open and transparent assessment of our performance across the three dimensions of quality; patient safety, clinical effectiveness and patient experience.

The 2025/26 quality account reviews our performance against the quality priorities identified for the previous year and describes the progress we have made in improving services for patients. It provides assurance to our patients, commissioners, regulators and partners that systems are in place to monitor, maintain and improve quality, while also identifying areas where further improvement is required. Where gaps remain, we set out clear actions and priorities for the year ahead.

This quality account has been prepared in line with the statutory requirements of the Quality Accounts Regulations and the national reporting guidance issued by NHS England. In line with this guidance, it aims to:

- Demonstrate our commitment to continuous quality improvement
- Provide transparent and accountable reporting on the quality of our services
- Support internal assurance, reflection and learning
- Set out our agreed quality priorities for 2026/27

- Show how patient, public and stakeholder feedback informs service improvement.

The Quality account is underpinned by robust governance arrangements. The trust has well-established clinical and quality governance structures that provide effective oversight, assurance and accountability at Board and operational level. These arrangements ensure that quality, safety and patient experience are central to performance management and decision making across the organisation.

Through this approach, Moorfields remains committed to delivering safe, effective and compassionate care, and to continuously improving the quality of services for all patients who rely on us.

1.3. Moorfields Eye Hospital's approach to improving quality

At Moorfields Eye Hospital NHS Foundation Trust, our core belief that people's sight matters, and this continues to underpin everything we do. Our purpose is to work in partnership with patients, staff and external partners to discover, develop and deliver outstanding eye care that is sustainable and delivered at scale.

During 2025/26, our approach to improving quality has been strengthened through a refreshed governance and transformation programme. This programme is designed to embed the principles of NHS IMPACT, align improvement activity with 'Getting It Right First Time' (GIRFT), and develop lasting local improvement capability across the organisation.

The transformation portfolio, supported by clear governance arrangements, provides the primary framework for delivering the trust's quality priorities and improvement initiatives. The portfolio brings together improvement activity across both clinical and corporate services, with a particular focus on the trust's major strategic priorities, including delivery of the Moorfields and UCL Centre for Eye Health and implementation of the trust-wide electronic patient record, MoorConnect.

Each programme within the transformation portfolio has clear executive sponsorship and operates within defined governance arrangements, enabling effective oversight and delivery against agreed outcomes. This structured approach supports systematic improvement and contributes to the reduction of unwarranted variation.

In 2025/26, projects were delivered through the transformation portfolio. Key areas of progress included embedding of the trust's patient experience principles, further embedding of the Patient Safety Incident Response Framework (PSIRF), and targeted improvements to patient correspondence and inventory management systems (IMS).

A central focus of the trust's improvement strategy in 2025/26 has been the development of local improvement capability. A local improvement network has been established to connect and support frontline teams, enabling staff to lead improvement, apply improvement methods in day-to-day practice, and share learning across the organisation. As part of this capability building work, around 20 staff have completed NHS IMPACT Operational Improvement training. Also, we have strengthened internal expertise and supported the spread and sustainability of improvement.

Improvement activity is closely aligned with GIRFT recommendations, with actions incorporated into service improvement plans and monitored through established governance structures. This ensures a sustained focus on reducing variation, improving clinical outcomes, and delivering more efficient and consistent ophthalmology services.

Wider programmes within the transformation portfolio, including surgical excellence, outpatient excellence, and development of the trust's digital clinical services division, continue to contribute to quality improvement by enhancing safety, access, productivity and patient experience.

Oversight of the quality account and delivery of quality priorities is provided by the quality and safety committee (Q&SC) on behalf of the Board. This ensures clear accountability, robust assurance and a continued focus on delivering high-quality, safe and compassionate care.

Further detail on quality priorities and improvement activity for 2025/26 is provided in Section 2.1 of this quality account.

For further information or to provide feedback, please contact Ian Tombleson, director of quality and safety, i.tombleson@nhs.net

Part 2: Priorities for improvement

2.1 Progress with 2025/26 priorities

The 2025/26 quality priorities reflect feedback from a comprehensive staff and patient involvement process including discussions at central quality forum, and the clinical governance committee, as well as patient feedback during Safer September. The development process also involved staff engagement and patient representative sessions, business planning, and discussions at various committee meetings. The priorities have been aligned with the trust's strategic objectives and will be implemented using continuous improvement principles, ensuring clear, measurable, and SMART objectives for success measurement.

The priorities were presented and discussed at the clinical governance committee, and the quality and safety committee. Our host commissioners, North Central London Integrated Care Board (NCL ICB), and Healthwatch Islington, have also considered the quality priorities for 2025/26 and are supportive of them. The priorities set out below are monitored through the relevant programme boards or committees for oversight.

The quality and safety committee, on behalf of the Board, takes responsibility for overseeing the development and delivery of the quality account and quality priorities. The tables below describe the identified priorities, their underlying drivers and how they will be monitored for improvement.

Most of the priorities for 2025/26 were included in the transformation programme and are monitored through the relevant programme board.

The implementation of the priorities is also following advice and guidance from NHS IMPACT (Improving Patient Care Together) and NHS England to ensure continuous improvement is applied, where appropriate, to their implementation.

This report outlines progress on each of the nine quality priorities for 2025/26, highlighting achievements to date and identifying any gaps in delivery, also providing a snapshot of current status across all priorities.

Drivers

Table 1 - Drivers for inclusion as 2025/26 quality priority

Heading	Priority	Division (inc. business planning)	Safer September (Patients/Staff)	Incident priority (PSRIF)	Staff	Risk	Incidents / Complaints	XDU workshop - high quality scoring
Safe	Failsafe	Y		Y	Y	Y	Y	Y
Safe	Safety and Experience learning system (previously Learning System)			Y	Y		Y	
Experience	Patient experience principles	Y	Y		Y	Y	Y	
Experience	Patient Transport (2024/2025 quality priority)	Y	Y		Y	Y	Y	Y
Experience	Quality of patient letters comms and AIS (includes AIS Phase 2)	Y	Y		Y	Y	Y	Y
Effective	Consent optimisation	Y	Y			Y	Y	Y
Effective	Scan for safety and IMS optimisation	Y	Y	Y			Y	Y
Effective	Patient Initiated Follow Up (PIFU) (Quality priority in 2023/2024)	Y				Y		Y
Effective	Referral management optimisation (including eRS improvement)	Y		Y	Y	Y	Y	Y

Descriptions

Table 2 - Summary of 2025/26 quality priorities

Heading	Status for 2025/26	Priority	Priority description	Rationale / Problem statement
Safe	NEW	Failsafe	To ensure a consistent and safe approach to A&V service delivery across the organisation by monitoring failsafe processes and evaluation under the oversight of the A&V Oversight and Development Group, supporting decision-making, promoting best practices, and addressing pathway sustainability	There is a need to evaluate and standardise the processes and effectiveness of current practices and address capacity challenges within Asynchronous and Virtual (A&V) pathways. This will help ensure that pathways can meet demand, focus on safety and are improved, without compromising the quality of service
Safe	Phase II of 2024/2025 priority	Safety and experience learning system (previously Learning System)	To further develop a learning system that aligns with PSIRF principles and improvement standards, which strengthens the processes for learning from incidents, complaints, and PALS feedback, promotes clear and consistent mechanism for sharing learning from events, and foster strong partnerships across divisions.	There is a need to embed learning from PSIRF responses to foster a learning culture and implement quality improvement and learning quality management system principles across the organisation.
Experience	Phase II of 2024/2025 priority	Patient experience principles	To provide a structured approach to achieve the trust-wide goals in relation to monitoring and improving patient experience.	•There is a need to further embed improvement principles across the organisation, ensuring that local changes are monitored for impact and that the work is sustained over time. • There is a need to support the facilitation of customer care requirements as outlined in national

Heading	Status for 2025/26	Priority	Priority description	Rationale / Problem statement
				and NHS reform guidance, ensuring that these standards are met and maintained.
Experience	Continuation of 2024/2025 priority	Patient Transport (2024/2025 quality priority)	To improve the experience and patient safety of eligible patients requiring transport to and from our sites.	•Transport is a consistent concern raised through complaints and incidents. •Removes variation across sites regarding transport services and data availability. •Addresses gaps in data related to third-party suppliers and KPIs. •Without data, implementing and monitoring effective changes to the transport service will be challenging.
Experience	NEW	Quality of patient letters comms and AIS (includes AIS Phase 2)	To improve the communication with our patients by improving our appointment letters (accuracy, frequency, numbers) Ensure all patient letters are AIS compliant. Building on phase 1, consider what aspects of the AIS process should be improved in parallel	•The implementation of Accessible Information Standard (AIS) principles is required to ensure effective communication and accessibility for all patients. •There is a need to address patient complaints and feedback regarding clinic locations and communication. •A review of letters is required to support MoorConnect processes and for clinic management in Oriel.
Effective	Rescope of 'To help patients make informed	Consent optimisation	Continue to improve consent processes across quality & governance, education & training, equipment, technology and accessibility. This	•Consent processes are not currently being used to support patient flow and reduce delays and inefficiencies.

Heading	Status for 2025/26	Priority	Priority description	Rationale / Problem statement
	decisions about their surgery' 2024/2025 priority		will continue to take forward the shared decisions about surgery quality priority from 2024/2025	•There is a need to ensure that shared decision-making and clear information is shared with patients
Effective	NEW	Scan for safety and IMS optimisation	To build on the work completed to enhance patient safety, and meet national traceability requirements and reduce the risk of incorrect implants	There is a need to address safety recommendations following a serious incident investigation and never event related to lens selection and processes The organisation needs to comply with National Traceability Requirements to ensure adherence to national traceability standards.
Effective	Rescope from 2023/2024 priority	Patient Initiated Follow Up (PIFU) (Quality priority in 2023/2024)	To roll out Patient Initiated Follow-Ups (PIFU) pathways across viable services, enabling patients to initiate follow-up appointments within agreed timescales, and to continue the work undertaken in 2023/2024.	•Some patients currently lack the ability to book follow-up appointments when they need them e.g. when experiencing changes in their condition. As a result, many are routinely scheduled for follow-up appointments they may not actually need, which can waste clinical capacity and delay access for others. •Not all services that could benefit from a Patient-Initiated Follow-Up (PIFU) approach are currently adapted to support it. This misalignment with the NHS transformation strategy and national planning guidance may limit the potential improvements in efficiency and patient-centred care that PIFU can offer.

Heading	Status for 2025/26	Priority	Priority description	Rationale / Problem statement
Effective	NEW	Referral management optimisation (including eRS improvement)	To continue to build on the standardisation of triage and eRS processes, as well as improving the management of referrals to our services	•There is some inconsistency regarding triage across the organisation that needs to be better understood in order to improve processes, where possible. •To enhance triage efficiency there will need to be some streamlining of workflows, benefiting both patients and healthcare teams.

Twelve-month progress update

This section looks at each priority in turn, providing both an overview of the activity to date and the current status.

Patient safety

Failsafe (monitored by the asynchronous and virtual (A&V) oversight and development group)

To ensure a consistent and safe approach to A&V service delivery across the organisation by monitoring failsafe processes and evaluation under the oversight of the A&V Oversight and Development Group, supporting decision-making, promoting best practices, and addressing pathway sustainability

Status: In progress, although progress regarding failsafe is slower than anticipated

Progress so far: The A&V Oversight and Development Group is established and functioning effectively, providing governance and coordination across services. Work has begun on the centralisation of the failsafe function, with early steps taken to define a trust-wide approach to A&V failsafe processes. The group is working closely with the Oriel project team to ensure alignment of A&V workflows and failsafe processes in the new space.

Current focus: Continued development of the trust-wide A&V failsafe process, including refinement of protocols and monitoring tools. Ongoing oversight by the A&V Development and Oversight Group to embed changes and ensure consistency.

Patient safety and experience learning system (monitored by the working together board under the PSIRF workstream)

To further develop a learning system that aligns with PSIRF principles and improvement standards, which strengthens the processes for learning from incidents, complaints, and PALS feedback, promotes clear and consistent mechanism for sharing learning from events, and foster strong partnerships across divisions.

Status: Continued progress throughout the year.

Progress: The governance structures are well established for the PSIRF, and learning and improvement responses are of a good standard. Learning responses seek to identify opportunities to inform development of the electronic patient record (EPR), via hazard workshops and other digital safety meetings. The growing number of improvement working groups and local improvement projects highlights the ongoing success of the project. Set against this progress, they continue to impact capacity across the central quality team and other areas.

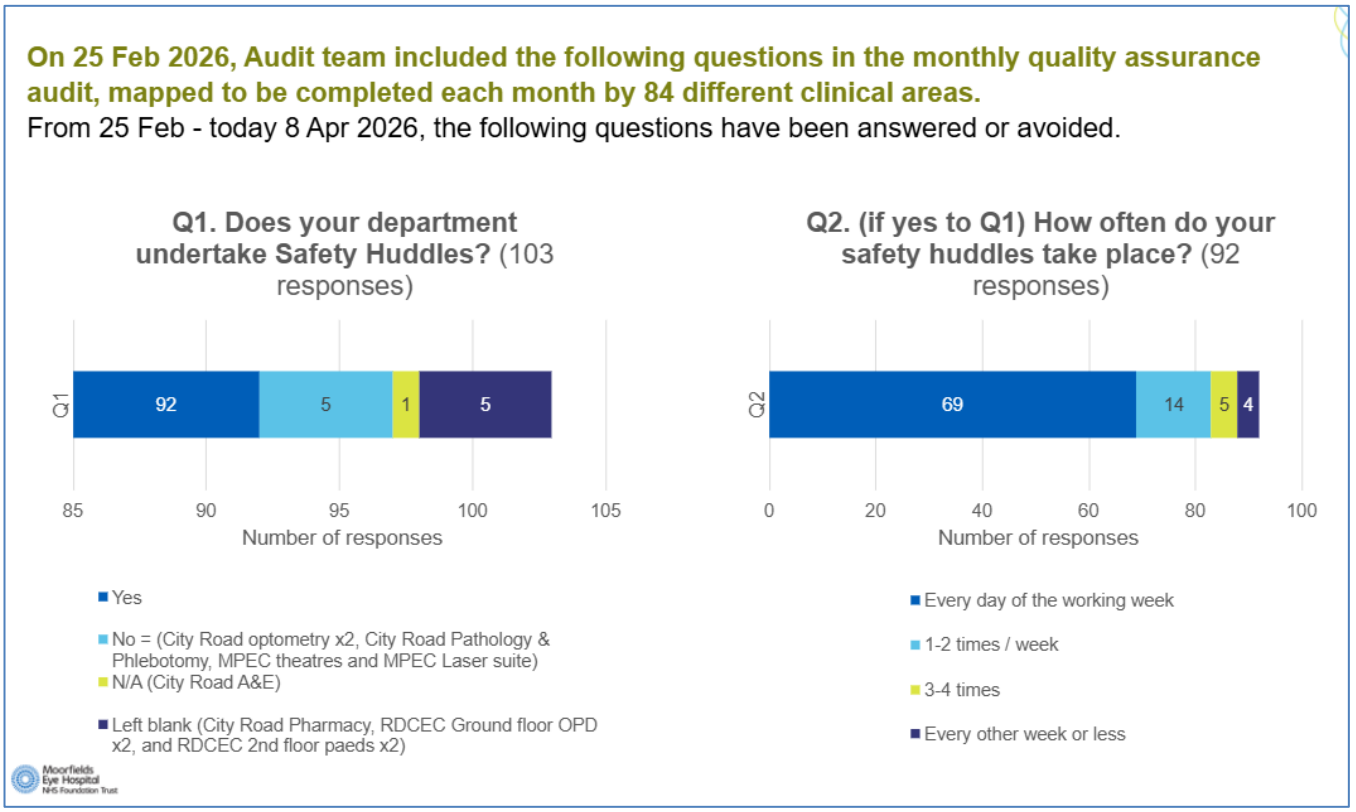
As part of our strengthened improvement approach, we have also undertaken a quality improvement self-assessment using the NHS IMPACT framework to review our current improvement maturity, identify priority areas for development and inform the next phase of our improvement and learning system strategy. This assessment provided a shared understanding of where improvement capability was established and where further focus is required to support both local and transformational change.

The local improvement network has now been formally established. The network provides a forum for connecting teams, sharing learning and supporting the spread of improvement practice across the organisation.

The next phase of this work will focus on embedding improvement and our quality management and learning system (QMLS) approach, ensuring that improvement activity is systematic, data-driven and sustained over time.

In addition to our wider focus on quality improvement and learning systems, safety huddles have been implemented across services and have received positive feedback from staff. These huddles support improved communication, the early identification of risks, and shared problem-solving at team level. Some variation has been identified in how huddles are delivered within outpatient clinics, and this is being actively addressed through targeted support and coaching.

Findings from our audits indicate an increase in the number of areas now undertaking regular safety huddles, with 84 compared with the baseline audit of 5 areas in 2023. However, further work is required to strengthen leadership, effectiveness and consistency. In particular, huddles are currently predominantly nursing-led, and not all sites consistently ensure they are multidisciplinary, action-focused or explicitly linked to improvement.



The next phase of work will focus on strengthening the quality and impact of safety huddles by promoting multidisciplinary participation, improving the use of actions and follow-up, and ensuring huddles are clearly aligned with local improvement priorities and learning from safety issues.

Future focus: The embedding of the quality management learning system will continue as a quality priority in 2026/27

Patient experience

Patients experience principles (previously monitored by working together board, now by local improvement network)

To provide a structured approach to achieve the trust-wide goals in relation to monitoring and improving patient experience.

Status: Year 1 successfully delivered a number of tools, techniques and processes to support structured implementation and improvement of the patient experience principles through the patient experience framework, including simple improvement tools such as 25 separate action labs with frontline teams, which are easy to adopt and run locally.

Progress: Year 2 focuses on consolidating and embedding the outputs of year one (including the action labs) and planning for the following years. Project Oriel has adopted the patient

experience principles as a fundamental base on which to build an excellent patient experience in the new centre and across the organisation.

Future focus: The central team and the divisions are working through the steering group to develop clear KPIs, indicators and other ways of ensuring we understand and monitor what changes and improvements are being made by the new patient experience principles/patient experience framework initiatives. Forward planning links these initiatives to meet the requirements of the 10-year health plan and the development of a quality strategy for Moorfields.

Patient transport (2024/2025 quality priority)

To improve the experience and patient safety of eligible patients requiring transport to and from our sites.

Status: Transition to business as usual

Progress: During the reporting period, notable progress has been made in strengthening availability of transport data and development of a governance structure to monitor improvement and identify deviations in transport provision early. Site-specific updates show that our south sites have made significant progress in submitting data and the new governance structure has ensured that the issues are raised with host trusts and actioned. Work continues at our other sites to ensure continued transport data availability to drive improvement with support from the matrons, head of nursing and quality partners. The project has also produced a standard operating procedure (SOP) for the management of transport at each site and trust. This has led to a reduction in complaints related to transport, with incidents related to delays also decreasing.

A new monitoring group will be established, with local quality partners tasked with managing data through local improvement plans and quality forums.

Future focus: The group will develop a standardised reporting template aligned with Moorfields' data standards. The trust is also evaluating our contract options, including those with DHL, smaller providers, and the potential for a unified contract model.

Quality of patient letters comms and AIS (includes AIS Phase 2) (monitored at admin and ops programme board)

To improve the communication with our patients by improving our appointment letters (accuracy, frequency, numbers) and to ensure all patient letters are AIS compliant. Building on phase 1, consider what aspects of the AIS process should be improved in parallel

Status: All patient letters have been reviewed, standardised, and prepared for implementation through the MoorConnect programme. Elements linked to the Accessible Information Standard (AIS) are dependent on MoorConnect functionality and will be progressed and actioned in collaboration with the electronic patient record (EPR) team as part of the wider digital delivery plan.

Progress: The project has completed a comprehensive review and standardisation exercise, supported by extensive stakeholder engagement. This has included collaboration with:

- The patient participation and experience committee
- The EPR team
- The quality and safety team
- Youth Forum

As a result of this work:

- The number of letters has been significantly reduced and standardised, streamlining content from an initial set of 43 letters to a core 15 letters.
- Letters now include clear, consistent digital communication information, specifically referencing use of the NHS App and DrDoctor applications to support patient access and engagement.
- Content consistency, clarity, and compliance have been improved, reducing variation and potential risk.

Future focus: The next phase of work will focus on:

- Establishing revised governance arrangements to support ongoing oversight, version control, and future changes to patient communications.
- Validating and maintaining accuracy of contact details, service locations, and key information across all letters.
- Working with the MoorConnect programme to build AIS elements wherever feasible within the platform, ensuring compliance and improved accessibility.
- Coordinating closely with the EPR team to ensure timely delivery of digital dependencies and alignment with wider EPR implementation milestones.

This approach will ensure that standardised patient communications are sustainable, digitally enabled, and fully aligned with Moorfields' strategic digital transformation objectives.

Consent optimisation

Continue to improve consent processes across quality & governance, education & training, equipment, technology and accessibility. This will continue to take forward the shared decisions about surgery quality priority from 2024/2025

Status: The consent optimisation project has identified critical barriers to achieving a fully digital consent process across the trust. Despite efforts to digitise patient consent, current workflows still rely heavily on paper documentation, particularly on the day of surgery. This reliance undermines the efficiency and effectiveness of digital consent capture.

Progress to date: Two key problem areas have been defined. First, there is no incentive to capture digital patient signatures in advance, as paper consent forms are still required in theatres. This results in clinicians defaulting to on-the-day consent, which is less efficient and potentially less compliant with best practice. Second, the technology currently used to capture digital signatures (specifically pin pads) has proven unreliable. Issues include hardware failures, missing components, poor connectivity with OpenEyes, and user interface challenges that affect patient confidence and usability. An audit conducted in October 2023 revealed that 50% of patients required printed consent forms on the day of surgery, resulting in an estimated 40 minutes of lost productivity per surgical list. Theatre 4 in City Road is using a digital and paperless solution that we are iteratively evolving and planning to spread digital working into the remaining City Road theatres and then our network sites.

What are the problems is Consent Optimisation trying to solve? - for info only

#	Problem statement	How is this a problem?	Why does the problem exist?	Options
1.	There is no incentive to capture digital patient signature in advance as paper consent needs to be printed on day of surgery	Even if the clinician can manage to capture the digital signature in clinic, the form needs to be printed again on day of surgery. This means the clinician can rely on capturing the signature on the day.	There is currently no way to remove paper working in theatres. Paper is minimally needed for: - Safer surgery check list - Consent process - Cataracts service also needs biometry & lens selection on paper	**1.** Digital trial to ensure we capture the key paper elements digitally on theatre on the whiteboard supported with appropriate technology to ensure surgery can be performed in theatres without use of paper and the key digital requirements listed; WHO, consent, biometry, lens selection.
2.	We don't have a technology solution (pin pads) that allow clinicians to reliably capture digital signatures on OE in OP clinic in advance of surgery	We cannot easily ***digitally*** capture patient consent to treatment in advance of day of surgery. This means we often need to go through primary consenting process on day of surgery which impedes productivity on day of surgery compared to ensuring primary consent is in place in advance. **Potential Productivity impact:** **Flow on the day audit October 2023 indicated that 50% of sample (N=100) needed a consent form printed for notes on day of surgery with additional process to patient to sign** **On list of 8, assuming 5 minutes for consenting process => 40 minutes of lost productivity**	The pin pad technology designed to capture patient signatures fails for a variety of reasons: - The pin pads don't work reliably - The pin pads "go missing" - Critical parts of the pin pads "go missing" – the signing pen - The pin pads don't always connect with OpenEyes - The pin pad interface the patient uses does not allow easy capture of signature* - OE stability affects ability to be able to capture consent - Have to print a piece of paper on the day anyway **Finding a solution to the reliability and maintainability of the pin pads has proven difficult**	**2a.** We continue to try and improve the technology experience with pin pads **2b.** We attempt to improve the technology experience using clinicians mobile phones linked to Openeyes **2c** We combine options **2a.** And **2b.**
3.	We do not always collect primary consent in clinic at time of listing ***and*** have no system for capturing primary consent once patient has left clinic	Once the patient has left clinic, we cannot currently get consent until day of surgery. This impacts productivity on day of surgery	We need to have a practical solution for collecting primary consent in clinic and for sharing a consent form with patients when collection has not happened in clinic This needs to be supported by operating procedure and policy	**3.** Implement Concentric as the tool to collect consent when missed in clinic. Ensure operating procedure allows for tracking of consent on record (failsafe) and implementation of consent prior to surgery with Concentric
4.	We often need to collect primary consent from patients on day of surgery	i) We need to find a digital solution for consent on day of surgery to be able to support an Oriel digital and paperless vision for theatres ii) GMC guidelines suggest we should not collect primary consent on day of surgery	i) There is no current technology to easily support clinicians to work digitally with consent on day of surgery ii) We lack a digital tool to be able to share consent forms with patients in advance of surgery	

Future steps: To address these challenges, the project team is considering a digital trial to capture all necessary consent elements (including WHO checklist, biometry, and lens selection) directly in theatre using appropriate technology. Additionally, options are being explored to either improve the existing pin pad experience or transition to clinician mobile devices for capturing digital consent. These steps aim to reduce reliance on paper, improve workflow efficiency, and align with the trust's broader digital transformation goals. The project team is currently trying to expedite the hardware order for the remaining City Road theatres (screens / tablets / workstations on wheels) working with the Oriel team, IT and EPR program to allow the remaining theatres begin to work digitally and without paper to perform surgery before spreading improved method to network sites.

Clinical effectiveness

Inventory management system (IMS) and scan for safety

To build on the work completed to enhance patient safety and meet national traceability requirements and reduce the risk of incorrect implants.

Status: Overall, we have moved from project delivery into an embedded improvement model, with clear next steps focused on medical device outcomes registry (MDOR) optimisation and scan-enabled safety systems as the next major opportunities for enhancing patient safety and reducing risk.

Progress: We have identified and progressed three core objectives through this programme.

- We have standardised the use of the Genesis system across all sites to improve safety, consistency, and productivity. This has reduced variation in practice and strengthened oversight of device and consumables management.
- We have explored integration of Genesis (IMS) with or OpenEyes (patient electronic record) to enable automated flagging of:
    - Incorrect or unapproved devices
    - Recalled products
    - Expired stock

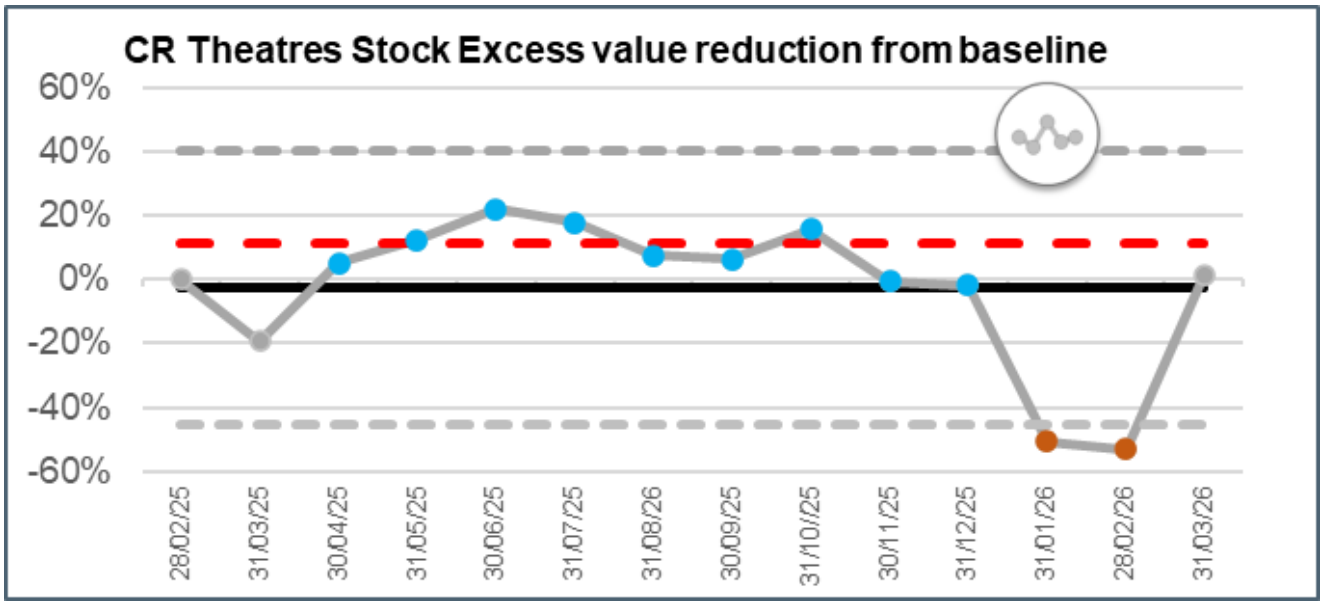
This integration has been identified as a critical step in reducing patient safety risks associated with device usage and is aligned to the broader EPR programme.

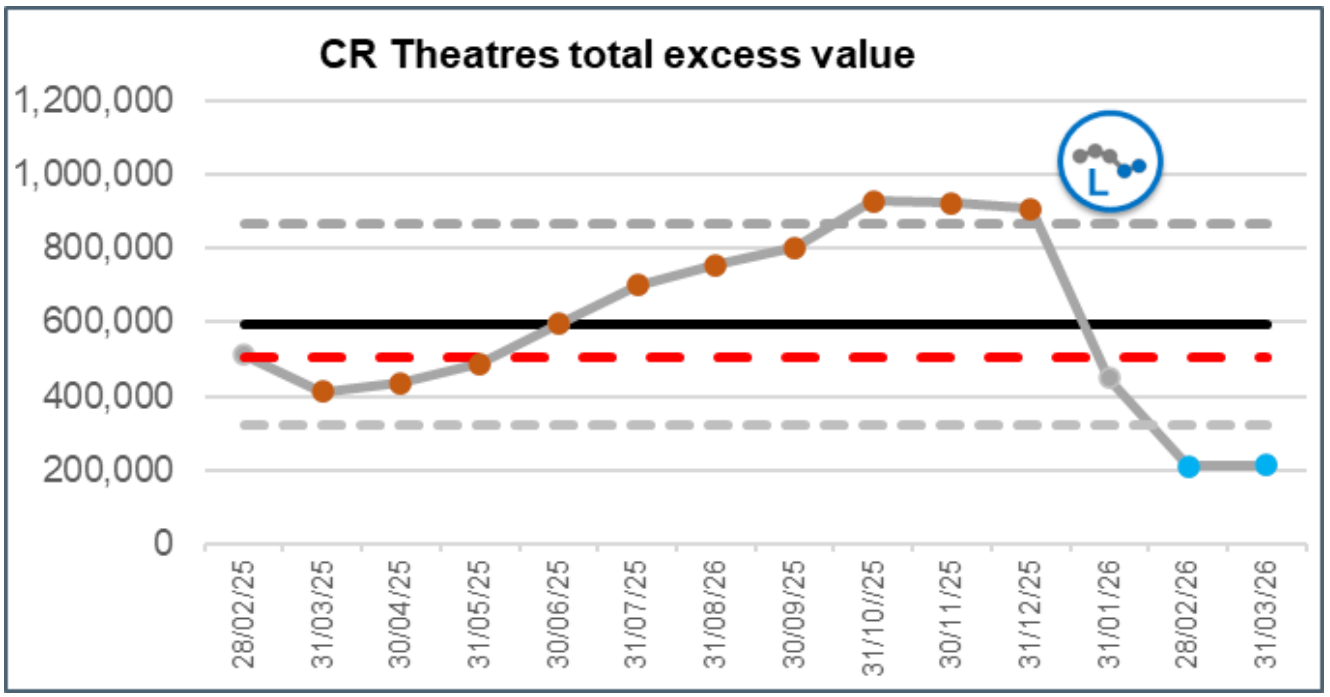
- We have scoped the automation of Medical Device Outcome Reporting (MDOR). While this element has been placed on hold pending EPR implementation decisions, we

continue to clarify requirements and positioning so that this can be progressed rapidly once system dependencies are resolved.

As a result of this work, we have:

- Achieved a reduction in excess and expired stock, lowering the risk of expired devices being used in clinical care.
- Improved stock visibility and control, reducing storage pressures and inefficiencies.
- Strengthened assurance around device governance and traceability.





Future steps / focus: We have identified the next phase of improvement, with a particular focus on enhancing patient safety, clinical assurance, and digital integration:

- We will progress integration with the EPR system (Expanse), enabling:

- Real-time flagging of device risks
- Improved tracking and traceability
- A future-state model where MDOR reporting is streamlined and automated
- Scan lens utilisation – improving barcode scanning and device capture to ensure accurate recording, traceability, and real-time safety alerts.

Patient initiated follow Up (PIFU) (quality priority in 2023/2024)

Patient initiated follow-up (PIFU) enables patients to initiate follow-up appointments within agreed timescales, rather than attending routine clinician-booked follow up appointments. The approach aims to improve patient experience, support more flexible care and ensure clinical capacity is used more effectively.

Project outcomes:

The PIFU project has now closed, with pathways successfully implemented across several City Road specialties, including genetics, uveitis, external diseases, ocular prosthetics, paediatrics and adnexal, and the external disease service at Northwick Park.

An SOP has been developed to support standardised delivery and governance across services. In addition, a self-implementation toolkit has been created to support any services wishing to implement new PIFU pathways following project closure.

The PIFU dashboard is now live on QlikSense and available to all staff, supporting consistent monitoring of pathway activity, patient requests, and operational performance across services.

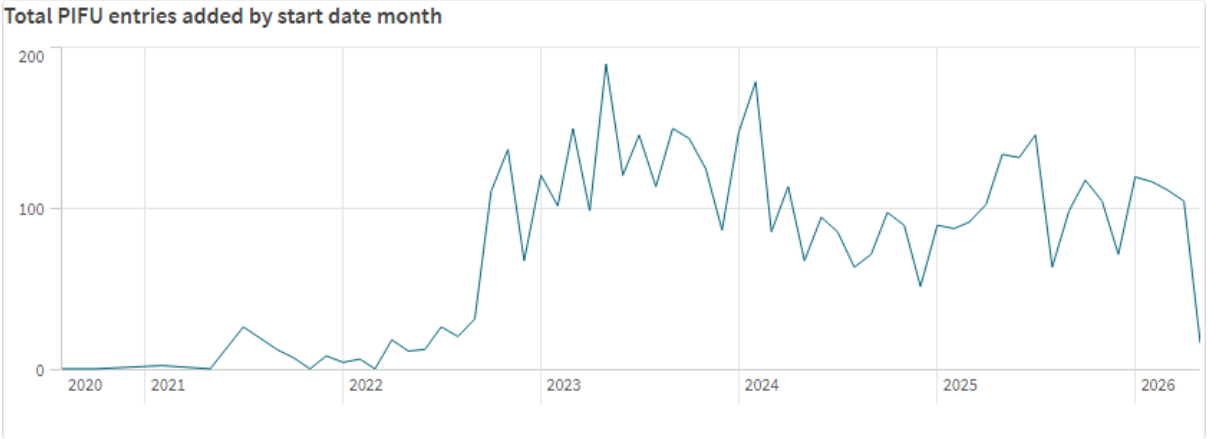
Governance arrangements are now embedded, with PIFU metrics and pathway performance monitored through the access meeting and divisional performance meetings to support ongoing oversight and escalation where required.

Incidents: Two incidents were reported, linked to the lack of governance, standardised processes, and failsafe mechanisms during the earlier paused phase of PIFU implementation. The incidents are currently being reviewed by the quality partner and service managers to assess any potential harm to patients. So far, no patient harm has been identified. The overall risk is considered low, as the patients involved were not on urgent or high-risk pathways, and no patient complaints have been received. The review process is also being used to identify learning and further strengthen governance and operational oversight across live PIFU services.

Ongoing focus:

While the project has closed, the focus continues on ensuring the principles and reporting are optimised and embedded including:

- Ensuring patients remain safe across all live PIFU services through ongoing governance, monitoring, and operational oversight.
- Embedding robust and consistent operational processes across services.
- Monitoring performance and patient activity through the live QlikSense PIFU dashboard and DrDoctor.
- Supporting benefits realisation by ensuring pathways deliver the intended operational and patient experience improvements.



2.2 Core clinical outcomes

Progress in 2025/26

The trust's performance against the core outcome standards demonstrates excellent clinical care, with every standard reported this year being met (considering 95% confidence intervals) and many being far exceeded.

The complete core outcome data is tabulated below. It should be noted that most outcomes are for all relevant patients across the trust over a full year. This increases the robustness of the data when compared with that from sample audits.

Table 3 - Trust core clinical outcomes 2025/26

Specialty	Metric	Standard	2023/24	2024/25	**2025/26**
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	0.88%	0.85%	0.68%
Cataract	Endophthalmitis after cataract surgery*	<0.04%	0.008%	0.012%	0.005%
Cataract	Biometry accuracy in cataract surgery*	>85%	92%	93%	94%
Cataract	Good vision after cataract surgery*	>90%	94%	94%	93%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	92%	93%	95%
Glaucoma	Tube (glaucoma drainage surgery) success*	>80%	94%	91%	90%
Glaucoma	PCR in glaucoma patients*	<1.95%	1.4%	1.1%	1.0%
MR	Endophthalmitis after intravitreal anti-VEGF injections*	<0.030%	0.009%	0.007%	0.005%
MR	Visual improvement after injections for macular degeneration*	>20%	24.1%	20.8%	21.6%
MR	Visual stability after injections for macular degeneration*	>80%	93%	91%	93%
MR	PCR in medical retina patients *	<4%	2.2%	2.3%	1.5%
MR	Time from screening to assessment of proliferative diabetic retinopathy*	80%	90%	92%	90%
VR	Success of primary retinal detachment surgery*	>85%	92%	88%	84%
VR	Success of macular hole surgery*	>80%	92%	95%	93%
VR	PCR in vitrectomised eyes*	No published standard	N/A	2.2%	2.8%
NSP	Significant complications of strabismus surgery*	<0.43%	0.35%	0.26%	0.39%
NSP	Premature baby eye (ROP) screening compliance*	99%	99.4%	93%	N/A

Specialty	Metric	Standard	2023/24	2024/25	**2025/26**
A&E	Patients seen within 4 hours*	>95%	98.6%	98%	98%
Ext Dis	PK for keratoconus (2-year survival from NHSBT report)*	See table below	100%	98%	97%
Ext Dis	DALK for keratoconus (2-year survival from NHSBT report)*	See table below	90%	98%	94%
Ext Dis	DMEK for FED (2-year survival from NHSBT report)*	See table below	88%	90%	92%
Ext Dis	DMEK for pseudophakic bullous keratopathy (2-year survival from NHSBT report)*	See table below	62%	70%	70%
Refractive	Accuracy LASIK (laser for refractive error) in short sight*	>85%	90.8%	94%	96.3%
Refractive	Loss of vision after LASIK*	<1%	0.72%	0%	0.13%
Refractive	Good vision without lenses after LASIK*	≥80%	92.2%	93.4%	95.7%
Adnexal	Ptosis surgery success	>85%	96%	96%	98.5%
Adnexal	Entropion surgery success	>95%	95%	99%	96.2%
Adnexal	Ectropion surgery success	>80%	96%	98%	98.4%

*Indicators marked with an asterisk are based on a whole year's data for all relevant cases trust wide. All other indicators are based on a significant sample of the totality of cases Trust wide over a 12-month period.

Table 4 - Detailed report of the survival of corneal grafts including confidence intervals

(Note: outcomes are after 2 years of follow-up)

	Jan 2020 – Dec 21 grafts	Jan 2021 – Dec 22 grafts	Jan 2022 – Dec 23 grafts
PK for KC	- Nationally: **96.6%** (95% CI: 92.4% - 98.5%) - At Moorfields: **100.0%** (95% CI: -) - No statistically significant difference	- Nationally: **94.3%** (95% CI: 89.6% – 96.9%) - At Moorfields: **98.4%** (95% CI: 89.1% – 99.8%) - No statistically significant difference	- Nationally: **93.7%** (95% CI: 89.8% – 96.1%) - At Moorfields: **96.9%** (95% CI: 88.2% – 99.2%) - No statistically significant difference
DALK for KC	- Nationally: **92.6%** (95% CI: 86.6% - 96.0%) - At Moorfields: **89.6%** (95% CI: 75.2% - 95.8%) - No statistically significant difference	- Nationally: **96.5%** (95% CI: 92.6% – 98.3%) - At Moorfields: **98.4%** (95% CI: 89.4% – 99.8%) - No statistically significant difference	- Nationally: **94.1%** (95% CI: 89.7% – 96.6%) - At Moorfields: **93.5%** (95% CI: 85.1% – 97.3%) - No statistically significant difference
DMEK for FED	- Nationally: **86.4%** (95% CI: 83.2% - 89.1%) - At Moorfields: **87.5%** (95% CI: 81.3% - 91.7%) - No statistically significant difference	- Nationally: **88.4%** (95% CI: 86.0% – 90.4%) - At Moorfields: **89.9%** (95% CI: 85.4% – 93.1%) - No statistically significant difference	- Nationally: **88.1%** (95% CI: 85.9% – 90.0%) - At Moorfields: **92.0%** (95% CI: 88.3% – 94.5%) - No statistically significant difference
DMEK for PBK	- Nationally: **69.9%** (95% CI: 59.8% - 77.9%) - At Moorfields: **62.1%** (95% CI: 40.6% - 77.8%) - No statistically significant difference	- Nationally: **73.0%** (95% CI: 65.6% – 79.1%) - At Moorfields: **69.8%** (95% CI: 55.5% - 80.3%) - No statistically significant difference	- Nationally: **74.6%** (95% CI: 68.5% – 79.8%) - At Moorfields: **69.6%** (95% CI: 58.0% - 78.5%) - No statistically significant difference

2.3 Performance against key local indicators for 2025/26

This financial year has seen a continued monitoring in the performance of many of our quantitative and qualitative key performance indicators. Much of this has also been driven by the introduction of the National Oversight Framework (NOF), which is a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The framework is supported by a focused set of national priorities, including those set out in the planning guidance for 2025/26, aiming to strengthen local autonomy. NHS England uses the performance assessment process to measure delivery against an agreed set of metrics, with these determining a segment score for each provider and identify where improvement is required. As well as covering several areas including access to services, effectiveness and experience of care, patient safety, and people and workforce, a key objective that heavily influences the segment score is finance and productivity, where providers are expected to deliver a surplus or breakeven position through efficiency programmes.

In its first publication covering quarter 1 (April to June 2025), Moorfields achieved the highest score of all applicable providers, and was ranked first in the national league table. Since then, Moorfields has remained in a top six position achieving a surplus financial position for each period, and in the latest report (quarter 3, October to December 2025), we recorded the highest 18 week referral to treatment and A&E performance amongst other applicable providers.

Table 5 - 2025/26 key indicators

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
National Oversight Framework Metrics (Monthly Metrics Used for Segmentation Scoring)					
% 52 Week RTT Incomplete Breaches (End of Year Position)	0.02%	0.03%	0.05%	≤ 1.00%	0.03%
18 Week RTT Incomplete Performance (End of Year Position)	77.9%	83.3%	83.1%	≥ 87.6%	85.8%
Difference Between Planned and Actual 18 week Performance (End of Year Position)	n/a	n/a	n/a	≥ 0%	-1.8%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.4%	98.6%	98.0%	≥ 95%	97.3%
% A&E Waits Over Twelve Hours	0.0%	0.0%	0.0%	n/a	0.0%
Average Days Between DRD and Discharge Date	0	0	0	n/a	0
Planned surplus/deficit	1.6	3.4	5.4	n/a	0
Variance year-to-date to financial plan	5.61	8.42	-1.27	≥ 0	6.64
MRSA (rate per 100,000 bed days)	0	0	0	0	0
Clostridium difficile year on year reduction	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	0	0	0	0	0
Staff Sickness (Rolling Annual Figure)	4.7%	4.5%	4.8%	≤ 4%	5.0%
National Indicators					

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
Reduction of over 18-week pathways (End of Year Position)	7,211	5,962	5,594	Reduction in line with 18-week trajectory	5,345
52 Week RTT Incomplete Breaches (Full Year)	97	144	118	0	262[1]
% of RTT Patients Waiting For a First Appointment (End of Year Position)	n/a	n/a	85.3%	No target set	90.2%
Cancer 28 Day Faster Diagnosis Standard	100%	92.3%	80.5%	≥ 80%	82.3%
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat	n/a	100%	98.2%	≥ 96%	97.8%
% Patients With All Cancers Treated Within 62 Days	n/a	98.4%	98.5%	≥ 85%	97.3%
Theatre Utilisation (Model Hospital)	88.7%	88.7%	90.5%	No target set	92.9%
Average Length of Stay (ALOS) – non-elective (1+ Days)	n/a	n/a	n/a	No target set	0.6
Cataract Cases Per Four Hour Theatre List	n/a	5.7	5.7	≥ 8	5.8
Theatre cancellation rate (non-medical cancellations)	1.01%	1.05%	0.88%	≤ 0.8%	1.25%
Number of non-medical cancelled operations not treated within 28 days	17	23	10	0	28
DNA Rate (First Outpatients)	13.6%	13.1%	13.0%	≤ 9.4%	12.9%
DNA Rate (Follow Up Outpatients)	11.9%	11.3%	10.8%	≤ 8.1%	9.7%

[1] The number of patients waiting over 52 weeks are comprised of a combination of those who have been transferred to us from other Trusts through a mutual aid process or our own patients who have experienced longer waits due to capacity pressures in specialist services

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
Summary Hospital Mortality Indicator	0	0	0	0	0
Mixed Sex Accommodation Breaches	0	0	0	0	0
% Discharged on Discharge Ready Date (DRD)	n/a	n/a	n/a	No target set	0
Duty of Candour (% Conversation informing family/carer occurred within 10 working days)	84.2%	83.5%	68.8%	100%	74.6%
Freedom of Information Requests Responded to Within 20 Days	96.2%	65.6%	87.2	≥ 90%	82.6%
Inpatient Scores from Friends and Family Test - % Positive	95.6%	95.9%	96.4%	≥ 90%	95.9%
Inpatient Scores from Friends and Family Test - % Response Rate	40.7%	40.8%	38.8%	≥ 30%	38.9%
Inpatient Scores from Friends and Family Test - % Negative	1.3%	1.1%	1.3%	≤ 5%	1.3%
A&E Scores from Friends and Family Test - % Positive	92.5%	92.9%	93.5%	≥ 90%	91.5%
A&E Scores from Friends and Family Test - % Response Rate	38.6%	38.3%	37.5%	≥ 20%	31.5%
A&E Scores from Friends and Family Test - % Negative	3.6%	3.6%	3.6%	≤ 5%	4.3%
Outpatient Scores from Friends and Family Test - % Positive	93.4%	93.6%	94.8%	≥ 90%	94.3%

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
Outpatient Scores from Friends and Family Test - % Response Rate	33.6%	34.3%	35.0%	≥ 15%	32.6%
Outpatient Scores from Friends and Family Test - % Negative	2.2%	2.0%	1.9%	≤ 5%	2.1%
Risk assessment of hospital-related venous thromboembolism (VTE)	98.2%	98.6%	99.5%	≥ 95%	99.0%
Occurrence of any Never events	3	2	2	0	1
Posterior capsule rupture rate for cataract surgery	0.8%	0.82%	0.90%	≤ 1.95%	0.68%
Proportion of Temporary Staff	14.5%	15.5%	12.3%	Reduction in Temp Staffing	8.0%
Proportion of Agency Staff	n/a	n/a	n/a	No target set	1.3%
Proportion of Bank Staff	n/a	n/a	n/a	No target set	6.6%
Maximum 6 week wait for diagnostic procedures	99.4%	99.4%	99.1%	≥ 99%	99.2%
Local Indicators					
Total pathways RTT Waiting List (pathways as at end of year)	n/a	35,656	33,136	Reduction in line with 18-week trajectory	34,886
Theatre Utilisation (Moorfields Definition)	62.1%	61.4%	63.1%	≥ 85%	65.1%
Average Call Waiting Time	216 sec	131 Sec	162 sec	≤120 Sec	209 sec
Call abandonment rate	17.1%	9.8%	12.1%	≤ 15%	13.5%
Outpatient Cancellation Rate (Hospital cancellations)	3.24%	3.72%	5.71%	No target set	5.20%

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
Outpatient Rebooking Rate (Hospital cancellations)	12.9%	14.8%	11.9%	No target set	6.2%
Median Outpatient Journey Times - Non-Diagnostic Face to Face Appointments (Wait at Year End)	n/a	97 Mins	97 mins	No set target	102 mins
Median Outpatient Journey Times - Diagnostic Face to Face Appointments (Wait at Year End)	n/a	45 Mins	43 mins	No set target	30 mins
Percentage of responses to written complaints sent within 25 days	70.4%	88.6%	62.1%	≥80%	44.0%
Percentage of responses to written complaints acknowledged within 3 days	90.6%	97.3%	76.6%	≥80%	77.9%
Information Governance Training Compliance (At end of year)	88.9%	90.1%	89.5%	≥ 90%	89.0%
MSSA Rate - cases	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	0	2	0	0	**0**
Recruitment Time To Hire (Days) (Wait at Year End)	42	50	39	≤ 40	52
Total patient recruitment to NIHR portfolio adopted studies	5,816	211 avg per Month 2,532 total year)	383 avg per month (4,208 Apr-Feb)	≥ 115 Per Month	233 avg per month (2,802)
Total patient recruitment to All Research Studies (Moorfields site only)	n/a	n/a	524 avg per month (5,765 Apr-Feb)	No set target	268 avg per month (3,211)
Active Commercial Studies (Open + Closed to Recruitment in follow up) (Year End Position)	n/a	60	58	≥44	72

INDICATOR	2022/23 results	2023/24 results	2024/25 results	2025/26 target	2025/26 results
Proportion of patients participating in research studies (as a percentage of number of open pathways) (position as at end of year)	5.9%	5.1%	3.6%	≥2%	3.0%
% implementation of NICE guidance	96.6%	94.5%	94.8%	≥ 95%	96.4%
Number of registered and ongoing clinical audits past their target deadline date	17.6% (34/193	33.5% (78/233)	13.2% (41/311)	≤ 20%	21% (71/338)

Unless stated, 2025/26 figures are for the period April 2025 to March 2026, with the position taken as of 20th April 2026

2.4 Performance against 2025/26 national performance and core indicators

Moorfields reports compliance against NHSE requirements, the NHS constitution and NHS outcomes framework to the trust board, both as part of monthly integrated performance reports (IPR) and as specific, issue-focused papers.

We consider that this data is as described in the sections and tables below, because of our internal and external data checking and validation processes, including audits, but it is subject to the caveats raised in the statement of directors' responsibilities. An integral part of the IPR process is to identify not just performance against a numerical target but also add value to the reporting process by articulating, using remedial action plans, any corrective actions the trust is taking to address areas of underperformance.

National performance data

All NHS foundation trusts are required to report performance against a set of core indicators using data made available to the trust by NHS England. Where the required data is made available by NHS England, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS England website and may not reflect the trust's current position (please note the data period refers to the full financial year unless indicated).

National performance measures

The trust uses comparative data to benchmark performance. The date ranges covered vary for each measure, but the latest available data has been used in the table below.

Table 6 - National performance measures

Description of target	2024/25 Performance	2025/26		Comparison with applicable trusts (latest)		
		Target	Performance	Average	Best	Worst
Infection control						
MRSA (rate per 100,000 bed days)	**0**	0	**0**	n/a	n/a	n/a

Description of target	2024/25 Performance	2025/26		Comparison with applicable trusts (latest)		
		Target	Performance	Average	Best	Worst
Clostridium difficile year on year reduction	**0**	0	**0**	n/a	n/a	n/a
Risk assessment of hospital-related venous thromboembolism (VTE) [i]	99.6%	≥95%	**99.0%**	91.4%	100%	14.9%
Waiting Times						
Cancer 28 Day Faster Diagnosis Standard[ii]	81.7%	≥ 80%	**82.8%**	75.6%	99.3%	38.5%
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat [ii]	98.4%	≥ 96%	**99.0%**	91.6%	100%	64.9%
% Patients With All Cancers Treated Within 62 Days [ii]	98.7%	≥ 85%	**98.8%**	69.2%	99.4%	44.4%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge [iii]	98.0%	≥ 95%	**97.3%**	74.7%	100%	48.2%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks [iv]	82.5%	≥ 92%	**83.8%**	66.7%	95.0%	41.3%
Maximum 6 week wait for diagnostic procedures[2]	99.1%	≥ 99%	**99.2%**	77.4%	100%	17.6%

[i] – Comparison data from NHS Statistical Work Areas – April 2025 to Dec 2025

[ii] – Comparison data from NHS Statistical Work Areas – Apr 2025 to Jan 2026

[iii] – Comparison data from NHS Statistical Work Areas – Apr 2025 to Feb 2026

[iv] – Comparison data from NHS Statistical Work Areas – Jan 2026, Ophthalmology Service only

Referral to treatment (RTT 18 weeks) performance

The trust is required to report RTT18 in the following ways:

- Incomplete standard as the sole measure of patients' constitutional right to start treatment within 18 weeks
- The number of new clocks starts
- The admitted and non-admitted operational standards were abolished in 2015/16, but the trust continues to report this information.

The table below identifies the performance of our full suite of RTT waiting time measures for the financial year and with a quarterly breakdown, and for incomplete pathways our latest position.

Table 7 - Referral to treatment (RTT 18 weeks) performance

Measure	Target	Year Start*	Q1	Q2	Q3	Q4	Year 2025/26	Year End*
18-weeks RTT incomplete	≥ 92%	83.1%	82.7%	81.2%	83.4%	84.9%	**83.1%**	**85.8%**
18-weeks RTT incomplete with decision to admit (DTA)	n/a	79.3%	81.7%	80.6%	79.9%	79.2%	**80.3%**	**79.1%**
18-weeks RTT admitted	n/a		82.5%	80.9%	77.9%	77.8%	**79.8%**	
18-weeks RTT non-admitted	n/a		78.4%	80.3%	77.0%	73.7%	**77.3%**	
New RTT periods (clock starts) all patients	n/a		34,816	34,667	36,074	37,590	**143,147**	

*Year Start is RTT Position on 1 April 2025, Year End is RTT Position on 1 April 2026

Our overall PTL (patient tracking list) position remains healthy. We have seen the PTL size start to decline from 35k patients per quarter to 34k. We have either reached points of stability or improvement against our pre-COVID levels in some of our largest services (Cataract, Medical Retina, Glaucoma). Our most challenged specialties are adnexal, paediatrics and strabismus.

Our overall RTT performance has stalled this last year. However, with the coming year, there are 5% improvements required by NHSE. With several initiatives taking shape, and a good grip and understanding of our performance, this target should be achieved.

Performance indicator data quality

A vital prerequisite for robust governance and effective service delivery is the availability of high-quality data across all areas of the organisation. The trust requires quality data to support several business objectives, including safe and effective delivery of care, and the ability to

accurately demonstrate the achievement of key performance indicators (KPIs). Our data quality policy sets out the specific roles and responsibilities of staff and management to ensure that data is effectively managed from the point of collection, through its lifecycle, until disposal.

The trust continues to utilise our data quality assurance framework, which has been identified as good practice by internal and external auditors. This process comprises of a regular review of a range of information sources used within the trust and is currently conducted annually by the data quality manager on a rolling programme.

Data quality continued to be given a high profile in 2025/26, with the continued inclusion of a large range of directly related KPIs published within performance reports and SUS (secondary user service) dashboards, which are refreshed each month and reported across the trust. These KPIs include:

- data quality - Ethnicity recording (outpatient and inpatient)
- data quality - NHS number recording (outpatient and inpatient)
- data quality - GP recording (outpatient and inpatient)
- data quality - Ethnicity recording (A&E)
- data quality - NHS number recording (A&E)
- data quality - GP recording (A&E).

The data quality audit team continued to utilise digital audit processes for some of the audit portfolio and are looking to further develop the audits into a digital arena. This ensures that data quality auditing remains viable in an agile working environment.

The team continues to use the Tendable digital application for some of the audit areas and are looking to increase utilisation of this for other audit areas. This provides continued assurance to the organisation that all audit areas, including data submissions to bodies such as NHS Improvement, and NHS England, are of a continued high standard.

The data quality team has worked closely with operational teams to develop processes that support the trust-wide implementation of standard operating procedures (SOPs) and will continue undertaking a series of compliance audits. This ensures that information capture processes are standardised and adhere to guidance, thereby ensuring accuracy and completeness. We continue to audit quarterly the documents which have been scanned into systems, to provide assurance that we provide a high-quality electronic patient record which is usable across the organisation. These audits are conducted using the BSI1008 standard as guidance. As a team we are working closely with the new EPR team to provide expert knowledge on scanning into new digital systems.

There is also ongoing work with research and digital projects to drive high quality data, which will continue to be supported through audit and other assurance processes.
The data quality team continued to lead in data improvement for areas such as next of kin (NOK); this work has seen our NOK data continue to improve with the trust now recording NOK in 25%- 95% of patient records. The data quality working group has the task of monitoring this and other ongoing items on the data quality agenda; this group has representation from across the trust and will continue to be at the forefront of data quality improvement and assurance providing expert guidance as we move into the new EPR.

28-day emergency readmission rate

The information below is gathered as part of our internal dataset. The trust is unable to provide national comparative data due to data not being available on the NHS Digital website. The trust considers this data is as described, as we have a robust clinical coding and data quality assurance process, and readmission data is monitored through the trust management committee monthly.

Table 8 - 28-day emergency re-admission rate

	2021/22	2022/23	2023/24	2024/25	2025/26
28 days readmission rate (Adult: 16+)- excluding retinal detachment	1.15%	1.59%	2.23%	2.48%	2.37%
28 days readmission rate (Adult: 16+)- retinal detachment only	4.21%	5.12%	4.60%	3.40%	4.20%
28 days readmission rate (Child: 0-15)	0.00%	4.55%	0.00%	0.00%	2.56%

* 2025/26 Position taken as of 20th April 2026

We have taken the following actions to improve these indicators and in turn the quality of services by:

- Improving electronic data capture using our improved electronic systems
- Continuing to audit data capture and use the results to improve data recording accuracy
- Further improving standard operating procedures and maintaining staff training programmes
- Using the data assurance framework to strengthen data capture across several defined criteria.

Patient participation

Throughout 2025/26, a range of supporting standard operating procedures and guidance has been utilised to actively engage patients and encourage their participation. These include mystery shopper questionnaires, patient stories, local patient engagement and education events, and the development of local user and patient forum groups. All engagement has been underpinned by the delivery of the ‘See the whole person’ patient experience principles which inform the Patient Experience Framework 2024-2028 objectives:

- Involve staff and patients to shape the care we provide and ensure we are making a positive
- Develop belief, skills and confidence in our staff to deliver 'See the whole person'
- Consistently reflect, learn and be innovative in our approach to patient experience.

The patient participation and experience committee (PPEC) has and continues to meet quarterly to provide oversight and understand the effectiveness of the implementation of these tools, and the impact on patient experience. In between quarterly committee meetings, patient and carer representatives are provided with ongoing opportunities to share feedback. This includes the ability to identify topics they would like to see discussed at future meetings, ensuring their voices directly inform the focus of engagement, participation, and service development activity. Escalations, key learning, and concerns are provided via an escalation summary for clinical governance committee after these meetings.

Accessible Information Standard

All NHS trusts are required to comply with the Accessible Information Standard (AIS). We have established a project group which has continued to meet throughout 2025/26 to drive improvements in this area.

Workstreams have focused on patient letters and communications, as outlined in the quality priority (Section 2) of this report, ensuring that information provided to patients is clear, consistent, and accessible.

In 2026/27, we will focus on targeted areas for further improvement. These will be enabled through the electronic patient record (EPR) programme and aligned operational developments, as set out in the 2026/27 quality priorities section of this report.

Family and Friends Test (FFT) for patients

During 2025/26, 202,440 (32.8%) of our patients who attended accident and emergency (A&E), or an outpatient or inpatient appointment responded to a FFT text, with approximately 94% of those respondents indicating they had a positive experience.

Table 9 - Family and Friends Test (FFT) trust results for 2025/26

Type	Score: 5 - Very Good 4 - Good 3 - Neither good nor poor 2 - Poor 1 - Very poor 0 - Don't know						Responses	Eligible	Positive	Negative	Response Rate
	5	4	3	2	1	0					
A&E	18,332	3,413	752	361	649	170	23,754	75,444	91.5%	4.25%	31.5%
Inpatient	12,395	1,485	210	70	117	116	14,479	37,262	95.9%	1.29%	38.9%
Outpatient	163,644	27,286	4,807	2,093	2,186	1,466	202,440	620,621	94.3%	2.11%	32.6%

FFT themed analysis of comments

Face-to-face consultations

Friends and Family Test (FFT) is a national mandated requirement for collecting patient feedback after every outpatient, inpatient or A&E visit. An SMS is sent to patients asking them to rate the service they have received. If this message is responded to, then a further message is sent, providing patients with the opportunity to tell us what would have improved their experience, via a free text response. FFT allows consistent engagement with our patients and allows us to gather timely insight into patient experience which supports ongoing evaluation and improvement.

In November 2025 FFT data began being captured via the trusts in-house FFT system. Monthly FFT performance data provides insight into the positive experience patients receive, complimented by qualitative narrative that provides insight into opportunities for further improvement to patient experience and care.

Where patients provided negative comments, or there are recognised themes indicating a concern, services are proactively analysing this information to inform continuous improvement efforts and ensure appropriate actions and escalations are taken to enhance quality. Services

adopt a ‘You Said We Did’ approach, demonstrating how insights from FFT and other data translate to tangible improvements. Representatives across all services have access to and oversight of their local FFT data and discuss this in local quality meetings and forums. Themes from FFT data are also presented as part of divisional updates at PPEC. Primary themes emerging from negative feedback include communication, appointment booking and staff attitude. Positive comments often focus on exemplary clinical care and provide clear examples of staff commitment to the ‘See the Whole Person’ patient experience principles.

Examples of positive FFT narrative:
“I feel that the whole visit was managed very well. The clinician who carried out the various tests was very professional, kind and explained different tests very well. The optometrist we saw to discuss the test results was also very reassuring. I would not change anything”

“The service was excellent from the greeting security officer through to nurse consultants. I couldn't fault the treatment, I felt listened too and the staff had time to listen making it very personal rather than a process, I left reassured thank you”

These examples highlight opportunities for improvement:
“I was given a virtual appointment. It would have been helpful to have had an explanation as to what this entailed beforehand.”

“By the time I saw the doctor and consultant at 5.45pm the last person, 3 hours and 15 minutes after my appointment time, we were all tired. We needed to discuss an operation that is routine for them, but for me scary. This was not as good an experience as it should have been.”

Complaints and PALS concerns
Complaints and PALS concerns are a valuable source of patient feedback about services, outcomes, and individual performance. They provide scope for learning and service improvement.

Complaints
The Trust received a total of 259 complaints in 2025/26, compared to 127 complaints in 2024/25. While this represents a significant increase in the number of complaints recorded, it does not necessarily indicate a deterioration in the quality of services provided. Part of the

increase is due to a backlog of unrecorded complaints in the previous year (2024/25) which were then included in the 2025/26 figures. Thus creating an inaccurate picture of what happened in the year. By 31 March 2026 the systems, processes and performance had been restored. Part of the increase is also attributable to the implementation of a more structured reporting system, enhanced processes for early identification of concerns, and improved accuracy and consistency in complaint recording. These developments have strengthened the Trust's ability to capture, monitor, and respond to feedback, providing a more comprehensive understanding of patient and stakeholder experiences and supporting continuous quality improvement.

PALS concerns

PALS received 4,419 enquiries in 2025/26 (5,593 the previous year). 131 of which were compliments, 976 were requesting information and 3,312 were concerns. Of the concerns, the largest number related to appointments, as with the previous year, followed by communication issues, delays (with follow-up, diagnosis, treatment and providing information) and transport concerns.

Compliments

The number of compliments received and logged centrally by PALS was low, as direct compliments are often received locally by individual teams and on trust social media channels. A large number (many thousands) of compliments have been received through the FFT.

Response time

The organisation did not meet its target in 2025/26 for complaints responses. Performance began well in the first half of the year but deteriorated during the second half for a number of reasons, including staff sickness and turnover and catching up on the complaints backlog. An improvement plan is in place, and the main indicator performance had been restored by 31 March 2026. We will continue to improve our patient focus and responsiveness when responding to complaints and PALS enquiries. The quality of our complaints responses remains high.

Table 10 - Complaints performance: Key performance indicators

KPI (key performance indicators)	Target	2023/24	2024/25	2025/26
Response ≤ 25 days	≥ 80%	88.6%	62.1%	44.0%
Acknowledgment ≤ 3 days	≥ 80%	97.3%	76.6%	76.8%

Venous Thromboembolism (VTE)

Patients admitted to hospital who were risk assessed for venous thromboembolisms (VTE) Moorfields considers this data is as described for the following reasons:

- All patients admitted for day surgery, or as overnight inpatients have their nursing assessments using our integrated care pathway document. 'VTE risk assessment and treatment plan' forms part of the risk assessments for all patients admitted.
- Most ophthalmic treatment, or ophthalmic surgery poses low risk for hospital acquired VTE. So far, there have not been any recorded incidents of hospital acquired VTE via our incident reporting systems.
- For those paediatric patients who are between the age of 16 and 18 and are being operated on and admitted onto the paediatric day care ward, rather than admitted via adult wards, we are continually conducting VTE assessment using the VTE risk assessment and treatment plan to risk assess. This was implemented five years ago, and we are continuing this practice in our children's hospital.

Table 11 - Venous Thromboembolism (VTE)

Indicator	2023/24 Results	2024/25 Results	**2025/26 Target**	**2025/26 Results**
Risk assessment of hospital-related venous thromboembolism (VTE)	98.6%	99.5%	≥ 95%	99.0%

Patient safety incidents (PSIs)

The incident reporting system has continued to be effective throughout the year, remaining available for use by all staff at all locations. We have continued to develop our use of the system to make improvements for users and to satisfy the requirements of the PSIRF and the learn from patient safety events (LFPSE) service.

We recognise the impact that involvement in an incident can have on both our staff and our patients and their families, and throughout the year we have continued to prioritise the support provided for people who have been involved in or affected by a PSI. We have developed written materials to support these groups, including staff and manager support guidance leaflets and a patient information leaflet for patients and their families who are involved in a patient safety incident investigation.

Throughout the year we have continued our work with our organisational development team to consider the opportunities that exist to further develop our safety culture, so that staff feel comfortable to report and discuss incidents and near misses without feeling that they will be individually blamed or criticised for their occurrence. It is very important to us that staff are confident that they will be treated fairly following an incident, and we do not want the fear of staff being blamed to stop them from reporting incidents or from raising concerns. Work to introduce use of the NHS England Being Fair tool, for use when concerns about an individual's conduct or fitness to practice are raised during a patient safety learning response, remains on-going. Exceptional use of the Being Fair tool will support decision-making for PSIs referred to workforce, via the disciplinary process, and will ensure that staff are not treated unfairly after a patient safety incident.

Statistical process control (SPC) charts have continued to be our preferred display method for incident data, and charts displaying data at both trust level and divisional level are maintained and shared throughout the year. Charts which show the numbers of reported incidents, open incidents, and incidents older than 28 days are produced and reviewed monthly as a minimum. Presentation of the information in this format provides the opportunity to identify data increases

or decreases which show concerning variation, and areas for which the need for improvement is evident.

Our trust-wide incident reporting data, for both PSIs and non-PSIs, has shown improving variation for the last three years (twelve quarters). When the PSI and non-PSI data is charted separately, the PSI data shows common cause variation over the last two quarters of 2025/26, with the data for quarter 3 haven fallen slightly below the mean for the first time in two years. Data for quarter 4 shows an increase in reporting to above the mean. This will continue to be monitored very closed as it is one of our measures of the successful implementation of the PSIRF.

Throughout the year we have continued to develop and improve our implementation of the PSIRF. In Q2 of 2025/26 we commenced review of our PSIR policy and plan and engaged with stakeholders to consider whether our existing local priorities (as described in the April 2024 plan) remained reflective of the operational and oversight processes that we have established. Also, that they maximised our opportunities for learning and improvement. Further, review of these documents enabled consideration to be given to the intelligence to be gained through our learning responses to those areas which support the design and implementation of the EPR and our move to Moorfields and UCL Centre for Eye Health, our new centre in Camden.. The application of processes that we have developed to support ongoing implementation and development of the PSIRF at Moorfields have remained subject to review throughout the year, and we have strived to apply a continuous improvement approach to this.

In 2025/26, we initiated one new PSII and this was classified as a wrong implant/prosthesis never event because one patient had the unintended strength intraocular lens (IOL) implanted during cataract surgery. During 2025/26 we completed and shared our findings and recommendations for another four PSIIs, all of which had been reported in the previous financial year. Each of these five PSIIs have, or will have, an associated improvement plan which will be monitored closely. The development plans are designed to ensure that all recommendations are translated into achievable safety actions and to ensure that we have confidence that the actions are resulting in the desired improvements for patients and our staff.

During the year we have continued to expand number of learning response tools that we use to help us understand why PSIs are occurring. We use the same tools to help identify what works well. The tools that we use are identified in the glossary of our patient safety incident response policy and plan, which is published on the trust website. In addition to PSIIs, we have specifically promoted the use of after-action reviews (AARs), thematic reviews, clinical audits, multi-disciplinary team (MDT) meetings, quality/safety summits and learning and improvement

action meetings (LIAMs) as learning responses. We will continue to develop our ‘toolbox’ of available learning responses, exploring alternatives based on need and using more than one learning response to understand an incident where it is proportionate to do so.

Moorfields considers that the incident data is as described for the following reasons:

- The trust uses an electronic reporting system, which undergoes continual improvement to satisfy the needs of reporters and internal subject matter experts (SMEs). The incident reporting system includes a complex range of notification rules to ensure that the correct managers are notified when an incident is reported, which are reviewed and maintained by the central risk & safety team.
- Functionality exists within the system to monitor PSIRF activity and continues to be developed by both the vendor and the central risk & safety team.
- The system is compliant with LFPSE requirements and will support both local and national safety improvements. The LFPSE version 6.0 taxonomy will be live in the system by the end of April 2026.
- We have an established incident review group (IRG), which meets weekly and which reviews all incidents that are considered to meet either local or national priority criteria. Our local priorities are not dependent on the level of harm that has been sustained, but instead the opportunity to learn, and improve our services. A part two meeting exists as a forum at which PSIs of concern, including concerns arising from the actual harm impact for an individual or group of patients, also exists. An increased focus on shared learning and improvement has been sustained throughout 2025/26.
- Once every six weeks, the IRG part one meeting is replaced by an action and improvement review (AIR) meeting. This is the meeting at which completed learning responses are reviewed and improvement plans are monitored for suitability and sustainability. The AIR meeting also considers IRG activity and is responsible for reporting escalations concerning incidents or emerging risks to the clinical governance committee.
- Incident reporting training and education has been provided by the risk and safety team throughout the year. This bespoke training has been delivered to individuals and or teams and is tailored to meet the specific needs or concerns communicated by the user(s).

The trust intends to take the following actions to improve this data, and therefore the quality of its services by:

- Continuing the use, availability, and development of SPC charts, particularly those that will impact the success of improvement projects associated with the local priorities identified in our PSIRF plan.
- Reviewing and updating the way in which improvement plans, and the associated safety actions and measures of improvement, are presented. This will not only increase the assurance that can be provided regarding the mitigation of risks but also show the benefit of a continuous improvement approach and encourage other staff to be involved.
- Continuing to adopt a continuous improvement approach to the implementation and embedding of our PSIRF plan, to maximise our opportunities for learning and improvement.
- Transitioning, in Q1 2026/27, to the LFPSE version 6.0 taxonomy dataset.
- Auditing the occurrence and content of any PSI records that have not been uploaded to LFPSE, to understand why the automated upload has not been effective and modifying our incident reporting system to minimise future occurrence.
- Seeking feedback from users in respect of any changes made to the electronic incident reporting system (Safeguard), to confirm that the change has been a success, and monitoring the impact via existing SPC charts.
- Continuing to review the way in which data entered into Safeguard by the central quality and safety team, relating to PSIRF implementation, provides the trust board with the system oversight that is required.

Table 12 - Summary of Never Events (NE)

Never Event title	Brief details
Implantation of the incorrect intraocular lens (IOL) (1 incident reported)	One patient received the incorrect IOL during cataract surgery. The error was identified shortly after the patient had left the operating theatre. Corrective surgery was undertaken on the same day. This incident satisfied the criteria for a wrong implant/prosthesis never event.

No additional PSIIs were initiated during 2025/26.

All completed PSIIs have an associated safety improvement plan, which details the safety actions that will be completed. The improvement plans, which include measures of improvement, are updated a minimum of quarterly and shared at action and improvement

review (AIR) meetings and clinical governance committee meetings, as well as in the quarterly quality and safety reports. The content and presentation of the improvement plans will be reviewed during 2026/27, to improve the oversight of action completion status and also to enhance the emphasis on the measures of improvement.

Learning from PSIs is shared via various mechanisms, including at divisional quality forums, service (sub-specialty) meetings, via divisional and quality team newsletters, safety huddles and learning and improvement following events (*LIFE*) bulletins (*LIFEline*).

Total number of reported PSIs

The table below shows the total number of reported PSIs during the period April 2022 to March 2026. Data from previous years has been refreshed.

Table 13 - Total number of reported patient safety incidents (PSIs)

Reporting period			
2022/23	**2023/24**	**2024/25**	**2025/26**
3993	4269	4332	4234

Rate of PSIs reported

The table below presents a summary incident reporting rate for the trust, during the period April 2022 to March 2026. Because Moorfields primarily provides ambulatory care, the organisation calculates a reporting rate based on incidents per 1,000 events. The reporting rates shown have been extracted from the Moorfields quality and safety dashboard. Data from previous years has been refreshed.

Table 14 - Rate of patient safety incidents (PSIs) reported

Reporting period			
2022/23	**2023/24**	**2024/25**	**2025/26**
5.24	5.25	5.35	5.21

Number of PSIs recorded as severe physical harm or fatal

In the NHS, degree of harm recording relates to the actual impact on a patient from the particular incident being reported. Patient safety harm definitions are applied based on the best information about the actual impact of the incident at the time of reporting. Harm gradings are reviewed an updated as more information regarding the impact on a patient becomes available.

Severe physical harm is when at least one of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Incident harm is recorded as fatal if, at the time of reporting, the patient has died and the incident may have contributed to the death.

The table below presents a summary of the total number of PSIs which resulted in severe harm or death that were reported from April 2022 to March 2026. The trust has a dynamic incident reporting process, and records are continually reviewed and updated. Data from previous years has been refreshed.

Table 15 - Number of patient safety incidents (PSIs) resulting in severe harm or death

Reporting period			
2022/23	**2023/24**	**2024/25**	**2025/26**
12 (incl. 1 death)	7	6	5

Percentage of PSIs resulting in severe harm or death

The table below presents a summary update of the percentage of PSIs resulting in severe harm or death. The percentage data in the table has been calculated based on the number of severe harm/death incidents as a proportion of the total number of PSIs reported during the period. Data from previous years has been refreshed.

Table 16 - Percentage of patient safety incidents (PSIs) resulting in severe harm or death

Reporting period			
2022/23	**2023/24**	**2024/25**	**2025/26**
0.30%	0.16%	0.14%	0.12%

Being open with our patients - Duty of Candour (DoC)

We have continued to strengthen and promote systems to support an open and transparent culture when things go wrong and show a willingness to report and learn from incidents. Our work to review and improve DoC compliance and governance arrangements incorporates the relevant PSIRF requirements, noting that these do not alter the statutory and professional requirements in relation to DoC. There is still a plan for policies that currently include DoC requirements to be superseded by a policy that describes the requirements for 'engaging and involving patients, families and staff following a patient safety incident'. At the point at which the new policy is produced, new guidance for staff will be developed and a review of the current e-learning package will be conducted.

Adherence with the individual elements of the DoC process continues to be captured within the electronic incident reporting system, and the risk and safety team and divisional quality partners monitor compliance on an ongoing basis. Compliance data has continued to be routinely shared at the AIR meeting, and subsequently with the clinical governance committee and the quality & safety committee. The report includes identification of those incidents for which full compliance has not yet been achieved and identifies the month in which the incident was reported and the clinical division to whom responsibility for completion is allocated. Where non-compliance is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. In order to improve oversight and compliance with DoC requirements, clinical divisions now report DoC non-compliance at executive performance meetings. We will also share non-compliance data with the clinical lead for each site, so that there is consultant ophthalmologist oversight of the relevant incidents.

As part of our ongoing work to create the new policy for engaging and involving patients, families, and staff following a patient safety incident, we are aligning the perception and application of the DoC to the trust's patient experience principles. On completion of the policy, we will review the existing DoC e-learning training package and update it to take account of PSIRF requirements and any local processes that are amended or established.

A re-audit will be undertaken during 2026/27.

Learning from deaths

The death of patients in our care is an extremely rare event. The scope of our learning from deaths policy is deliberately broad to make the best provision for potential learning opportunities. It includes not only mandatory national inclusion requirements (for example, an inpatient death, the death of an individual with a learning disability or mental health needs, the

death of an infant or child) but also deaths within 48 hours of surgery, deaths of patients who are transferred from a Moorfields site and who die following admission to another hospital, and deaths about which the trust becomes aware of following notification by HM Coroner.
We have established a medical examiner (ME) service, which is provided by University College London Hospitals NHS Foundation Trust (UCLH). The UCLH service covers all Moorfields sites, with onward referral to the local ME service (where one exists) being co-ordinated and overseen by the UCLH ME service.
The trust has continued to scrutinise patient deaths that have occurred outside of a Moorfields care setting, where there has been interaction with a patient in the days or weeks prior to the death. We have followed the structured judgement review (SJR) methodology to review the deaths that we have become aware of, where the death falls within the scope of our learning from deaths policy. All reviews which are completed are now reviewed and signed off by a multi-disciplinary panel, prior to the report and any learning being shared via the AIR meeting. Any learning identified is included in the quarterly learning from deaths report to the trust board but has not been detailed below, as it is outside the national inclusion criteria.
The following statements meet the requirement set by NHS England and are described against the relevant statement number.

Mortality review data 2025/26

The table below sets out the number of deaths at Moorfields Eye Hospital NHS Foundation Trust during 2025/26, together with the number of structured judgement reviews (SJRs) completed and the number and proportion of deaths judged more likely than not to have been due to problems in care. The figures below represent those deaths.

Table 17 - Mortality review data 2025/26

Indicator	Apr – Jun	Jul – Sep	Oct – Dec	Jan – Mar	Total
Number of patients who died (as per mandatory national requirement)	0	0	0	0	0
Number of case record reviews initiated for learning	1	1	1	1	4
Number and percentage of patient deaths judged to be more likely than not due to problems in care	0%	0%	0%	0%	0%

Mortality Review Data 2024/25 (retrospective reviews)

The table below shows structured judgement reviews completed during 2024/25 relating to deaths that occurred prior to 1 April 2025.

Table 18 - Mortality review data 2024/25 (retrospective reviews)

Indicator	Apr – Jun	Jul – Sep	Oct – Dec	Jan – Mar	Total
Number of case record reviews completed after 1 April 2025 relating to earlier deaths	0	0	0	0	0
Number and percentage of patient deaths judged to be more likely than not due to problems in care	0%	0%	0%	0%	0%

These retrospective reviews demonstrate continued learning and assurance, with 0 deaths (0%) identified as more likely than not due to problems in care. Findings from these reviews have been incorporated into organisational learning and quality improvement activity.

- Percentages are calculated as a proportion of deaths reviewed.
- All deaths are subject to independent review by a medical examiner and are considered through the trust's structured mortality review process.
- SJRs are undertaken using NHS England methodology to support consistency, learning, and identification of themes.

Part 3: Statements of assurance from the Board

3.1 Statements of assurance and review of trust services

The trust board receives assurance about quality and safety from the quality and safety committee, which provides assurance about quality and safety activities across the trust. The quality and safety committee receives several annual quality and safety reports, including a quarterly review of quality and safety covering the three domains of patient safety, patient experience, and clinical effectiveness, led by the medical director, and the chief nurse. The board receives regular briefings from the chair of the quality and safety committee. The board also receives reports about quality and safety as per its statutory responsibilities.

Review of trust services

During 2025/26, Moorfields provided ophthalmic NHS services covering a range of ophthalmic sub-specialties (A&E, adnexal, anaesthetics, cataract, cornea and external disease, glaucoma,

medical retina, neuro- ophthalmology, optometry, orthoptics, paediatrics, strabismus, and vitreo-retinal).

Moorfields has reviewed all the data available about the quality of care in all the ophthalmic services that we provide. At Moorfields, we regularly review all healthcare services that we provide. During 2026/27, we will continue with our programme of reviewing the quality of care and delivery of services through our transformation programme.

The income generated by the NHS services under review in 2025/26 represents the total income generated from the provision of NHS services.

Freedom to speak up (FTSU) service

Following extensive consultation, during 2023/24 Moorfields FTSU model was revised to include an independent substantive lead FTSU guardian, an anonymous speak up platform and a champions model. The model also includes an assistant to the lead guardian and four voluntary FTSU guardians.

If individuals are not happy to raise concerns via these guardians, or their concern is about the guardians themselves, or is at trust board level, these can be raised with Adrian Morris the appointed non-executive director of the trust board responsible for FTSU. Moorfields has a FTSU policy which sets out the scope of the FTSU arrangements. FTSU is provides additional support for staff should concerns not be resolved locally. Examples of potential FTSU concerns in the policy include, but are by no means restricted to:

- Unsafe patient care.
- Unsafe working conditions.
- Inadequate induction or training for staff.
- Lack of, or poor, response to a reported patient safety incident.
- Suspicion of fraud.
- Bullying and harassment.
- Sexual safety.
- A criminal offence has been committed, is being committed or is likely to be committed.
- Concerns about staff well-being.
- That the working environment has been, is being, or is likely to be damaged.

FTSU guardians ensure that staff concerns are resolved via the most appropriate route. They also ensure that staff are supported during the period that their concern is addressed, and staff

can provide feedback directly to guardians about their experience of how their concern has been resolved.

FTSU guardians meet regularly to discuss the impact of their role and how to make themselves available and accessible to staff who require their services, including what communication routes should be used. Quarterly FTSU reports and an annual report are produced for the trust board, and data is also submitted to the National Guardian's office quarterly.

Provision of seven-day services

The trust is compliant with the relevant clinical standards that apply. These include:

- Clinical standard 2 – trust policy is that consultant review should be arranged within 6 hours of admission during working hours (8am to 8pm) and within 14 hours of admission if out of hours.
- Clinical standard 5 – relates to access to diagnostic services. CT and ultrasound are available Monday-Friday with no weekend services. There are some occasional Saturday clinics for ophthalmic imaging, but they are available on an ad hoc basis as the services are required. MRI is only available on weekends via formal arrangement off-site. Whilst not run or administered by Moorfields, microbiology support is available through UCLH microbiologists on a 24/7 basis. Similarly, our testing labs are offering a 7-day service so samples can always be sent for testing.
- Clinical standard 6 – the only element that applies is access to emergency surgery which is available on weekdays and weekends.
- Clinical standard 8 – as a single specialty ophthalmology hospital we do not admit patients with high dependency needs so CS8 does not apply.

Relevant standards are audited as part of the clinical audit programme. The 7DS template is submitted to the board twice a year for assurance purposes.

Guardian of safe working

As required under Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Board receives quarterly reports and an annual report from the guardian of safe working hours. These reports provide assurance in relation to safe rostering, working hours compliance, exception reporting, rest and welfare arrangements, and any themes requiring local action. During 2025/26, this reporting continued to support Board oversight of safe working arrangements for resident doctors and informed local action where rota, operational or working environment issues required review. During this

period, there have been no rota gaps, and all on-call shifts were adequately and safely staffed. Over the course of the year, 1,212 locum shifts (ranging from one hour to one day shifts) were used to address demand surges and rota gaps to ensure a safe and adequately staffed service.

NHS doctors and dentists in training

During 2025/26, the trust continued to strengthen its support for resident doctors, with a focus on improving both the day-to-day working experience and the wider quality of the training environment. This work has been progressed in the context of NHS England's improving the working lives of doctors in training agenda and the associated 10 point plan, which has required trusts to place greater emphasis on induction, rota quality, rest facilities, wellbeing support, access to food and drink out of hours, flexible support arrangements, clear escalation routes, and a culture in which concerns can be raised safely and acted upon.

At Moorfields, this has translated into increased and ongoing work across medical HR, medical workforce, operational management and education teams. Activity during the year has included strengthening onboarding and local induction arrangements, improving signposting to rest facilities, wellbeing support and key local processes, reviewing rota quality and local working arrangements, reinforcing exception reporting and routes for raising concerns, and supporting divisional and service level ownership of issues affecting resident doctors in practice. This has required closer coordination between the director of medical education, guardian of safe working, medical HR, operational leads and divisional teams to ensure that concerns are identified early, responded to promptly and used to inform service and workforce improvement.

The trust's approach during resident doctor industrial action also highlighted the importance of this work. In supporting safe service delivery during periods of industrial action, the organisation strengthened its operational guidance, daily recording and oversight arrangements, manager support, and communication routes with resident doctors. This included a clearer emphasis on respectful engagement, accurate recording of industrial action, timely operational escalation, and the need for local managers to maintain clear and consistent communication while supporting safe staffing arrangements. The learning from this has reinforced that support for resident doctors cannot be limited to induction or education processes alone, but must also include robust operational management, clear local accountability, and consistent day to day workforce practices.

In 2025/26, the role of medical workforce development lead for non-consultant and non-resident doctor career grades was created within the medical directorate. The post-holder,

working with the medical director for workforce and associate director of medical workforce, has commenced work on a review of the support and career development opportunities for SAS doctors and locally employed doctors (also known as clinical fellows) within the trust. This includes the provision of support for doctors wishing to progress to specialist registration via the GMC's portfolio pathway, access to autonomous practice privileges, and other key initiatives. The trust continues to be committed to enhancing the quality of roles and careers within the organisation for doctors in alternative career grades.

Participation in clinical audits and national confidential enquiries

The national clinical audit reports received from NOD, including the eighth annual cataract report and third report of age-related macular degeneration (AMD), were reviewed by the Moorfields in 2025-26 and these were discussed in the clinical audit and effectiveness committee, reviewed by the trust's medical director, and shared and discussed within the cataract and medical retina services. Moorfields is a leading provider in the submission of this data and although positive results were evident, report data is from 2023-24 and 2022-23. Services involved have discussed the findings, challenges, and shared ways to improve patient outcomes and quality of healthcare provision.

The completed reports of 200 local clinical audits were submitted by auditors and reviewed by Moorfields teams in 2025-26. Prior to final sign off the service audit lead agree the findings and design of each audit report, and the central clinical audit team quality check to ensure each report includes sufficient findings, learning and conclusions as well as a SMART action plan. The audit team will advise and provide guidance on when and how to re-audit as required. All actions from audits are chased for completion by the audit team to ensure progress and improvements to services and healthcare.

The national clinical audits and national confidential enquiries that Moorfields was eligible to participate in during 2025-26 are as follows:

National audits

- National audit of corneal graft outcomes (UK ocular tissue transplant audit)
- National ophthalmology database (NOD) cataract audit
- National ophthalmology database (NOD) age-related macular degeneration (AMD) audit
- NAP8 major complications of regional anaesthesia and perioperative nerve injury
- Emergency front of neck airway registry (eFONAr).

National confidential enquiries

- No studies were undertaken that were relevant for Moorfields to participate in 2025-26.

The national clinical audits and national confidential enquiries that Moorfields participated in, and for which data collection was completed during 2025-26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 19 - Participation in clinical audits and national confidential enquiries

National audit	Numbers of cases submitted & relevant/eligible
National audit of corneal graft outcomes	*1,155/1,459 (79.2%)* *(data from 01/04/2025-31/03/2026)*
National ophthalmology database (NOD) cataract audit	**Unavailable* *(data from 01/04/2024-31/03/2025)*
National ophthalmology database (NOD) AMD audit	***2,529/3,629 (69.7%)* *(data for number of patient eyes starting neovascular AMD treatment from 01/04/2023-31/03/2024)*

*Due to a significant number of delays for the cataract audit, NOD were unable to provide Cataract Audit data for year 2024-25.

**The NOD AMD audit received data from Moorfields (including Croydon and Bedford) for 3,629 naïve eyes starting treatment for neovascular AMD between April 2023 - March 2024. 2,529 eyes were eligible for analysis and 1,100 were excluded due to the patients' age being <=55yrs at start of treatment (468) or not treatment naïve (632).

The national studies involving anaesthesia *(NAP8 Major Complications of Regional Anaesthesia and Perioperative Nerve Injury and Emergency Front of Neck Airway Registry)* began collecting data from March 2026 and subsequent reports will be shared on completion of each project.

Table 20 - National confidential enquiries

National Confidential Enquiries	Numbers of cases submitted & relevant
Not applicable	Not applicable

There were no national confidential enquiries (NCE) in 2025-26 whereby the trust was required to take part or actively contribute data. Any relevant NCE studies are discussed at the trust's bi-monthly clinical audit and effectiveness committee (CAEC).

Although Moorfields did not qualify for submission for any of the studies in 2025-26, details of current NCE studies were shared at CAEC, including a NCEPOD report on rehabilitation following critical illness; a national audit of organisational practices in discharge opioid prescribing in NHS day-surgery units; abnormal blood sodium levels; and emergency care for young people.

Of the 1459 ocular transplant forms received from the NHS Blood and Transplant team for 2025-26, the trust completed and returned 1,155 (79.2%.) However, some of the forms received were for planned appointments yet to take place. The corneal graft clinic (clinic 10) also proactively submits details to the NHS Blood and Transplant team without waiting for receipt of a form. Since 1 April 2025, the trust has also submitted several forms received during the previous year. In total, during 2025-26, the trust submitted details of 1,383 patients to the NHS Blood and Transplant team.

A bespoke report was received in March 2026 from NHSBT covering 2 years graft survival estimates for patients receiving their first corneal transplant from 1 Jan 2022 – 31 December 2023. This demonstrated 2-year follow-up until the end of 2025 and was separated by type of skin graft and indication. Results are included in the trust core outcomes 2025/26 (section 2.2 - table 3). Results will be discussed at CAEC in May 2026.

Moorfields continues to maintain local management and record of data (including submissions to the NHSBT), and this quality account includes the numbers of ocular transplant forms received from NHSBT, and how many have been completed and returned following patient review.

The NOD produced a third annual report in March 2025 on age-related macular degeneration (AMD) covering the period April 2022- March 2023. Findings were shared and discussed at CAEC in September 2025. The eighth and most recent annual report for cataract surgery was published in July 2025 and assessed data from April 2023 – March 2024. Findings were shared and discussed at CAEC in September 2025.

Moorfields' intends to take the following actions to improve the quality of healthcare provided as outlined in table 20 below.

Table 21 - National audit reports

National Audit Report	Discussed	Actions
NHSBT: A bespoke report for data covering 2 years graft survival estimates for patients receiving their first corneal transplant from 1 Jan 2022 – 31 December 2023 was received in March 2026. Analysis will be shared and discussed in May 2026	Corneal Service	Progress with NHS Blood and Transplant audit data is discussed at CAEC throughout the year. The trust maintains internal processes to monitor data submission to the NHS Blood and Transplant team as no external reports have been forthcoming. Data shared by the NHSBT in March 2026 will be presented at CAEC in May 2026.
The eighth annual NOD report for cataract surgery (1 April 2023 to 31 March 2024) was published in July 2025.	Cataract Service	Findings were shared with the Medical Director and Cataract Service. Results were shared and discussed on 24 September 2025 at CAEC.
The third report of age-related macular degeneration (AMD) audit was published in March 2025 and includes details of patients starting treatment for neovascular AMD between 1 April 2022 to 31 March 2023.	Medical Retina Service	Findings were shared with the medical director and medical retina service Details including a summary of Moorfields' results discussed at CAEC on 24 September 2025.

During the period 2025/26, the trust proposed and approved 54 audits assessing national clinical standards/guidelines[2] (many of which have been completed or were re-audits).
The 54 clinical audits derived from national standards and guidelines that Moorfields participated in from 1 April 2025 to 31 March 2026 can be summarised as:

- 9 CQC/NHSLA/trust policy/guidelines
- 1 General Medical Council (GMC)

[2] National audits are those registered by all trusts where benchmarking and comparisons can be made between organisations. Due to the single specialty nature of Moorfields, many national audits are not relevant. Moorfields therefore also audits against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists, National Institute for Health, and Care Excellence (NICE), and national service frameworks. These are referred to as 'nationally derived' audits whereby all trusts undertake them but there is no benchmarking as these are done individually by trusts.

- 4 National audit (part of the national clinical audit and patient outcomes programme)
- 5 National Audits (not part of the national clinical audit and patient outcomes programme)
- 9 NHS England
- 7 National Institute for Health and Care Excellence (NICE)
- 4 Patient Reported Outcome Measures (PROMs)
- 7 Patient safety first
- 4 Royal College of Anaesthetists
- 4 Royal College of Ophthalmologists (RCO).
  (1 proposal has since been archived)

There were 39 nationally derived audit 'reports' completed and submitted during this time, summarised as:

- 5 CQC/NHSLA/trust policy/guidelines
- 1 National audits (part of the national clinical audit and patient outcomes programme)
- 5 National audits (not part of the national clinical audit and patient outcomes programme)
- 7 NHS England
- 6 National Institute for Health and Care Excellence (NICE)
- 3 Patient Reported Outcome Measures (PROMs)
- 6 Patient safety first
- 1 Royal College of Anaesthetists
- 3 Royal College of Ophthalmologists (RCO)
- 2 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT)

Participation in clinical research

Research studies

Moorfields Eye Hospital conducted 33 sponsored research studies, 29 commercial studies as the lead site and 94 hosted studies. Commercial studies formed almost 50% of our study portfolio in 2025/26. There are currently 79 open, funded research studies, of which 30 are commercial, with approximately 93 at the concept or grant application stage. The National Institute of Health Research (NIHR) Clinical Research Facility (CRF) recruited 1,167 participants in 2025/2026 and total recruitment to studies was 2,650. This is a decrease on the previous year due to the closing of several high recruiting, observational studies although our

recruitment performance is still comparable to the period between June 2023 and October 2024 before the higher recruiting studies began.
Our current studies are now mainly interventional ones requiring more intensive assessment, investigations and long term follow up. Less participants are required to give meaningful conclusions in such studies. Since 2023/24, we have maintained the split between commercial and non-commercial studies in our portfolio at around 50%.
The NIHR funds research into the most important research questions in ophthalmology and we have invested in grant writing as well as academic statistical support to ensure Moorfields continues to attract a pipeline of such high-profile studies.

Collaborations

Moorfields is currently collaborating with the Lowy Medical Research Institute (USA) on several studies, including two that have recently opened. These studies are focused on investigating macular telangiectasia type 2, a rare eye condition that affects the central part of the retina responsible for detailed vision.
The NIHR and the Department of Health and Social Care (DHSC) expects Clinical Research Facilities to make the UK as attractive a place as possible for research funded by pharmaceutical companies. Moorfields has set up partnership boards with several industry partners to facilitate research, education, as well as service development. We are research funded by a range of industry sponsors. The trust has also established a collaboration with a company who have strong relationships and contacts with biotech companies across the USA that could support ophthalmic work in the UK. This collaboration is intended to result in further research from these companies.

Improving our delivery

We developed the research management workflow (RMW) platform in-house to streamline our set up and research delivery processes to ensure that we can meet the demanding timelines rightly expected by our national & international partners. The platform supports research application reviews, covering project costing and setup, grant submissions and contract review and sign off. To date, the platform has processed 492 research projects across all aspects from planning to delivery.
Moorfields Discovery were recently awarded £310,884 from Moorfields Eye Charity (MEC) to support the development of a grant application support service for ophthalmology research (GASSO). GASSO will include experts that together can provide all-round support and training to early career researchers in ophthalmology, supporting them to begin or grow their research careers and enabling an increase the number of investigator-led studies and development

awards. The funding from MEC is to fully support a trial methodologist and part fund a director of clinical trials and statistics for two years.
We have been improving the Research Opportunities at Moorfields (ROAM) platform, developing the next version of the application based on stakeholder feedback. ROAM increases the visibility of research activities to patients; records consent to contact and allows us to understand representativeness of those who interact with the platform to inform patient engagement and involvement activities. In 2025/26, 481 patients were registered onto the ROAM platform, taking the total number of registrants to 4,171.
We have been reviewing and refreshing our governance, in order to clarify the support structures for research delivery and quality management.

Funding applications

We were successful in three investigator-initiated trial funded by Alcon and one investigator-initiated trial funded by Bayer. These trials will be exploring (i) Direct Selective Laser Trabeculoplasty (DSLT) as a treatment option to reduce intraocular pressure (IOP) in eyes with ocular hypertension (Alcon x2), (ii) two intraocular lens and their efficacy and patient experience when prescribed in patients with bilateral age-related cataract, and (iii) clinical outcomes of patients with polypoidal choroidal vasculopathy in neovascular age-related macular degeneration receiving intravitreal aflibercept 8mg injections.
We were also awarded one NIHR project grant and three charity funded grants in the last financial year. The NIHR EME funded grant will recruit 250 patients with proliferative diabetic retinopathy over 25 sites from across the UK onto a study that will compare efficacy and safety of rapid surgical intervention for patients with retinal bleeds to the current standard of care where surgical intervention is offered as a last resort. The charity funded grants (supported by EUROQOL, Glaucoma UK and EURETINA) are supporting data driven projects that are (i) investigating psychometric performance of the EQ-5D-5L and the vision bolt-on dimensions of the quality of life measurement instruments in a population with diabetes in India using the SMART-India dataset (EUROQOL), (ii) development of virtual models (digital twins) of glaucoma patients to provide personalised predictions of disease progression and treatments (fellowship from Glaucoma UK) and (iii) development of an AI pipeline for the automated detection and quantification of Retinal Ischemic Perivascular Lesions (RIPL) on OCT scans, and to investigate the role of RIPL as a non-invasive biomarker for systemic CVD risk (EURETINA).
One Moorfields employee was also awarded the NIHR Senior Clinical Practitioner Research Award which provides funding to develop their research career. The awardee plans to use this

funding to establish a collaborative research programme leveraging the award-winning NHS England Eyecare Accelerator service in London. Using this innovative, live service as a research platform, the awardee aims to address critical under-represented questions, including patient choice, healthcare inequalities, and the clinical and economic outcomes of community-delivered pathways.
Lastly, INSIGHT was successful in their bid to MRC to develop the next phase of their research hub, which will see the team enhance and expand INSIGHT to encompass a wider range of NHS trusts and datasets thereby transforming it into a national ophthalmic bioresource.

Equality and diversity

Two large national bioresource genomic studies closed at the end of September. These have been replaced by the Improving Black Health Outcomes (IBHO) national multicentre Bioresource study, which is now opening with the Moorfields target of over 500 and a national target of 5,000. Our expanded skilled genetics recruitment team means that we are well placed to recruit to IBHO and other studies. We are now collaborating with the St George's clinical resource facility (CRF) in delivering trials there. A study to explore methods of improving the consenting process of cataract surgery for non-English speaking patients recently opened at Moorfields at Stratford.

Quality review

During 2025/2026, the quality management system continued to be improved with the introduction of one new standard operating procedure (SOP) and 5 new templates. Standard two-year reviews of 25 SOPs were conducted and in addition to these standard reviews, 8 SOPs were updated to align with new regulatory guidance or to refer to the new templates.
As per the internal audit schedule agreed by the quality review group, two internal audits were carried out. No critical findings were identified. Corrective and preventative action (CAPA) plans are developed by the auditees following each audit to ensure the audit findings are appropriately addressed. Effectiveness checks may now be carried out to provide further assurance the implemented preventative actions have been successful. The final effectiveness check in a series assessing changes to the study amendments process was completed in January 2026.
Quality reviews of study documents within the electronic trial master file (eTMF) platform have been implemented, initially focussing on two regulated studies. To date, four reviews have been carried out. Corrective actions are completed by the study and R&D support teams.

Preventative actions will be considered at a portfolio level to ensure they are applied more widely and applicable SOPs and templates updated accordingly.

Three external audits were hosted by the Clinical Research Facility. No critical findings were identified. The CAPA plans addressing the findings were accepted as satisfactory by the sponsors.

Notifications about potential FDA site inspections were received from three commercial sponsors. Two of the sponsors conducted their external audit to help the study team prepare for a potential inspection. The FDA has not yet contacted the Principal Investigator for any of the three studies, and the potential risk of inspection for these studies remains.

There were no serious breaches identified across the Moorfields-sponsored portfolio. One serious breach on a non-regulated study hosted at Moorfields was reported by the sponsor to the Research Ethics Committee (REC). The CAPA plan for the breach has been agreed with the sponsor.

The safety reporting compliance reports received from the pharmacovigilance (PV) team confirm all reports were submitted to the regulatory authorities and REC with the required timeframes.

Work has continued to decommission the Moorfields cells for sight facility based at UCL Institute of Ophthalmology. The cells for sight team, R&D and Moorfields eye bank have worked together to ensure the smooth transition of the records to Moorfields.

Commissioning for quality and innovation (CQUIN) framework

CQUINs have been removed from the requirements in 2025/26 and are not part of the contractual process.

Registration with the Care Quality Commission (CQC)

The trust must be registered with the CQC and is currently registered without conditions. The CQC has not taken any enforcement action against the trust in 2025/26, nor at any time previously.

The trust has not been inspected by the CQC since its inspection of Moorfields Private Eye Centre (MPEC) in September 2023 (an overall rating of ‘Good’ was achieved). The trust meets regularly with the CQC to share news and progress and to answer any questions the CQC might have.

A major piece of work for 2026/27 will be the registration of the Moorfields and UCL Centre for Eye Health (formally Oriel) site.

Information governance

Information governance (IG) includes records management, data security, confidentiality, data sharing, freedom of information, and transparency. We have supported the work on the deployment of the electronic patient record, the move of City Road, and IT transformation. We led on work with ICS partners by facilitating development of processes that rely on multiple electronic systems and paper records to process data along complex patient journeys where the trust is one of many providers. Engagement with patients and the public continues to be delivered as a core IG activity to meet the trust's duty to be transparent. We worked with patient representatives on the public and patient experience committee (PPEC) to review practice around managing data and acted on feedback to improve the accessibility of information about data.

Further work to support prospective researchers and innovators has been undertaken internally to support moves to simplify process and reduce duplication and complexity. This work included engaging external partners on ideas to improve approach and understanding of process.

The volume of work generated by the increasing rate of digitisation, and ongoing support, has been reviewed with internal stakeholders and has led to improvements in workflows. The trust is supporting its IG team members with their own personal and professional development by ensuring there is protected time for professional development and training with peers at London level.

The CQC is clear that safety of patient data is a patient safety matter. The data security and protection elements of information governance are driven by standards set down in the NHS operating framework as measured by compliance with the data security and protection toolkit (DSPT). Last year, the Trust exceeded NHSE's expectations in several areas due to improvements IG made to systems, processes, and infrastructure; this put the Trust in a stronger position to address the threat landscape.

The IG team continues to contribute to the success of the Trust by ensuring that the IG function is fit to deliver the Trust's ambition. The scope of IG work continued to expand to meet the challenges of AI and new technology, and additional funding was secured to expand capacity. A refreshed approach to the management of risk at Trust level has resulted in better internal alignment and visibility for IG risks.

Data quality & audit

Moorfields submitted records during 2025/26 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data (April 2025 to

January 2026). The percentages of records in the published data, which included the patient's valid NHS number, were:

- 99.9% for admitted patient case
- 100% for outpatient care
- 98.1% for accident and emergency care.

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

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

In 2025/26, the trust has not been subject to the data quality and performance management audit.

There have been no other external audits conducted which have included recommendations regarding data quality related issues, during 2025/26.

We have continued to hold the amalgamated information management and data quality working group (IMDQG) to ensure a better constructive interaction between the two related issues. This group continues to meet every two months and discusses core data quality areas, including audit results. A data quality working group is also fully implemented and continues to meet bi-monthly and feed back into this group and other trust forums. Evidence of data quality will continue to be provided for the trust DSPT submissions.

Clinical coding

Moorfields was subject to the annual clinical coding audit as part of the data security and protection toolkit (DSPT) during January 2026. The aim of this audit was to improve the data quality of clinical record coding, which underpins hospital management and planning, commissioning of services for the population, clinical research, and financial flows. The audit's objectives are to evaluate the accuracy and completeness of coded clinical data against patient case notes, or electronic patient records (EPR) and the impact of data collection procedures which underpin the coding process. This helps sustain high standards of reliable clinical information and target improvements where required.

The final report indicated an excellent standard of primary and secondary diagnosis and procedure coding. The accuracy rates published in the audit report were:

Table 22 - Clinical coding

Audit year	Diagnosis		Procedure	
	Primary	Secondary	Primary	Secondary
DSPT Audit 25/26	100%	98.3%	100%	99.7%
DSPT Audit 24/25	99.5%	98.4%	100%	99.5%
DSPT Audit 23/24	100%	99.5%	100%	99.7%
DSPT Audit 22/23	98.%	99.4%	99%	99.9%

The overall findings of the audit demonstrated an excellent standard of clinical coding, with the trust attaining the necessary percentages to pass the standards exceeded level as outlined in data security standard 1. The trust was commended in achieving a very high level of accuracy in both primary and secondary diagnosis and procedure coding.

The percentages of overall coding accuracy are much higher than national averages and the trust is proud of demonstrating a keen interest towards improving and maintaining coding data quality.

Below are the key recommendations made from these audits:

- Continue collaboration with clinical divisions, administrative leads and relevant software teams to work towards streamlining, and improving the accuracy and relevancy of, comorbidity documentation
- Collaborate with clinicians across all trust sites to ensure that the information contained within operation notes is as uniform across all sites and detailed as possible, particularly in relation to anterior and posterior capsulorhexis procedures in City Road, North and St George's.
- Provide guidance to clinical coders, or training where necessary, emphasising the need to search all documentation within the timeframe of the inpatient spell, capturing all mandatory and relevant comorbidities, all procedures and any other influencing factors

Health inequalities

The second annual report on healthcare inequalities in the delivery of the trust's high-volume activity was received by the quality and safety committee on 17 March 2026. Routine performance indicators of activity are reported by age, deprivation, ethnicity, clinical risk and need, to identify any variations in access and uptake of services; highlighting areas for deeper scrutiny to inform actionable change where any variations are found to be unwarranted (indicating inequality).

The underlying data are accessible to teams on the QlikSense platform to support service level reviews and planning, and to inform programmes of work and health impact and quality assessments.

Key findings

- The findings remain positive, continue to challenge some assumptions around inequalities; raise issues that would have been masked by routine performance reporting alone; and provide further value of the quality of services delivered by Moorfields.
- Demographic factors are not key drivers for variations in access and uptake of our services but how we do things – our practice & pathways (clinical) and our processes (operational and administrative), i.e. how we provide, organise, deliver & record them.
- Cancellations of booked out-patient appointments by patients or by the hospital consistently occur more frequently than Did Not Attends (DNA), so reporting DNA outcomes alone will significantly underestimate Non-Attendance outcomes i.e. both uptake and access of booked out-patient appointments.
- Variations reported for access and uptake of services by clinical risk and need call for deeper scrutiny and monitoring as changes to service organisation and delivery are implemented and embedded.
- Data quality issues persist for ethnicity data and recording of out-patient appointment outcomes.
- The feasibility and utility of routine annual reporting on healthcare inequalities in the delivery of trust services has been established but requires continued focus to embed.

Recommendations

Take forward the proposed deep dives / clinical audits to:

- better understand any underlying issues contributing to the variations observed from this high-level reporting
- inform action on any variations subsequently found to be unwarranted.

Improve data quality by

- standardising staff training, processes and systems for data collection and quality assurance: ethnicity, appointment outcomes etc.
- providing patient information on why their personal data is collected and how it is used to mitigate their hesitancy / uncertainty for providing it.

Mainstream annual healthcare inequalities reporting to -

- Monitor and review:
  - emerging trends in healthcare variations (potential inequalities) in trust activity
  - impact of clinical and administrative changes in service organisation and delivery.
- Meet statutory and policy requirements of NHS organisations and provide demonstrable evidence of the trust's core value of equity.

Assign dedicated analytical capacity and oversight for annual analyses and reporting of healthcare inequalities metrics, and maintenance of the QlikSense dashboard.

Part 4: Priorities and indictors for 2026/27

4.1 Priorities for improvement in 2026/27

The development of this quality account has been led by the director of quality and safety, working closely with the trust's executive quality and safety leads, including the chief nurse and director of allied health professionals and the medical director, with input from the chief operating officer.

The Trust's organisational strategy was launched in 2023/24, and over the subsequent five years our vision will be delivered through the transformation portfolio, which provides the framework for delivering strategic priorities and improvement activity.

The 2026/27 quality priorities have been informed by a comprehensive process of staff and patient engagement. This included discussions at the central quality forum and the clinical governance committee (CGC), alongside patient and staff feedback gathered during Safer September. The development process also incorporated staff engagement events, patient representative sessions, business planning discussions, and consideration at a range of Trust committees. The resulting priorities are aligned with the Trust's strategic objectives and will be delivered using quality improvement methodologies, with clear, measurable and SMART objectives to support effective monitoring of progress.

The proposed priorities were presented to and reviewed by the clinical governance committee, the quality and safety committee, and trust management committee (TEC). In addition, our host commissioners, NHS Islington CCG, and Healthwatch Islington reviewed the quality account priorities for 2026/27 and confirmed their support.

Moorfields sets out its quality priorities under the three established Darzi domains: patient safety, patient experience, and clinical effectiveness. Oversight of progress against these priorities will be provided through the relevant programme boards and governance committees.

The quality and safety committee, on behalf of the board, is responsible for overseeing the development and delivery of the quality account and the associated quality priorities. The committee has reviewed this quality account and confirmed that it presents a balanced and accurate reflection of the trust's priorities across patient safety, patient experience and clinical effectiveness. The tables below set out the agreed priorities, the drivers for change, and the arrangements in place for monitoring improvement.

Table 23 – 2026/27 quality priorities: drivers

Darzi Heading	Quality Aim Statement	Division (inc. business planning)	Safer September (Patients/Staff)	Incident priority (PSRIF)	Staff	Risk	Incidents / Complaints
Safe	We will integrate the learning from our PSIRF learning and improvement responses, incidents, audits, PALs and complaints into a unified quality management learning system (QMLS). Our QMLS will drive continuous improvement, strengthen proactive risk management, and promote a consistent organisational and learning culture.	x	x	x	x	x	x
	We will embed a restorative and just culture supported through application of the 'being fair' tool, so that staff feel safe to speak up, supported after incidents, and treated fairly, enabling higher engagement, wellbeing and safer patient care.	x	x	x	x	x	x
Patient experience	We will continue to implement and utilise the Patient Experience Framework to drive meaningful improvements in patient experience, and care and treatment.	x	x		x	x	x
	Strengthen the complaints and PALS service to ensure a responsive, high-quality, patient-centred service focussed on good customer experience and service improvements.						
	Strengthen communication with patients across digital, telephone and written communication channels, supported by improved administrative and operational processes.	x	x	x	x	x	x
Effectiveness	We will drive performance and operational standardisation across clinical and administrative pathways (including GIRFT and NHS IMPACT improvement principles) to reduce unwarranted variation and drive transformation.	x	x	x	x	x	x

Table 24 - 2026/27 quality priorities: descriptions

Darzi Heading	Quality Aim Statement	Rationale	KPIs / Outcome measures
Safe	We will integrate the learning from our PSIRF learning and improvement responses, incidents, audits, PALs and complaints into a unified quality management learning system (QMLS). Our QMLS will drive continuous improvement, strengthen proactive risk management, and promote a consistent organisational and learning culture.	Integrating learning from incidents, complaints, audits, and quality metrics enables earlier and more effective identification of trends and system-level insights. Using a systems-thinking approach shifts the focus from isolated person-focussed events to the wider factors that shape outcomes, thereby strengthening proactive risk management and supporting a culture of learning and improvement. A unified framework ensures that improvements identified through learning responses lead to changes that are measurable, sustained, and aligned with trust and national patient-safety priorities.	Number of improvement workstreams and projects integrated into the trust's QMLS
			Plan on a plan and systems supportive documents
			% of improvement projects linked to learning from incidents, PALS, complaints, audits and risk reviews
			% of directorates and divisions using the unified learning and improvement approach
			Number of local improvement projects logged and utilising continuous improvement (CI) methodologies
			Audit of safety huddles and other QMLS processes
	We will embed a restorative and just culture supported through application of the 'being fair' tool, so that staff feel safe to speak up, supported after incidents, and treated fairly, enabling higher engagement, wellbeing and safer patient care.	A restorative and just culture creates the conditions for staff to speak up without fear of blame and to learn meaningfully from incidents. It focuses on restoration and healing after something goes wrong, recognising that people and systems are interconnected. This strengthens psychological safety, improves staff retention and engagement, and supports safer, more reliable care. It also aligns with PSIRF expectations and national workforce priorities, ensuring that we respond to incidents in a fair, transparent and compassionate way.	Staff Survey "I feel safe to speak up" and "I am treated fairly when errors occur" scores.
			Number of policies reviewed and amended to reflect restorative and fair-culture principles
			% of ER cases involving a patient safety incident where a learning response led to a non-disciplinary outcome
			Staff retention and sickness rates
			Staff survey outcomes following being involved in incident
Patient experience	We will continue to implement and utilise the Patient Experience Framework to drive	This includes increasing patient engagement and involvement activity; ensuring that patient feedback mechanisms are robust, efficient and accessible;	Patient Experience Framework (per clinical area) Friends & Family Test (FFT) response rate and % positive recommendation. Staff are aware of the feedback patients

Darzi Heading	Quality Aim Statement	Rationale	KPIs / Outcome measures
	meaningful improvements in patient experience, and care and treatment.	ensuring that all activities are linked to improvement pathways which enhance processes, patient experience and ensures we see the whole person through the patient experience principles. This also is recognised in the NHS 10- year Plan. We want to increase patient and satisfaction levels, ensure services are delivered to meet the needs of the population, and empower staff to understand what matters to our patients.	are providing and discuss FFT results and themes across team meetings to inform improvements
	Strengthen the complaints and PALS service to ensure a responsive, high-quality, patient-centred service focussed on good customer experience and service improvements.	Processes will be reviewed and improved and linked to activities to improve the patient experience and/or care and treatment.	% of complaints responded to within national and Trust timeframes % of PALS acknowledged within 3 days (local standard). Number of learning actions from complaints and PALS completed each quarter.
	Strengthen communication with patients across digital, telephone and written communication channels, supported by improved administrative and operational processes.	We know through our analysis of patient and staff feedback that one of the most common areas of concern across the organisation is how we communicate with our patients. Improving clarity, timeliness, and accessibility of communication reduces anxiety, minimises PALS concerns and improves flow through services. It also reduces the burden on administration teams and call handling. A transformation programme will provide standardisation, reduce administrative variation, support efficiency, and improve the overall patient journey.	Number of calls Call abandonment rate Reduction in communication-related complaints Improvement in Accessible Information Standard (AIS) audit results
Effectiveness	We will drive performance and operational standardisation across clinical and administrative pathways (including GIRFT	Consistent processes and pathways improve equity, reliability, and efficiency, helping staff deliver care to expected standards. Learning from incidents and	Variation-reduction measures (e.g., consistency in waiting times, theatre utilisation, clinic flow) % of clinics meeting agreed productivity and flow standards

Darzi Heading	Quality Aim Statement	Rationale	KPIs / Outcome measures
	and NHS IMPACT improvement principles) to reduce unwarranted variation and drive transformation.	audits shows variation in some workstreams, such as theatre scheduling and failsafing, where standardisation would strengthen safety and efficiency. Standardisation, with clear, supportive standards and processes, also strengthens governance, supports training, enables benchmarking, and, using GIRFT and NHS IMPACT principles, enhances operational resilience and patient flow.	Staff adherence to standardised administrative processes - audit

4.2 Key indicators for 2026/27

Moorfields monitors quality through a wide range of standards and indicators, many of which support delivery of the quality priorities. These are all areas where we seek quality improvement to increase the benefits to our patients, either by improving experiences directly or by making processes more efficient and less onerous for staff and patients.

The trust is currently undertaking a review of our integrated performance report (IPR) which is produced each month and review internally, and every two months is taken to the trust Board. A provisional list of KPIs (key performance indicators) we are focusing on in 2026/27 can be seen in the following tables, many of which have been carried forward from previous years, however we expect this to change over the next financial year for several reasons, including the changing reporting requirements at both national (DHSC, NHS England and the national oversight Framework guidance) and local level (ICB), and as the trust's strategic programmes continue to evolve.

While internal and external influence will determine what we report, the balance between operational activity, patient safety, and patient experience has and will continue to be maintained.

As with previous years, the board updated the document to report key performance indicator results using NHS England recommended 'Making Data Count' statistical process control (SPC) charts methodology.

Table 25 - Provisional 2026/27 key indicators

INDICATOR	2023/24 results	2024/25 results	2025/26 target	2025/26 results	2026/27 target
National Oversight Framework Metrics (Monthly Metrics Used for Segmentation Scoring)					
% 52 Week RTT Incomplete Breaches (end of year position)	0.03%	0.05%	≤ 1.00%	0.03%	≤ 1.00%
18 Week RTT Incomplete Performance (end of year position)	83.3%	83.1%	≥ 87.6%	85.8%	≥ 88.6% at Year End (Monthly Trajectory towards this)
Difference Between Planned and Actual 18 week Performance (end of year position)	n/a	n/a	≥ 0%	-1.8%	≥ 0%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	98.6%	98.0%	≥ 95%	97.3%	≥ 95%
% A&E Waits Over Twelve Hours	0.0%	0.0%	n/a	0.0%	No Breaches
Average Days Between DRD and Discharge Date	0	0	n/a	0	0
Planned surplus/deficit	3.4	5.4	n/a	0	n/a
Variance year-to-date to financial plan	8.42	-1.27	≥ 0	6.64	≥ 0
MRSA (rate per 100,000 bed days)	0	0	0	0	0
Clostridium difficile year on year reduction	0	0	0	0	0

Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	0	0	0	0	0
Staff Sickness (Rolling Annual Figure)	4.5%	4.8%	≤ 4%	5.0%	≤ 4%
National Indicators					
Reduction of over 18-week pathways (end of year position)	5,962	5,594	Reduction in line with 18- week trajectory	5,345	Reduction in line with 18- week trajectory
52 Week RTT Incomplete Breaches (full year)	144	118	0	262	54 (Full Year) 2 at Year End
% of RTT Patients Waiting For a First Appointment (end of year position)	n/a	85.3%	No target set	90.2%	≥ 88.0%
Cancer 28 Day Faster Diagnosis Standard	92.3%	80.5%	≥ 80%	82.3%*	≥ 80%
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat	100%	98.2%	≥ 96%	97.8%*	≥ 96%
% Patients With All Cancers Treated Within 62 Days	98.4%	98.5%	≥ 85%	97.3%*	≥ 85%
Theatre Utilisation (model hospital)	88.7%	90.5%	No target set	92.9%	No target set
Average Length of Stay (ALOS) – non-elective (1+ Days)	n/a	n/a	No target set	0.6	No target set
Cataract Cases Per Four Hour Theatre List	5.7	5.7	≥ 8	5.8	≥ 8
Theatre cancellation rate (non-medical cancellations)	1.05%	0.88%	≤ 0.8%	1.25%	≤ 0.8%

Number of non-medical cancelled operations not treated within 28 days	23	10	0	28	0
DNA Rate (first outpatients)	13.1%	13.0%	≤ 9.4%	12.9%	≤ 9.4%
DNA Rate (follow up outpatients)	11.3%	10.8%	≤ 8.1%	9.7%	≤ 8.1%
Summary Hospital Mortality Indicator	0	0	0	0	0
Mixed Sex Accommodation Breaches	0	0	0	0	0
% Discharged on Discharge Ready Date (DRD)	n/a	n/a	No target set	0	No Target Set
Duty of Candour (% Conversation informing family/carer occurred within 10 working days)	83.5%	68.8%	100%	74.6%	No Breaches
Freedom of Information Requests Responded to Within 20 Days	65.6%	87.2	≥ 90%	82.6%	≥ 90%
Inpatient Scores from Friends and Family Test - % Response Rate	40.8%	38.8%	≥ 30%	38.9%	≥ 30%
A&E Scores from Friends and Family Test - % Response Rate	38.3%	37.5%	≥ 20%	31.5%	≥ 20%
Outpatient Scores from Friends and Family Test - % Response Rate	34.3%	35.0%	≥ 15%	32.6%	≥ 15%
Risk assessment of hospital-related venous thromboembolism (VTE)	98.6%	99.5%	≥ 95%	99.0%	≥ 95%
Occurrence of any Never events	2	2	0	1	0

Proportion of Temporary Staff	15.5%	12.3%	Reduction in Temp Staffing	8.0%	Reduction in Temp Staffing
Maximum 6 week wait for diagnostic procedures	99.4%	99.1%	≥ 99%	99.2%	≥ 99%
Local Indicators					
Total pathways RTT Waiting List (pathways as at end of year)	35,656	33,136	Reduction in line with 18- week trajectory	34,886	Reduction in line with 18- week trajectory
Theatre Utilisation (Moorfields definition)	61.4%	63.1%	≥ 85%	65.1%	≥ 85%
Average Call Waiting Time	131 Sec	162 sec	≤120 Sec	209 sec	≤120 Sec
Call abandonment rate	9.8%	12.1%	≤ 15%	13.5%	≤ 15%
Outpatient Cancellation Rate (hospital cancellations)	3.72%	5.71%	No target set	5.20%	No target set
Outpatient Rebooking Rate (hospital cancellations)	14.8%	11.9%	No target set	6.2%	No target set
Median Outpatient Journey Times - Non-Diagnostic Face to Face Appointments (wait at year end)	97 Mins	97 mins	No set target	102 mins	No target set
Median Outpatient Journey Times - Diagnostic Face to Face Appointments (wait at year end)	45 Mins	43 mins	No set target	30 mins	No target set
Percentage of responses to written complaints sent within 25 days	88.6%	62.1%	≥ 80%	44.0%	≥80%

Percentage of responses to written complaints acknowledged within 3 days	97.3%	76.6%	≥80%	77.9%	≥80%
National Patient Safety Alerts (NatPSAs) breached	2	0	0	**0**	No Breaches
Total patient recruitment to NIHR portfolio adopted studies	211 avg per Month 2,532 total year)	383 avg per month (4,208 Apr-Feb)	≥ 115 Per Month	233 avg per month (2,802)	≥ 115 Per Month
Frequency of any Never events (days since last)	n/a	n/a	n/a	n/a	Monitoring for Frequency Changes
Endophthalmitis Rates	n/a	n/a	n/a	tbc	Monitoring if Rates by Operation Type show risk
Unexpected Moorfields Admission Following Surgery	n/a	n/a	n/a	tbc	TBC, metric in development
Staff Turnover Rate (all staff)	n/a	n/a	n/a	tbc	≤ 10%
Statutory Mandatory Training	n/a	n/a	n/a	tbc	≥ 80%
% Outpatient attendances that were performed remotely	n/a	n/a	n/a	tbc	Target to be Confirmed
% PIFU of Total Outpatient Attendances	n/a	n/a	n/a	tbc	Target to be Confirmed
Safer Staffing - Inpatient (overnight) Ward Fill Rate	n/a	n/a	n/a	tbc	≥ 90%

Freedom To Speak Up (FTSU)	n/a	n/a	n/a	tbc	Metric to be Confirmed
% of NIHR Portfolio Clinical Research Studies Set Up in Time (90 day component)	n/a	n/a	n/a	tbc	TBC, metric in development
Average Time Taken to Set Up NIHR Portfolio Clinical Research Studies (90 day component)	n/a	n/a	n/a	tbc	TBC, metric in development
% implementation of NICE guidance	94.5%	94.8%	≥ 95%	96.4%	≥ 95%
Number of registered and ongoing clinical audits past their target deadline date	33.5% (78/233)	13.2% (41/311)	≤ 20%	21% (71/338)	≤ 20%

Part 5: Other information

Statement from North Central London Integrated Care Board

NHS
West and North London

11 June 2026

West and North London ICB
15 Marylebone Road
London
NW1 5JD
0203 198 9743

NHS North West and North London Integrated Care Board Statement
Moorfields Eye Hospital NHS Foundation Trust

North Central London Integrated Care Board (NCL ICB) has worked closely with Moorfields Eye Hospital NHS Foundation Trust (MEH) throughout 2025/26 and welcome the opportunity to provide this commissioner statement as the newly formed West and North London ICB. As the lead commissioner, the ICB works closely with Moorfields to ensure the delivery of safe, high-quality care to our local population and wider community.

The ICB commends the Trust's Electrophysiology department for achieving the national Improving Quality in Physiological Services (IQIPS) accreditation, reflecting its adherence to the highest safety and quality standards.

The Trust continues to strengthen its digital infrastructure, expanding the rollout and integration of its Electronic Patient Record (EPR) system.

The Patient Safety Incident Response Framework (PSIRF) has been embedded, strengthening the Trusts learning culture and supporting a proactive approach to safety.

Despite these achievements we recognise the systemic pressures experienced by the Trust, through high volumes of patients attending A&E, rising numbers of referrals have impacted on meeting the national targets on waiting times.

We are supportive of the quality priorities for 2026/27, embedding the People Strategy and the anticipated opening of the Oriel Centre in Camden in 2027.

We are satisfied that this Quality Account provides a fair and balanced reflection of the quality of care provided by the Trust and look forward to working with you as a collaborative partner throughout the coming year.

Yours sincerely

Jennifer Roye
Chief Nurse Officer
NHS West and North London

Statement from Healthwatch Islington

Healthwatch Islington have received a copy of the document but have been unable to review it on this occasion.

Appendix 1: Glossary

A&E	Our **accident and emergency** team offers A&E treatment for urgent, sight-threatening problems and issues that cannot wait for a routine appointment with a GP.
AAR	An **after-action review** is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
AIS	**Accessible Information Standard** is a legal right of patients to be supported and empowered in their care by accessible information
BAU	**Business as usual** is the usual operations of the Trust
CAEC	The **clinical audit and effectiveness committee** meets bi-monthly to discuss progress of the clinical audit and effectiveness programme across the trust.
CGC	The **clinical governance committee** meets bi-monthly to discuss and present a variety of governance, clinical risk, and quality related topics.
CoO	The **College of Optometrists** is the professional, scientific and examining body for optometry in the United Kingdom
CQC	The **Care Quality Commission** is the health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for quality and innovation** is a payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in high quality care for all (the NHS next stage review report) of an NHS where quality is the organising principle.
CRF	Since 2007, the NIHR Moorfields **Clinical Research Facility** has pioneered the translation of laboratory discoveries for the benefit of patients with eye conditions.
CVI	**Certificates of Visual Impairment** are official documents issued to individuals with significant sight loss.
Deep Dive	A **deep dive** is a detailed analysis, investigation, or examination of a topic.
DHSC	The **Department of Health and Social Care** is a ministerial department of the Government of the United Kingdom. It is responsible for government policy on health and adult social care matters in England, and oversees the English National Health Service (NHS)
DNA	Where a patient **Did Not Attend** an appointment of admission. Was Not Brought (WNB) / Could Not Attend (CNA) / Refusal to attend for appointments or admission are connected
DoC	**Duty of Candour** is open, honest and transparent communication with patients, their families and carers following a patient safety event.
DoLS	**Deprivation of Liberty Safeguards** ensures people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty.

	Arrangements are assessed to check they are necessary and, in the person's, best interests.
DSPT	The **Data Security and Protection Toolkit** is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.
ECLO	**Eye clinic liaison officers** provide advice and information about services outside the hospital for patients living with sight loss. ECLOs are available to offer emotional support and practical advice to all patients at Moorfields, their families and carers.
EDI	**Equality, diversity, and inclusion**: the trust is committed to providing an environment where people feel valued, included and empowered and where intolerance and discrimination in all its forms is eliminated.
EPR	An **electronic patient record** system is a digital platform that brings all patient information, from medical history to results of investigations and medications prescribed, together in one place.
FFT	The **Friends and Family Test** aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.
FoI	The **freedom of information** Act 2000 provides a right of access to a wide range of information held by public authorities, including the NHS.
FTSU	**Freedom to speak up** is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon.
GIRFT	**Getting It Right First Time** is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.
ICB	**Integrated Care Boards** are NHS organisations responsible for planning health services for their local population.
IMDQG	The **information management and data quality working group** oversees the validation of the standards and integrity of the information management processes, ensures the trust adheres to external NHS information and data standards and provides governance and assurance of an appropriate level of data quality across the trust.
IPR	The **integrated performance report** highlights a series of metrics regarded as Key Indicators of Trust Performance and covers a variety of organisational activities within several directorates including Operations, Quality and Safety, Workforce, Finance and Research.
IRG	The **incident review group** is the forum where incidents which potentially fulfil our criteria as a local or national priority are reviewed and actioned accordingly.
KPI	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organisation or of a particular activity in which it engages.

LED	**Locally employed doctors** are employed by trusts on local terms and conditions, so they are usually non-permanent posts and do not have nationally agreed terms and conditions.
LFPSE	The **learn from patient safety events** service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare.
LIFE	**Learning and improvement following events**: Sharing learning following an incident, complaint, claim or other event is essential to create a culture in which workers feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or affects their experience in the workplace.
MAST	**Mandatory and statutory training:** statutory training is required by law, and mandatory training is determined by the organisation based on local risk assessments and training needs analysis.
ME	**Medical examiners** are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.
MECC	**Make Every Contact Count** enables the delivery of consistent and concise health and wellbeing information and encourages individuals to engage in conversations about their health at scale across organisations and populations.
MEH	**Moorfields Eye Hospital** NHS Foundation Trust.
MRI	**Magnetic resonance imaging** is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
NatPSA	**National patient safety alerts** are notices from NHS England that share information about risks that can cause serious harm or death. They set out what health or care organisations need to do to reduce the risk.
NCP	**New Citizenship Project** is an external partner, to work with the patient experience team to develop Patient Experience Principles.
NE	**Never events** are patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
NEI	**National Eye Institute** funded by the United States Federal Government is the largest funder of ophthalmic research in the world.
NHSBT	**NHS Blood and Transplant** is responsible for the supply of blood, organs, tissues and stem cells. It collects and supplies blood to hospitals in England and is the organ donation organisation for the UK.
NHSE	**NHS England** leads the NHS in England.
NICE	**National Institute for Health and Care Excellence**: a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money.

NIHR	The **National Institute of Health Research** funds research into the most important research questions in ophthalmology .
NIHR	The **National Institute for Health and Care Research** is the major funder of clinical, public health, social care and translational research.
NOD	The **National Ophthalmology Database** collects data on cataract surgery performed in England and Wales and provides individual surgeons, healthcare providers and the public with benchmarked reports on performance, with the aim of improving the care provided to patients.
NOK	**Next of kin** refers to a person's closest living relative(s).
NOF	The **National Oversight Framework** is a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England and DHSC works with systems and providers to support improvement.
NRLS	The **National Reporting and Learning System** is designed to collect information on safety incidents to enable analysis and generate learning to improve the state of care.
OpenEyes	**OpenEyes** is Moorfield's electronic heath record system.
Oriel	A joint project between Moorfields Eye Hospital, UCL and Moorfields Eye Charity. **Oriel** is our new centre for eye care, research and education.
OWL	The **outpatient waiting list** is a virtual waiting list for patients who require a follow-up appointment more than six weeks ahead of their last appointment.
PALS	The **Patient Advice and Liaison Service** offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
PEP	The **patient engagement portal** (DrDoctor)improves and increase the speed and efficiency by which the trust and patients can communicate with each other with regards to specific administrative and clinical functions.
PIFU	**Patient initiated follow-ups** allows selected/suitable patients with stable or low risk conditions that can be self-monitored, to initiate follow-up attendances within agreed timescales.
PLACE	This is the **patient led assessment of care environment.**
PPRG	The **policy and procedure review group** has governance oversight for all the trust's policies and procedural documents (such as clinical guidelines and standard operating procedures).
PROM	**Patient-reported outcome measures** are used to assess the quality of healthcare experiences, focusing on patients. These measures help the trust make informed changes to their services.
PSI	**Patient safety incidents** are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare.

PSII	**Patient safety incident investigations** are undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
PSIRF	**Patient safety incident response framework** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
PSIRP	The **patient safety incident response plan** sets out how the Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of the work to continually improve the quality and safety of the care provided.
PTL	A **patient tracking list** is an established, forward-looking, management tool that can be used by the NHS to help achieve and sustain short Referral to Treatment and diagnostic waits.
QSC	The **quality and safety committee** is a formal committee of the board and provides assurance on matters concerning quality, health and safety.
RCO	The **Royal College of Ophthalmologists** is an independent professional body who set the standards and examinations for ophthalmologists, and provide surgical skills training, as well as services to those who have completed their training.
RCoA	The **Royal College of Anaesthetists** is the professional body responsible for the specialty of anaesthesia throughout the United Kingdom.
RNIB	The **Royal National Institute of Blind People** is a UK charity that offers information, support and advice to people in the UK with sight loss.
RSC	The **risk and safety committee** has responsibility for ensuring that risk management policy, systems and process are in place across the organisation.
RTT	**Referral to Treatment**: the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
SAR	Data protection legislation gives individuals the right to request access to personal data held on them by organisations. This is known as a **subject access request**
SBAR	This stands for **Situation Background Assessment Recommendation**, and is a key element of the incident review process
SDMC	The **shared decision-making council** is part of the joint process in which healthcare professionals work together with patients and people to reach a decision.
SI	**Serious incidents** include acts or omissions in care that result in unexpected or avoidable death or injury resulting in serious harm - including those where. the injury required treatment to prevent death or serious harm.
SPC	NHS England recommended 'Making Data Count' **statistical process control** charts methodology.
TCS	**Terms and conditions of service** for NHS doctors and dentists in training (England) 2016

Tendable	**Tendable** is a smart inspection application (app) that replaces the manual pen and paper aspects of collecting data assessing outcomes and improving quality for audits and inspections across clinical areas.
UCLH	**University College London Hospitals** NHS Foundation Trust comprises University College Hospital, University College Hospital at Westmoreland Street, the UCH Macmillan Cancer Centre, the Royal National ENT and Eastman Dental Hospitals, the Hospital for Tropical Diseases, the National Hospital for Neurology and Neurosurgery, the Royal London Hospital for Integrated Medicine, and the Royal National Throat, Nose and Ear Hospital.
VLAG	The **vision loss advisory group** is a key patient participation group.