Our commitment to quality excellence

Quality Account 2023/24

(includes Quality priorities for 2024/25)

FINAL v1.0

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Part 1: Statement on quality

1.1. Statement on quality from the chief executive

As I reflect on the progress and achievements at Moorfields over the past year, I'm proud to say that our commitment to ensuring our patients reliably experience high quality care in accordance with our values of excellence, equity and kindness has remained steadfast.

Safety remains paramount, and we've taken significant strides in the development of our Patient Safety Incident Response Framework (PSIRF) policy and plan. This framework underscores our dedication to learning, continuous improvement, and compassionate engagement with both patients and staff following safety incidents and will be launched in April 2024. The embedding of the PSIRF principles also form part of our quality priorities for 2024/25.

Another of our key focuses has been on service transformation, finding innovative ways to support and treat our patients effectively. Our hub model, reducing clinic times and enhancing patient convenience, has continued to expand with the opening of our Stratford site and the move of our Brent Cross site to a new location.

I was also thrilled that Moorfields Private was recognised as "Hospital of the Year" in the Doctify Patient Voice Awards, a testament to our unwavering commitment to patient-centered care.

Our strategic vision, launched in 2022/23, emphasises our values of excellence, equity, and kindness, reaffirming our core belief that people’s sight matters. During 2023/24 we have continued to drive this vision forward through our excellence portfolio and our excellence delivery unit (XDU), ensuring sustainable positive change for both staff and patients.

While we've made strides, we recognise there is still work to be done, particularly in enhancing staff wellbeing and addressing areas for improvement highlighted in our staff survey. We continue to focus on our equality, diversity, and inclusion (EDI) programme. We are also committed to ensuring a safe and positive culture that supports our people and provides a good working environment. An initiative we have implemented, following staff feedback, is the launch of a new anonymous freedom to speak up (FTSU) platform, *WorkInConfidence*. We have also taken a number of actions to improve our FTSU service and it’s great to see these initiatives come to life.

Finally, I want to express my sincere gratitude to our exceptional staff. Their dedication, teamwork, and passion are the driving force behind our ability to deliver outstanding care to our patients. We will continue to work together to build on our achievements and ensure Moorfields remains a beacon of excellence in eye care.

Martin Kuper
Chief executive

Our values

Excellence is at the heart of Moorfield's 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.

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 2023/24

Quality lies at the core of all our decisions at Moorfields. Our strategy, crafted in collaboration with both patients and staff, guides our path towards achieving excellence in all that we do.

Quality accounts are a way for NHS trusts to report on the quality of care they provide and show improvements in the services they deliver. The Quality Account is a key mechanism to provide demonstrable evidence of improving the quality of NHS trusts' services by examining the effectiveness of the treatment patients receive, patient safety, and patient feedback about the care provided.

Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2023/24. It is an opportunity to assure our service users and stakeholders that we provide high quality clinical care to our patients. It also shows where we could do better and our commitment to quality improvement.

Quality Accounts incorporate the requirements of the Quality Accounts regulations, as well as those of NHSE's additional reporting requirements. The purpose of the account is to:

- Promote quality improvement across the NHS.
- Increase public accountability.
- Enable the trust to review its services.
- Demonstrate what improvements are planned.
- Respond to and involve external stakeholders to gain their feedback, including patients and the public.

The integrity of our Quality Account hinges upon strong governance practices. We have a robust clinical governance structure to monitor the quality of evidence presented, complemented by equally robust corporate governance systems. Both pillars rely on the foundation of our information governance, underscoring our belief that excellent care and effective governance are interdependent. This not only facilitates continuous improvement but also ensures a transparent and accountable process for scrutiny, assurance, and the delivery of our Quality Account.

1.3. Moorfields Eye Hospital's approach to improving quality

At Moorfields, our core belief is 'people's sight matters', and our purpose is working together to discover, develop and deliver excellent eye care, sustainably and at scale.

The Excellence Portfolio, an executive led framework for change activity across the trust, has continued to support our quality priorities and improvement projects, with assurance for delivery of portfolio projects being provided by our Excellence Delivery Unit (XDU). This has ensured that a consistent method has been applied to projects, enabling data driven decision making and proactive management of interdependencies across our work. The excellence portfolio is made up of five aligned programmes within four boards (working together, discover, develop, and deliver, and sustain and scale), with each board having dedicated executive sponsorship.

This approach draws on good practice methodology and embeds principles, such as agreeing measures to show impact. In 2023/24, there were over 40 projects live with the XDU tools and around 20 more coming on board. The Excellence Portfolio is also the delivery vehicle for our strategy, through our four executive-led programme boards and nine excellence areas. Quality Excellence is sponsored by Sheila Adam, chief nurse and director of allied professionals. The Quality Excellence roadmap is a live document that sets out our quality projects across the next five years. During 2023/24, 16 quality-led projects were supported by the Working Together Excellence Programme Board to progress. Examples include, the implementation of our Patient Experience Principles, Patient Safety Incident Response Framework (PSIRF), and enhancing our Freedom to Speak Up (FTSU) service. As part of our quality priorities, we are also developing a learning system which will help us understand more clearly about how learning is happening on a continuous basis. More detail related to these projects can be found in the 2023/24 quality priority section (section 2.1) of this account.

In addition, many other projects across the Excellence portfolio have a positive impact on quality, for example, theatres excellence, outpatients excellence, and the development of our department of digital medicine. The XDU monitors project delivery in all these areas and promotes the routine use of tools such as quality impact assessments to ensure our impacts on quality are understood and well managed.

The Quality and Safety Committee (Q&SC), on behalf of the Board, takes responsibility for the overview and scrutiny of the development and delivery of the Quality Account and quality priorities.

For more information, or to provide feedback on this Quality Account, please email Ian Tombleson, director of quality and safety, at i.tombleson@nhs.net

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Progress with 2023/24 priorities

Throughout this period, we have focused on ten board approved quality priorities which were set out in last year's quality account. These were based on the three Darzi domains of quality: patient safety, clinical effectiveness, and patient experience. They were developed collaboratively with patients, staff, governors, commissioners, and relevant charities. The rationale for including them as quality priorities was based on the progress made with the 2022/23 priorities, as well as staff and patient feedback regarding how we could further improve their experience at Moorfields.

As part of the consultation process, a forum was arranged with key external stakeholders, including representatives from patients, and the RNIB. Staff views were also sought, and the priorities continue to be influenced by findings from incident investigations and feedback from our staff and patients. The trust's host commissioners, and other external bodies, such as Healthwatch Islington, have also considered the contents of the quality report and were supportive of the quality priorities for 2023/24. A summary of the drivers for the 2023/24 quality priorities can be found in table 1.

Building on the progress made in 2022/23, the quality priorities for 2023/24 were the foundation for the trust's strategy to deliver improvements in patient and service user care, and for achieving compliance with key performance and regulatory requirements.

Throughout 2023/2024 period, progress to achieve our quality priorities was monitored by the XDU and overseen by the Working Together and Develop and Deliver excellence boards, as well as the trust's Clinical Governance Committee (CGC).

In line with the XDU principles, the identified priorities have specific metrics to demonstrate and measure performance throughout this period.

A six-month progress report (a regular part of the overall quality priority process) was presented at the Clinical Governance Committee's meeting in October 2023.

Information for each of the quality priorities, identifying what has been achieved to date and indicating if there are any gaps to delivery, is described below. The information provided sets out the progress with the quality priorities for 2023/24 during the period April 2023 to March 2024. Having set ambitious priority targets, the trust has demonstrated progress across them all. In some areas, full achievement has not been possible. This is explained in the narrative against each of the 2023/24 priorities, and some of the priorities will also continue into 2024/25. A summary of the priorities can be found in table 2.

Table 1 - Drivers for inclusion as 2023/24 Quality priority

Quality Account Priority 2023/24	Quality Domain	Underpinning drivers				
		Excellence programme (XDU)	National initiative	Learning from SIs/ Complaints/ feedback	Themes from patient/staff engagement	Carried over from 2022/23
Implementation of the National Patient Safety Incident Response Framework (PSIRF)	Safe	✓	✓	✓	✓	✓
An integral part of PSIRF, is the development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)		✓	✓	✓	✓	✓
Improved care of deteriorating patients		✓	✓	✓	✓	
Implementation of patient experience principles	Patient experience	✓		✓	✓	
Virtual reality to improve communication project		✓			✓	
Patient Portal – digital patient communications		✓	✓		✓	
Continue to embed the Accessible Information Standard (AIS) across Moorfields' network		✓	✓	✓	✓	✓
Making Better Use of Routine Health Data	Effective	✓		✓	✓	
Build further on the work undertaken in 2022/23 to reduce health inequalities via 'Make Every Contact Count'		✓	✓	✓	✓	✓
Patient Initiated Follow Up (PIFU)		✓	✓	✓	✓	

Table 2 – Summary of 2023/24 Quality Priorities

Patient safety

Quality priority	Description	Measurement of improvement	Monitoring
Implementation of the National Patient Safety Incident Response Framework (PSIRF) (part of 2022/23 quality account)	PSIRF represents a significant shift in the way the NHS responds to patient safety incidents, focusing on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight.	• Patient safety incident response plan (PSIRP) agreed by commissioners. • Increase in incident reporting. • Improved safety culture scores on NHS survey • Reduction in moderate harm and above incidents related key safety priority areas.	Working Together Programme Board
An integral part of PSIRF, is the development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)	The development of a learning system will ensure the analysis of aggregate reported patient and staff data looking for improvement opportunities. Most importantly, the mission is that the ability to learn is embedded in our structure and internal processes at every level and reinforced through the culture and behaviours of staff.	• Impact of actions taken monitored through data (incident trends, complaint etc.) and audit. • Increase in incident reporting and reduction in complaints. • Increased knowledge of events and actions taken to reduce recurrence tested directly or indirectly e.g., via walkabouts and quality rounds. • Increase in % use of QR codes and *LIFEhub* web page.	Working Together Programme Board

Quality priority	Description	Measurement of improvement	Monitoring
Improved care of deteriorating patients	To ensure that staff have the training, knowledge, and skills to effectively manage patients who deteriorate and require an emergency response.	• Themes identified from incidents. • MAST compliance figures • Feedback from training sessions • No. of sites visited, and number of staff/ volunteers involved in simulation sessions. • Evidence of appropriate management of patients who deteriorate when events reviewed by the resuscitation team (thematic analysis)	Working Together Programme Board

Patient experience

Quality priority	Description	Measurement of improvement	Monitoring
Development and implementation of patient experience principles	Moorfields has commissioned NCP to work with the Patient experience team to develop Patient Experience Principles to better understand and elevate the patient experience, incorporating the values of kindness, equity, and excellence across the whole patient pathway.	• KPIs to be finalised when the developed principles are implemented. • Complaints and PALS enquiries • Friends and Family Test (FFT)	Working Together Programme Board
Virtual reality to improve communication project	Enhancement of the patient experience for patients with sight loss by developing a comprehensive training package for clinical and non-clinical staff. This will ensure that all staff are mindful and understand the needs of our patients who have sight loss and that their needs are met in a compassionate way using virtual reality as a teaching aid.	• 25% of staff identified to complete training for the Waiting room, Having Compassionate conversations, and theatre will have completed training in Q1 23/24 • All other staff identified will have completed training through 23/24. • A reduction in complaints regarding staff not meeting the needs of our patients with sight loss (evidence from complaints metrics)	Working Together Programme Board
Patient Portal – Digital patient communications	To expand the use of digital appointment letters across all Moorfields sites in collaboration with *DrDoctor*. This will mean that we are able to deliver letters to patients faster and conveniently, reduce environmental impact of printing all letters, provide a financial saving by reducing the amount of paper and improve the DNA rate with more patients receiving correspondence in time.	• % of letters uploaded that had a notification sent to patients (via text or email) • % of letters read online / viewed • % of letters read online / viewed that resulted in a financial benefit (print avoided) • CO_2 saving	Deliver Programme Board

Quality priority	Description	Measurement of improvement	Monitoring
Development and implementation of patient experience principles	Moorfields has commissioned NCP to work with the Patient experience team to develop Patient Experience Principles to better understand and elevate the patient experience, incorporating the values of kindness, equity, and excellence across the whole patient pathway.	• KPIs to be finalised when the developed principles are implemented. • Complaints and PALS enquiries • Friends and Family Test (FFT)	Working Together Programme Board
Continue to embed the Accessible Information Standard (AIS) across Moorfields' network. (included in 2022/23 quality account)	Improve the patient experience and care of those with accessible information needs by improving the delivery of accessible information to those that need it. By meeting the Accessible Information Standards, we will ensure that we have a consistent approach for communicating with people who have a disability, impairment, or sensory loss, in line with their individual needs and wishes.	• Proportion of patients with a NEW AIS need recorded out of all patients seen in the month. • Reported patient experience of AIS needs quantitative and qualitative measures from patient survey and expert patient group. • Percentage of patients seen in the month that have an AIS need recorded (before or within 7 days of their attendance) • Out of all patients seen in the month with an AIS need recorded, the percentage of AIS needs recorded as 'No AIS need'.	Working Together Programme Board

Clinical Effectiveness

Quality priority	Description	Measurement of improvement	Monitoring
Making Better Use of Routine Health Data	As an NHS organisation we are required on a business as usual (BAU) basis to identify and quantify any health inequalities or disparities across our network or within clinical services, as a means for addressing underlying predisposing factors and for taking necessary actions. Apart from the arrangements for operational reporting on mandatory performance KPIs, there is currently no overall structure or process to accommodate a more comprehensive approach for systematic, routine reporting of potential disparities	• KPIs to be finalised when the project is complete and will be used to monitor improvement. • The project will establish a systematic and strategic analytical and reporting process (approach, methodology and metrics) providing health information for broader, routine review of trust performance and potential disparities in our operational and clinical activity, on a BAU basis.	Working Together Programme Board
Patient Initiated Follow Up (PIFU)	Patient initiated Follow Ups (PIFU) allows selected/suitable patients with stable or low risk conditions that can be self-monitored, to initiate follow-up attendances within agreed timescales. The benefits of PIFU include, reduced number of follow-up appointments, reduced clinical time being used for unnecessary follow-up appointments, cost saving related to a reduced number of unnecessary follow-up appointments and reduced (did not attend) DNA rates	• % of outpatient follow-up appointments by service on a PIFU pathway • Number of PIFU active referrals • Follow-up ratio for services with PIFU • Number patients on PIFU pathway who have initiated a follow-up. • PIFU requests actioned by admin teams within 48h of receipt. • Number patients on PIFU pathway who were removed from pathway due to lack of engagement. • DNA rate for PIFU services	Deliver Programme Board

Quality priority	Description	Measurement of improvement	Monitoring
Build further on the work undertaken in 2022/23 to reduce health inequalities via 'Make Every Contact Count.' (included in 2022/23 quality account)	To utilise the principles of making every contact count (MECC) and our day-to-day interactions with patients to encourage changes in behaviour, there is an opportunity to have a positive effect on the health and well-being of our patients, community, and wider population.	• It is a challenge to measure the impact of MECC interventions. However, a MECC evaluation framework will be developed to support implementation.	Working Together Programme Board

Twelve-month progress update

Patient safety

Quality Domain: Safety

Priority 1: Implementation of the National Patient Safety Incident Response Framework (PSIRF) and building our learning system

Priority Lead: Julie Nott

Rationale

Building on the work done in 2022/23 to implement the National Patient Safety Strategy, we will build on the principles of the PSIRF, which represents a significant shift in the way the NHS responds to patient safety incidents. Under PSIRF, we are required to ensure that our review following events is focusing on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight. By moving to PSIRF, we will also move away from investigating incidents using root cause analysis to other tools that facilitate a system thinking approach to how we review events.

What success will look like by the end of March 2024:

The trust will have transitioned to the PSIRF as described in the trust PSIR plan and policy. The policy and plan will be published on the trust's website.

What we will measure:

Increase in incident reporting
Safety culture scores on NHS survey
Reduction in moderate harm and above incidents related key safety priority areas.

Background

Launched as part of NHS England and NHS Improvement's National Patient Safety Strategy in July 2019, PSIRF

What did we achieve to date?

Implementation of PSIRF has been supported by the XDU delivery team and monitored by the Working Together Programme Board, to which monthly updates were provided. We successfully (following extensive engagement with key stakeholders and review of our safety profile), published our PSIRF plan and policy on 2 April 2024.

We continue to be involved in the pan-London webinars and UCLP-led North Central London PSIRF workshops. Embedding the principles of PSIRF and the associated governance processes are now our area of focus. As such, embedding PSIRF has been included as a trust quality priority for 2024/25.

What are the gaps in delivery?

No gaps in delivery of the project identified.

Quality Domain: Safety

Priority 2: An integral part of PSIRF, is the development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)

Priority Lead: Kylie Smith

Rationale

In order to support the principles, set out in the PSIRF, there is a requirement to have in place a learning system that can promote a culture of learning and improvement by encouraging staff to apply findings and recommendations from events to their own practices and workflows.

What success will look like by the end of March 2024:

The trust will have transitioned to the PSIRF as described in priority 1 and have a developed plan for embedding the learning system across the organisation.

What we will measure:

- Monitoring associated KPIs related to improvement recommendations from the review of multiple data sources
- Staff survey to determine how staff have understood the learning from an event
- QR code hits to the feedback survey from safety briefings.

Background

One of the key principles of the PSRIF relates to ensuring organsational learning following the review of an event and that there is evidence of improvement following the implementation of recommendations. By building an organsiational learning system we will have a structured environment or framework to facilitate the acquisition, retention, and application of learning across the organisation. There is also a need to ensure that there are adequate feedback mechanisms within the learning system to enable participants to provide feedback on the response

process and suggest areas for improvement. This feedback loop ensures that recommendations following the review of an event are incorporated into future practices and systems.

What did we achieve to date?

Implementation of PSIRF has been our priority this year and is required for the development of our learning system. While we have developed our learning system strategy, work is required to understand how we embed the system into the governance and other organisational processes across the trust. As such, we have commissioned an external consultant to support us in this work and will continue to work on the recommendations of this review though 2023/24.

What are the gaps in delivery?

Recommendations from the learning system consultation requires implementation for the ambition of this priority to be realised. As such, the embedding of our learning system will form part of the PSIRF quality priorities for 2024/25.

Quality Domain: Safety

Priority 3: Improved Emergency Response for Patients with Acute Deterioration

Priority Lead: Sarah Buddle

Rationale

To ensure that staff have the training, knowledge, and skills to effectively manage patients who acutely deteriorate and require an emergency response.

What success will look like by the end of March 2024:

Improved confidence of staff in caring for patient's when they deteriorate and increased mandatory and statutory compliance rates.

What we will measure

- Themes identified from incidents
- MAST compliance figures
- Feedback from training sessions
- No. of sites visited, and number of staff/ volunteers involved in simulation sessions

- Evidence of appropriate management of patients who deteriorate when events reviewed by the resuscitation team (thematic analysis).

What did we achieve to date?

- Training packages were implemented with the support from of the learning and development team
- To increase higher level training at City Road and to be able to take training out to the satellites. A business case was submitted, and funding was granted for a band four administrator/basic trainer to support this
- The senior instructors now manage the increase in the higher-level training and have implemented a simulation programme which is being undertaken at satellite sites.
- 81% has been met on all levels (1-4) of compliance

What are the gaps in delivery?

No gaps in delivery identified, this project has now closed. It is to be noted that since spring 2024, the Evenezer Street site has housed the resuscitation training/simulation equipment.

Patient experience

Quality Domain: Patient experience

Priority 4 Development and implementation of Patient Experience Principles

Priority Lead: Ian Tombleson

Rationale:

Moorfields has commissioned an external partner, New Citizenship Project (NCP), to work with the patient experience team to develop Patient Experience Principles to better understand and elevate the patient experience, incorporating the values of kindness, equity, and excellence across the whole patient pathway.

What success will look like by the end of March 2024:

By the end of 2023/24, with support from our external partners we will embed the Patient Experience Principles within Moorfields by utilising facilitated 'Action Labs' and developing a piece of creative communication to explain the principles to staff across the trust.

What we will measure and when:

- KPIs to be finalised when the developed principles are implemented
- Complaints and PALS enquiries
- Friends and Family Test (FFT)

Background

Drawing on the learning from our co-creation process and interviews, we have identified a need to find the most practical and supportive way to embed the Patient Experience Principles across the trust. We will undertake an 'Action Lab' facilitated by NCP, with a group of 4-6 teams across the trust, to build, refine and learn from the Patient Experience Principles and draft behaviours framework, ultimately intended to result in improved patient experience across the trust. The principles align with the trust's core values and although not in place yet, we will ensure that there is alignment with the evolving behaviours framework.

- We are undertaking two strands of work:

1. An ‘Action Lab’ is our mechanism for piloting the embedding process with our teams. This work will be facilitated by NCP, to build, refine and learn from the principles by putting them into practice.

2. In parallel, NCP will develop the architecture for communicating the staff behaviours framework and Patient Experience Principles across a wider staff cohort (achieved through meetings, working sessions, and drawing Action Lab learnings), as well as toolkit content, including creative assets (film clips, stories written up alongside principles or behaviours).

- Outcome and output measures will also be defined during phase 2. We plan to move from phase 2 to wider implementation as quickly as possible. This is likely to require a third project brief to define exactly how roll out will take place and the support required for that including extensive collaboration across the organisation and working with the HR/workforce team. Discussion with the XDU will be required to make that happen.

What did we achieve to date?

- The trial Action Labs went ahead as planned and an updated project brief has been approved by the XDU board which sets out the plan for the next 12 months ahead of transition to BAU.
- The teams involved in the trial each delivered a local improvement action that had a tangible benefit to patient experience within that individual service/team.
- A similar Action Labs model to that used in the trial has been developed and the comms plans will be delivered over the next 12 months.

What are the gaps in delivery?

- Work on the trust’s staff behaviours framework has not kept pace with the principles project work; however, the two projects remain aligned and will maintain contact with each other. The principles and framework will also feature as a quality priority in 2024/25

Quality Domain: Patient experience

Priority 5: Using virtual reality (VR) to improve communication project with our patients.

Priority Lead: Kathy Adams

Rationale

Enhancing the experience of patients with sight loss by developing a comprehensive virtual reality training package for clinical and non-clinical staff. This will ensure that all staff are mindful and understand the needs of our patients who have sight loss and that their needs are met in a compassionate way.

What success will look like by the end of March 2024:

There will be an established training programme for the delivery of the training.

What we will measure and when:

- There will be a reduction in complaints regarding staff not meeting the needs of our patients with sight loss (evidence from complaints metrics)
- 25% of staff identified to complete training for the Waiting room, Having Compassionate Conversations, and Theatre will have completed training in Q1 23/24
- All other staff identified will have completed training through 23/24

Background

Our patient experience and communications are inconsistent. Working with a range of stakeholders, Moorfields has developed sight loss awareness training; staff take-up of this training has been excellent. This priority is aimed to build on this by launching immersive VR training to improve customer focus in clinical environments.

What did we achieve to date?

Following a successful pilot and positive feedback the VR training is being rolled out across the organisation. The project has now been closed and moved to business as usual.

What are the gaps in delivery?

No gaps identified in the delivery of this quality priority

Quality Domain: Patient experience

Priority 6: Patient Portal – Digital Patient Communications.

Priority Lead: Gerry Hanna

Rationale:

To expand the use of digital appointment letters across all Moorfields sites in collaboration with *DrDoctor*, our patient portal provider. This will mean that we are able to deliver letters to patients faster and conveniently, reduce environmental impact of printing all letters, provide a financial saving by reducing the amount of paper and improve the DNA rate with more patients receiving correspondence in time.

What we will measure:

- Number of Letters Uploaded: 818,347
- Number of letters uploaded that had a notification sent to patients (via text or email): 755,429
- Number of letters read online / viewed: 426,316
- Number of letters read online / viewed that resulted in a financial benefit (print avoided) - 426,316

Background

The patient portal project consists of two key components:

1. Trust wide roll out of digital letters.

The Trust is now live with digital appointment letters. We aim to expand to include digital clinical outcome letters and digital surgical appointment letters in the coming 12 months.

2. Trust wide roll out of digital questionnaires / PROMS.

This function is now embedded as BAU.

What did we achieve to date?

Moorfields Eye Hospital NHS Foundation Trust has been collaborating with DrDoctor since March 2021, with the aim of the development and Trust-wide expansion of a Patient Engagement Portal [PEP]. The Trust is now 15 months into its 2-year contract extension with DrDoctor, which will run until March 2025. The primary aim of the Patient Engagement Portal is to improve 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.

We have had many successes to date, including:

- Patient Initiated Follow up is now live, utilising features within the DrDoctor PEP to allow patients to request appointments as and when they are needed.
- The DNA predictor pilot expanded to include the Diagnostic Hub in Croydon.
- Over one million appointment letters have been sent to patients digitally via the DrDoctor PEP.
- Following the successful expansion of digital questionnaires and surveys these features have now been embedded as business as usual within the Trust.
- Ongoing collaboration with both DrDoctor and Xerox to identify and realise savings linked to the proposed digitisation of clinical outcome letters and surgical appointment letters.
- Covid-19 messaging removed from all outbound SMS, resulting in a reduction in SMS spend.
- Ongoing utilising DrDoctor 'Quick Question' functionality to support demand smoothing in services and sites with longer waiting times, leading to much shorter wait times for patients currently awaiting treatment and reducing the overall wait for those being referred in.

Opportunities for the next 12 months:

- Go live with the NHS App.
- Trustwide expansion of DNA predictor.
- Adoption of Direct Messaging feature.
- Digitisation of clinical outcome letters and surgical appointment letters (following successful integration with *OpenEyes*).
- Ability to upload photos as part of digital questionnaires and surveys and have the survey data stored directly against a patient's medical records.
- Ongoing management and future development/expansion of the DrDoctor PEP to be absorbed by the newly created Digital Clinical Services Division.
- Further SMS savings opportunities.

What are the gaps in delivery?

Project on track: Moorfields has been collaborating with DrDoctor since March 2021, with the aim of the development and Trust-wide expansion of a Patient Portal as part of the Patient Portal Project, under the Outpatients Excellence Programme. The primary aim of the Patient Portal is to improve 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. The Patient portal will, in due course, come under the governance and management of the newly created Digital Clinical Services Division

Quality Domain: Patient experience

Priority 7: Continue to embed the Accessible Information Standard (AIS) across Moorfields network.

Priority Lead: Ian Tombleson. From Q3 2023/24 Laura Brewster.

Rationale

Improve the patient experience and care of those with accessible information needs by improving the delivery of accessible information to those who need it. By meeting the Accessible Information Standards, we will ensure that we have a consistent approach for communicating with people who have a disability, impairment, or sensory loss, in line with their individual needs and wishes.

What success will look like by the end of March 2024/25:

- Improved systems and processes to manage AIS needs
- Good patient awareness of what service to expect in relation to accessible information
- Enhanced awareness of AIS needs for staff involved in administration and care of patient on their journeys
- Increase the number of patients with AIS flags on our electronic systems
- Improvement in the patient experience at Moorfields when we provide support for AIS needs.

What we will measure and when:

- Proportion of patients with a NEW AIS need recorded out of all patients seen in the month.
- Reported patient experience of AIS needs quantitative and qualitative measures from patient survey and expert patient group.
- Percentage of patients seen in the month that have an AIS need recorded (before or within 7 days of their attendance)
- Out of all patients seen in the month with an AIS need recorded, the percentage of AIS needs recorded as ‘No AIS need’.

Background
Legal and Regulatory compliance: AIS is a legal right of patients to be supported and empowered in their care by accessible information. It is also included as part of CQC's regulatory framework. **Patient Experience** • The trust has had formal complaints and legal challenge about lack of AIS provision • Consistent PALS comments about poor customer care • Comments coming through FFT attributed to poor support for patients with sight loss • 'Strategic' momentum across the trust to improve the patient experience and comply with the standard.
What did we achieve to date? Over the past 12 months, we have agreed and initiated development for our clinical records system, *OpenEyes*, to reflect and accurately capture a patients' AIS needs. Alongside this, we have prioritised and rationalised the NHSE flags for AIS, to enable operational teams to effectively implement a clear record of a patients' communication requirements. We have undertaken a number of working sessions with our expert patient group to help inform and guide our priorities for AIS, as well as test out our plan for implementation. Finally, we have built a clear road map for delivery of the AIS standard in 2024/25, articulating the interdependencies for other changes needed across the organisation.
What are the gaps in delivery? We are reliant on the release of the *OpenEyes* upgrade which will allow operational teams to record the patient communication needs. This is due in the summer of 2024. Whilst this is pending, we will be running a series of small pilots across our clinics, to encourage staff to begin to talk to patients' more about their AIS needs. We need to understand the impact of these conversations on the flow of our clinics, ensuring our staff have enough time and resources to speak to patients and capture their requirements. Further to this, we will be developing trust-wide training videos to support staff understanding of the AIS standard and what is expected of them. As such, this project will continue as a quality priority in 2024/25.

Clinical effectiveness and patient outcomes

Quality Domain: Effective

Priority 8: Making Better Use of Routine Health Data

Priority Lead: Parul Desai

Rationale

As an NHS organisation we are required on a business as usual (BAU) basis to Identify and quantify any health inequalities or disparities across our network or within clinical services, as a means for addressing underlying predisposing factors and for taking necessary actions. Apart from the arrangements for operational reporting on mandatory performance KPIs, there is currently, no overall structure or process to accommodate a more comprehensive approach for systematic, routine reporting of potential disparities have a positive effect on the health and well-being of our patients, community, and wider population.

What success will look like by the end of March 2024:

The trust will have in place metrics that can be used to for analytical and reporting processes across the trust

What we will measure and when:

The project will establish a systematic and strategic analytical and reporting process (approach, methodology and metrics) providing health information for broader, routine review of trust performance and potential disparities in our operational and clinical activity, on a business-as-usual basis.

Background

The identifying, monitoring, and review of health inequalities as a means for addressing their underlying predisposing factors, is a key NHS priority, further galvanised following the pandemic. Its requirements are enshrined in primary legislation, embedded in operational guidance and integral to the NHS contract. From a healthcare provider perspective, our duty of care is to ensure equitable availability and access to services and outcomes of care provided.

An approach for making better use of routine health data arising from trust operational activity and provision of health care is a means for generating health information and intelligence for multiple purposes to meet NHS requirements for action on inequalities and the trust's strategic objectives and core values.

What did we achieve to date?

We have made great strides in developing a process for accessing, collecting, and analysing our health inequalities data. We have now focused our approach for routine reporting, review, and utilisation of data on service delivery for health inequalities

What are the gaps in delivery?

There are no gaps in the delivery of this quality priority, however, the approach for routine use of the data will be a quality priority for us in 2024/25

Quality Domain: Effective

Priority 9: Build further on the work undertaken in 2022/23 to reduce health inequalities via 'Make Every Contact Count' (included in 2022/23 quality account)

Lead: Roxanne Crosby-Nwaobi/Tendai Gwenhure

Rationale:

To utilise the principles of making every contact count (MECC) and our day-to-day interactions with patients to encourage changes in behaviour, there is an opportunity to have a positive effect on the health and well-being of our patients, community, and wider population.

What success will look like by the end of March 2024:

The trust will have in place a robust mechanism to sign post patients to support to cease smoking.

What we will measure

It is a challenge to measure the impact of MECC interventions. However, a MECC evaluation framework has been developed to support implementation.

Background

This project focused on utilising MECC principles to support and encourage smoking cessation for our patients.

What did we achieve to date?

The smoking and vaping policy has been updated with relevant advice, educational leaflets on smoking's effects on eyes were developed, and smoking cessation champions were recruited in several locations. We also appointed a lead and held a staff training/campaign on National No Smoking Day.

What are the gaps in delivery? Certain upgrades are required to our electronic health records to support this work; however, these are being considered as part of trust transition to an EPR (electronic patient record) and through upgrades on our electronic heath record system (*OpenEyes*). However, the objectives of this specific project have been met. Completion rates for the training are currently low. The training is currently not mandatory.

Quality Domain: Effective

Priority 10: Patient Initiated Follow Up (PIFU)

Priority Lead: Kelly Mackenzie

Rationale:

Patient initiated Follow Ups (PIFU) allows selected/suitable patients with stable or low risk conditions that can be self-monitored, to initiate follow-up attendances within agreed timescales.

What success will look like by the end of March 2023:

The benefits of PIFU include, reduced number of follow-up appointments, reduced clinical time being used for unnecessary follow-up appointments, cost saving related to a reduced number of unnecessary follow-up appointments and reduced (did not attend) DNA rates.

What we will measure and when:

- % of outpatient follow-up appointments by service on a PIFU pathway
- Number of PIFU active referrals
- Follow-up ratio for services with PIFU
- Number patients on PIFU pathway who have initiated a follow-up
- PIFU requests actioned by admin teams within 48h of receipt
- Number patients on PIFU pathway who were removed from pathway due to lack of engagement.
- DNA rate for PIFU services

Background
Patient initiated Follow Ups (PIFU) allows selected suitable patients with stable or low risk conditions that can be self-monitored to initiate follow-up attendances within agreed timescales rather than be scheduled a routine follow-up appointment.
What did we achieve to date?
The first pilot scheme was successfully delivered with the Uveitis service. Since then, pathways in genetics and prosthetics have also gone live. All three active PIFU pathways are using the DrDoctor patient portal assessment module without integration with Moorfields PAS. Additional PIFU pathways are waiting for one-way integration between DrDoctor and PAS before rolling out. This roll-out will be facilitated by e-learning modules for admin and clinical staff, communications plan, and standard operating procedure document.
What are the gaps in delivery?
The PIFU project has had a few delays, primarily an 8-week delay around Nov-Dec 2023 waiting for PAS updates to be completed and then tested. The project has completed IT updates and testing, the SOP was submitted to PPRG for approval, and the first of two e-learning modules are being tested. We are conducting readiness meetings with each PIFU service to ensure they are prepared for roll-out, expected to start in the next two months. We have also kicked off a sub-project to develop a process for flagging clinic codes across the trust, essential for the safe implementation of PIFU, Outpatient Waiting List (OWL) and diagnostic failsafe. After the roll-out, we expect to spend two-three months monitoring the live services and then will prepare for closure and handover.

2.2 Core clinical outcomes

Progress in 2023/24

The trust's performance against the core outcome standards demonstrates excellent clinical care, with every standard being met (95% confidence intervals) and many being far exceeded. Because few DMEK (Descemet's membrane endothelial keratoplasty) grafts were done for PBK, the 95% confidence intervals for graft survival were wide both nationally and at Moorfields. Importantly, the confidence intervals overlap, demonstrating that there is no statistically significant difference between the Moorfields and the national outcomes for these corneal grafts.

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.

Trust core clinical outcomes 2023-2024

Specialty	Metric	Standard	2021/22	2022/23	**2023/24**
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	0.81%	0.90%	**0.88%**
Cataract	Endophthalmitis after cataract surgery*	<0.040%	0%	0.010%	**0.008%**
Cataract	Biometry accuracy in cataract surgery*	>85%	93%	92%	**92%**
Cataract	Good vision after cataract surgery*	>90%	90%	94%	**94%**
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	86%	94%	**92%**
Glaucoma	Tube (glaucoma drainage surgery) success	>80%	93%	95%	**94%**
Glaucoma	PCR in glaucoma patients*	<1.95%	1.2%	1.3%	**1.4%**
MR[1]	Endophthalmitis after intravitreal anti-VEGF injections*	<0.030%	0.006%	0.012%	**0.009%**
MR	Visual improvement after injections for macular degeneration*	>20%	23.9%	20.6%	**24.1%**
MR	Visual stability after injections for macular degeneration*	>80%	92.8%	91%	**93.3%**
MR	PCR in Medical retina patients*	<4%	2.4%	1.4%	**2.2%**
MR	Compliance: Time from screening to assessment of proliferative diabetic retinopathy*	80%	87%	87%	**90%**

[1] Medical Retina

Specialty	Metric	Standard	2021/22	2022/23	**2023/24**
VR[2]	Success of primary retinal detachment surgery*	>85%	85%	81%	**92%**
VR	Success of macular hole surgery*	>80%	90%	98%	**92%**
VR	PCR in vitrectomised eyes*	No published standard	2.6%	2.6%	**TBC**
NSP	Significant complications of strabismus surgery*	<0.43%	0%	0.53%	**0.35%**
NSP	Premature baby eye (ROP) screening compliance	99%	99.6%	99.5%	**99.4%**
A&E	Patients seen within 4 hours*	>95%	99.9%	99.4%	**98.6%**
Ext Dis	PK[3] for keratoconus (2-year survival from NHSBT report) *	See table below	96%	96%	**100%**
Ext Dis	DALK[4] for keratoconus (2-year survival from NHSBT report) *	See table. below	98%	91%	**90%**
Ext Dis	DMEK[5] for FED[6] (2-year survival from NHSBT report) *	See table below	87%	81%	**88%**
Ext Dis	DMEK for pseudophakic bullous keratopathy (2-year survival from NHSBT report) *	See table below	56%	59%	**62%**
Refractive	Accuracy LASIK (laser for refractive error) in short sight*	>85%	N/A	91.2%	**90.8%**
Refractive	Loss of vision after LASIK*	<1%	N/A	0.12%	**0.72%**
Refractive	Good vision without lenses after LASIK*	≥80%	N/A	94.1%	**92.2%**
Adnexal	Ptosis surgery success	>85%	100%	96%	**96%**
Adnexal	Entropion surgery success	>95%	95%	97%	**95%**
Adnexal	Ectropion surgery success	>80%	100%	96%	**96%**

*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.

[2] Vitreo-retinal surgery
[3] Penetrating Keratoplasty
[4] Deep Anterior Lamellar Keratoplasty
[5] Descemet's membrane endothelial keratoplasty
[6] Fuch's Endothelial Dystrophy

Detailed report of the survival of corneal grafts including confidence intervals (CI) (outcomes are after two years of follow-up):

	2018/19 grafts	2019/20 grafts	2020/21 grafts
PK for KC	- Nationally: **93.6%** (95% CI: 89.1% - 96.3%). - **At MEH: 96.0%** (95% CI: 84.7% - 99.0%). - Not statistically significantly different	- Nationally: **90.4%** (95% CI: 83.6% - 94.5%). - **At MEH: 96.2%** (95% CI: 75.7% - 99.4%). - Not statistically significantly different	- Nationally: **96.6%** (95% CI: 92.4% - 98.5%) - **At MEH: 100.0%** (95% CI: -) - Not statistically significantly different
DALK for KC	- Nationally: **95.2%** (95% CI: 90.6% - 97.6%). - **At MEH: 97.8%** (95% CI: 91.6% - 99.5%). - Not statistically significantly different	- Nationally: **92.5%** (95% CI: 85.8% - 96.1%). - **At MEH: 90.8%** (95% CI: 77.1% - 96.5%). - Not statistically significantly different	- Nationally: **92.6%** (95% CI: 86.6% - 96.0%) - **At MEH: 89.6%** (95% CI: 75.2% - 95.8%) - Not statistically significant
DMEK for FED	- Nationally: **83.8%** (95% CI: 80.0% - 86.9%). - **At MEH: 86.7%** (95% CI: 78.9% - 91.8%). - Not statistically significantly different	- Nationally: **83.1%** (95% CI: 78.7% - 86.6%). - **At MEH: 81.3%** (95% CI: 70.8% - 88.3%). - Not statistically significantly different	- Nationally: **86.4%** (95% CI: 83.2% - 89.1%) - **At MEH: 87.5%** (95% CI: 81.3% - 91.7%) - Not statistically significant
DMEK for PBK	- Nationally: **69.2%** (95% CI: 57.0% - 78.6%). - **At MEH: 55.6%** (95% CI: 28.5% - 75.9%). - Not statistically significantly different	- Nationally: **68.1%** (95% CI: 56.8% - 76.9%). - **At MEH: 58.9%** (95% CI: 38.4% - 74.5%). - Not statistically significantly different	- Nationally: **69.9%** (95% CI: 59.8% - 77.9%) - **At MEH: 62.1%** (95% CI: 40.6% - 77.8%) - Not statistically significant - *Risk-adjusted survival: National **74%**, MEH **73%***

2.3 Performance against key local indicators for 2023/24

This financial year has seen the continued focus on responding to the Covid-19 pandemic recovery and returning to business-as-usual levels of activity and beyond, where achievable. Whilst the tables on the following pages reflect a comparison with previous years, that comparison must be viewed with caution given the operational pressures over three years.

2023/24 Key Indicators

INDICATOR	2020/21 results	2021/22 results	2022/23 results	2023/24 Target	**2023/24 results**
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	94.7%	97.9%	95.0%	≥ 93%	**96.5%**
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	100%	99.1%	96.3%	≥ 94%	**100.0%**
Cancer 28 Day Faster Diagnosis Standard	87.2%	93.3%	100%	≥ 75%	**92.3%**
RTT Pathways Over 18-week pathways	-	8,842	7,211	N/A	**5,962**
52 Week RTT Incomplete Breaches	-	Year: 395	Year: 97	0	Year: **144**
Average Call Waiting Time	618*	237 secs	216 sec	≤ 120 secs	**131 Sec**
Call abandonment rate	-	14.5%	17.1%	≤15%	**9.8%**
Theatre cancellation rate (non-medical cancellations)	0.49%	0.7%	1.01%	≤0.8%	**1.05%**
Number of non-medical cancelled operations not treated within 28 days	-	18	17	0	**23**
Mixed Sex Accommodation Breaches	0	0	0	0	**0**
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	0%	1.13%	1.79%	≤ 2.67%	**2.17%**
Posterior capsule rupture rate for cataract surgery	0.98%	1.03%	0.8%	≤ 1.95%	**0.82%**
Occurrence of any Never events	2	2	3	0	**3**
Endophthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	new	1	0	0	**0**
Escherichia coli (E. coli) bacteremia bloodstream infection (BSI) - cases	0	0	0	0	**0**
MSSA Rate - cases	0	0	0	0	**0**
Inpatient Scores from Friends and Family Test - % positive	95.2%	95.0%	95.6%*	≥ 90%	**95.9%**
A&E Scores from Friends and Family Test - % positive	94.3%	92.7%	92.5%*	≥ 90%	**92.9%**
Outpatient Scores from Friends and Family Test - % positive	93.2%	93.3%	93.4%	≥ 90%	**93.6%**
Paediatric Scores from Friends and Family Test - % positive	94.7%	93.7%	94.3%	≥ 90%	**95.0%**

INDICATOR	2020/21 results	2021/22 results	2022/23 results	2023/24 Target	**2023/24 results**
Summary Hospital Mortality Indicator	0	0	0	0	**0**
National Patient Safety Alerts (NatPSAs) breached	0	1	0	0	**2**
Percentage of responses to written complaints sent within 25 days	88.1%	73.5% (Apr-Feb)	70.4%	≥ 80%	**88.6%**
Percentage of responses to written complaints acknowledged within 3 days	97.0%	99.0%	90.6%	≥ 80%	**97.3%**
Freedom of Information Requests Responded to Within 20 Days	95.1%	95.3%	96.2%	≥ 90%	**65.6%**
Subject Access Requests (SARs) Responded to Within 28 Days	97.9%	96.0%	95.2%	≥ 90%	**94.4%**
Number of Serious incidents (SIs) open after 60 days	2	0	0	0	**1**[7]
Number of Incidents (excluding Health Records incidents) remaining open after 28 days (At time of reporting)	86	-	166	n/a	**286**
Mandatory Information Governance Training Compliance (At time of reporting)	95.1%	93.6%	88.9%	≥ 90%	**90.1%**
Appraisal Compliance (At time of reporting)	78.2%	74.9%	70.6%	≥ 80%	**75.6%**
Proportion of Temporary Staff	6.7%	12.2%	14.5%	n/a	**15.5%**
Overall financial performance vs. Plan (£m) - Year End Position	-	4.58	5.61	≥ 0	**8.42**
Commercial Trading Unit Position vs Plan (£m) - Year End Position	-	1.17	-1.11	≥ 0	**-0.50**
Total patient recruitment to NIHR portfolio adopted studies	1,986	8,550	5,816	≥ 115 Per Month	**211 (2,532 total year)**
Proportion of patients participating in research studies (as a percentage of number of open pathways) (At time of reporting)	-	5.6%	5.9%	≥ 2%	**5.1%**
% implementation of NICE guidance	97%	100%	96.6%	95%	94.5%
Number of registered and ongoing clinical audits past their target deadline date	15.8%	20.7%	17.6% (34/193)	≤ 20%	33.5% (78/233)

Unless stated, 2023/24 figures are for April 2023 to March 2024, with position taken as of 8 April 2024

[7] A new indicator will be developed for the 2024/25 quality account as the trust is transitioning to the patient safety incident response framework (PSIRF) from April 2024.

2.4 Performance against 2023/24 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 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:

Description of target	2022/23 Performance	2023/24		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
Clostridium difficile year on year reduction	0	0	**0**	n/a	n/a	n/a
Risk assessment of hospital-related venous thromboembolism (VTE)[1]	98.2%	≥95%	98.6%	n/a	n/a	n/a
Waiting Times						
Two-week wait from urgent GP referral for suspected cancer to first outpatient appointment[2]	97.3%	≥ 93%	Year: 90.2% Apr-Sep: 100%	78.3% (Apr-Sep)	100% (Apr-Sep)	40.1% (Apr-Sep)
Cancer 31-day waits – diagnosis to first treatment[3]	99.3%	≥ 96%	100%	90.5%	100%	71.7%

Description of target	2022/23 Performance	2023/24		Comparison with applicable trusts (latest)		
		Target	Performance	Average	Best	Worst
All 62 days from urgent GP referral to first definitive treatment[3]	100%	≥ 85%	100%	59.7%	100%	0%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.4%	≥ 95%	98.6%	78.2%	100%	40.2%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks [3]	77.9%	≥ 92%	82.1%	65.6%	99.7%	31.6%
Maximum 6 week wait for diagnostic procedures[3]	99.4%	≥ 99%	99.4%	82.8%	100%	15.8%

Unless stated, 2023/24 figures are for April 2023 to March 2024, with position taken as of 8 April 2024

[1] – National data collection suspended

[2] – National data collection for Two-week wait Cancer replaced from October 2023, no provider level figures available after this date.

[3] – Comparison data from NHS Statistical Work Areas – April 2023 to Feb 2024

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.

Measure	Target	Year Start*	Q1	Q2	Q3	Q4	Year 2023/24	Year End*
18-weeks RTT incomplete	≥ 92%	80.5%	81.3%	81.3%	82.8%	83.0%	**82.1%**	**83.3%**
18-weeks RTT incomplete with decision to admit (DTA)	n/a	60.2%	70.0%	67.5%	72.2%	76.0%	**71.3%**	**76.0%**
18-weeks RTT admitted	n/a	67.1%	67.2%	61.6%	63.9%	69.9%	**65.8%**	**75.9%**
18-weeks RTT non-admitted	n/a	83.9%	78.6%	75.8%	78.9%	78.3%	**77.9%**	**85.5%**

Measure	Target	Year Start*	Q1	Q2	Q3	Q4	Year 2023/24	Year End*
New RTT periods (clock starts) all patients	n/a		33,910	34,366	33,845	35,819	**137,940**	

* Year Start is RTT Position on 1st April 2023, Year End is RTT Position on 1st April 2024

Our overall PTL (patient tracking list) position remains healthy. We have seen the PTL size start to stabilise at approximately 35,500 patients per quarter, rather than continue to fall below our pre-COVID PTL size of 28,000 patients. We have either reached points of stability or improvement against our pre-COVID levels in some of our largest services (Cataract, Medical retina, Glaucoma). The recovery for specialised services has been more limited.

We have also seen a decrease in referrals for our Cataract services as the independent sector captures more of the referrals market through direct relationships with optometrists.

Our overall RTT performance continues to improve with some areas of concern within the smaller specialties, which are being addressed with the relevant teams.

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 organisation 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 carried out twice yearly by the data quality manager on a rolling programme.

Data quality continued to be given a high profile in 2023/24, 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 has also moved onto the *Tendable* digital application and has been using this for over 12 months. 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 are working 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 all 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.

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 a task and finish group which is supporting data improvement for areas such as Next of Kin (NOK); this work has seen our NOK data continue to improve from a previous NOK completeness of 0% - 5% to between 16% - 93%. The data quality working group has also been implemented, to support the ongoing Data Quality Agenda, with representation from across the trust. This group will continue to be the forefront of Data Quality improvement and assurance.

28-day emergency re-admission 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.

	2019/20	2020/21	2021/22	2022/23	2023/24
28 days Readmission rate (Adult: 16+)- excluding retinal detachment	3.98%	1.74%	1.15%	1.59%	2.23%
28 days Readmission rate (Adult: 16+)- retinal detachment only	6.70%	5.33%	4.21%	5.12%	4.60%
28 days Readmission rate (Child: 0-15)	0.00%	0.00%	0.00%	4.55%	0.00%

* 2023/24 Position taken as of 11 April 2024

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

2024/5 will see the rollout of our 'Patient Experience Principles'. The principles, developed in co-design with staff and patients, set out the basis of how we expect to deliver consistently excellent patient experience. At the centre of these principles, we are ensuring that our focus in on 'See the Whole Person' at every point of the patient journey at Moorfields.

Following a successful trial, and alongside trust-wide communications, the principles will be introduced in a series of 'Action Labs'. During Action Labs, cohorts of teams engage in an initial eight-week programme, which introduces the principles in more detail, and each team will identify and complete an action that will ensure a tangible improvement to a patient experience related area of practice.

Accessible Information Standard

All trusts are required to meet the Accessible Information Standard (AIS). A project group has continued to meet in 2023/24 to drive improvement in this area. This project is a category 1 project monitored by the Working Together Excellence Board, supported by the XDU. Workstreams have been focusing on immediate implementation of AIS improvements, and adapting digital systems (PAS, *OpenEyes*) to support the AIS process as well as the relevant indicators. As this is an important area of work for the trust, this work will continue, and AIS has been identified as a quality priority for 2024/25.

Family and Friends Test (FFT) for patients

During 2023/24, 250,250 (35%) of 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.

FFT Trust results for 2023/24

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	22,445	3,577	592	366	637	394	28,011	73,219	92.9%	3.58%	38.3%
Inpatient	13,808	1,519	203	74	103	279	15,986	39,195	95.9%	1.11%	40.8%
Outpatient	164,871	28,222	4,116	2,001	2,108	4,935	206,253	600,816	93.6%	1.99%	34.3%

FFT themed analysis of comments

Face to face consultations

It has not been possible to theme all FFT comments from a trust wide perspective due to the volume, although they are themed and acted on locally by the receiving division. Most comments are positive, commenting on the kindness, friendliness, and service delivery of staff.

Waiting times and not being informed of delays were the main issues raised by patients providing scores of 1 or 2 in FFT returns. The second largest number of concerns related to staff attitude and poor customer service. Each division is responsible for reviewing its FFT feedback and making service improvements as a result. These improvements are publicised locally in the form of 'you said, we did' posters in clinics and on quality boards and are shared at the Patient Participation and Experience Committee to ensure learning is shared widely throughout the trust.

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 had received a total of 149 complaints in 2023/24, compared to the 223 received in the previous year. The drop in the number of complaints received can be attributed to changes made following the introduction of new national guidance on NHS complaints handling, with more cases being resolved using early resolution methods (i.e. via PALS) rather than following the formal complaints processes.

Clinical concerns continue to be the cause of most complaints, often related to delays, failures, or explanations about treatment. All complaint responses relating to clinical care are reviewed by the divisional clinical director and shared with the risk and safety, and safeguarding teams. Where appropriate, complaints are also discussed at the trust's serious incident panel.

In line with local strategy following the introduction of new national standards in NHS complaint handling in 2023/24, the trust has had a decrease in formal complaints with the shift to earlier, local resolution. Given this shift, the number of Patient Advice and Liaison Service (PALS) enquiries remained broadly the same this year compared to previous years. The main themes of complaints remain clinical concerns, staff attitude, and communication. PALS enquiries generally focused on appointment management and communication. The patient participation and engagement committee (PPEC) continues to meet to discuss patient feedback and what changes and learning is made as a result.

Complaint investigations are undertaken at a divisional level with oversight and sign-off by the Chief Executive; should the complainant remain dissatisfied following receipt of the trust's response to their complaint, or have outstanding concerns, a further review will take place. If they continue to be dissatisfied, a meeting may be offered (if beneficial and/or not done earlier) and advice given about contacting the Parliamentary and Health Service Ombudsman (PHSO) for an independent review.

PALS Concerns

PALS received 4,374 enquiries in 2023/24 (4,565 in the previous year). Of these, 128 were compliments, 1,662 were requesting information and 2,584 were concerns. Of the concerns, the largest number related to appointments management, followed by communication issues (including telephone responses), transport concerns and questions about clinical care or treatment.

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.

Complaints performance: Key performance indicators

KPI (Key Performance Indicators)	Target	2021/22	2022/23	2023/24
Response ≤ 25 days	≥ 80%	73.5% *(Apr-Feb)*	70.4%	88.6%
Acknowledgment ≤ 3 days	≥ 80%	99.0%	90.6%	97.3%

Re-opened cases: During 2023/24, there were four re-opened cases. These were from complainants who had further concerns or who challenged the trust's findings. The majority were satisfied following a second response or a meeting.

Response time: In cases where the final response breached the 25-day KPI, this was often due to the response requiring a complex investigation with multiple aspects and issues needing to be explored. There has been a continuous focus on improving the patient experience of complaints handling and the central teams and divisions continue to work together to develop this.

The organisation exceeded its target in 2023/24 for complaints responses. As noted, where response times breached, this was mainly due to the complexity of the complaints received. However, where a complaint response was delayed, patients were kept informed. We will continue to improve our patient focus and responsiveness when responding to complaints and PALS enquiries.

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 has not been any recorded incidents of hospital acquired VTE via our incident reporting systems and the incident reviewing system, including Serious Incident Panel.
- 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 carrying out VTE assessment using the VTE Risk Assessment and Treatment Plan to risk assess. This was implemented four years ago, and we are continuing this practice in our children's hospital.

Indicator	2021/22 results	2022/23 results	2023/24 Target	**2023/24 results**
Risk assessment of hospital-related venous thromboembolism (VTE)	98.6%	98.2%	**≥ 95%**	98.6%

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. Several improvements, including some requested specifically by staff, have been made during the year, however it is recognised that more comprehensive adjustments are required to improve the staff experience of reporting an incident. It is hoped that reporting rates will increase once the reformatting of the reporting form has been completed.

By the end of September 2023, and ahead of the NHS England implementation deadline, the trust had successfully transitioned from the National Reporting and Learning System (NRLS) to the Learn from Patient Safety Events (LFPSE) service. During 2024/25 we will be auditing our implementation of LFPSE, to ensure that all PSIs have been uploaded to the service and are therefore informing national learning across the NHS.

The trust has continued to use statistical process control (SPC) charts as the preferred display method for incident data. Data is displayed at both trust level and divisional level and the presentation of the information in this format provides the opportunity to identify deviations of concern or improvement and to consider the specific reasons for their occurrence. Use of SPCs for incidents, which has increased during the year, has not only enhanced our oversight of incident reporting rates but also our oversight of incident management by the clinical divisions and corporate functions. Most clinical divisions present incident data to staff in SPC format, at divisional quality meetings, and it is anticipated that this will extend to all clinical divisions during the next year. For PSIs, except for a six-month period from the start of 2019, the trust has achieved pre-pandemic reporting levels and there is an apparent increasing trend for reported PSIs over the last three quarters. Data has remained above the mean for the last five quarters and no special causes have been identified.

A focus of trust activity throughout the year, specifically in relation to PSIs, has been the work undertaken in respect of PSIRF. Development of our PSIRF policy and plan, as already referenced in the quality priority section, has been informed by a coordinated review of data, including that relating to PSIs, staff and patient surveys, safety culture focus groups, and

concerns highlighted through the freedom to speak up process. Our Policy and Plan have been finalised and both are available for review on the trust internet page. Following transition from the SI Framework to PSIRF during quarter four, our focus for the next year will be on embedding and improving our new processes and ensuring that we can demonstrate improvement in patient safety. The embedding of our PSIRF arrangements, along with the development of a learning system to support knowledge transfer following events as described in the trust's Plan, will both be monitored as quality priorities in 2024/25.

In 2023/24, we declared five serious incidents (SI), three of which were classified as never events (wholly preventable patient safety incidents which have the potential to cause serious patient harm or death). There is an expectation that they should never occur because safety guidance or safety recommendations exist at a national level and there is a requirement for this to have been implemented. Examples of never events that may be relevant to trust activity are surgery on the wrong eye or eye muscle and implantation of the incorrect intraocular lens. The trust continued to work collaboratively with the integrated care board (ICB) in relation to declared serious incidents and welcomed support from the ICB to apply the new method of investigation that will be used under the PSIRF to our three most recent SIs. At the end of 2023/24, three SI investigations remained on-going with closure scheduled for Q1 2024/25.

Throughout the year, and in anticipation of the implementation of the PSIRF, the trust has encouraged the application of previously underutilised investigation methodologies such as after-action reviews (AARs). At the end of 2023, and to increase the available resources to lead or support learning responses, multiple staff completed the nationally mandated PSIRF training and/or AAR training.

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. New notification rules have been developed to take account of the new sites and services that have been introduced, such as Moorfields at Stratford. In addition to these notification rules, the risk & safety team notifies additional managers and SMEs, as required, and individual users can do the same.
- Until the end of February 2024, the trust had a weekly SI panel, chaired by a consultant ophthalmologist which considered in detail those incidents that fell within the scope of the terms of reference (as a minimum). This included, for example, incidents (excluding complications) graded as moderate or above harm and potential never events. From March 2024, SI panel was repurposed to the Incident Review Group (IRG) and the governance arrangements that would apply following formal transition to PSIRF in April 2024 were tested. New terms of reference for the IRG have been developed, which reflect the key aims of the PSIRF. A decision to review an incident is no longer driven by harm to a patient, but the opportunity to learn and improve our services. An increased focus on shared learning and improvement has been sustained throughout 2023/24.

- Incident reporting training and education has been provided by the risk & 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:

- Further developing the use and availability of SPC charts, particularly those that will inform the impact of improvement projects associated with the local priorities identified in our PSIRF Plan.
- Adopt a quality improvement approach to the implementation and embedding of our PSIRF Plan, to maximise our opportunities for learning and improvement.
- 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 in Safeguard by the central quality & safety team, relating to PSIRF implementation, provides the trust board with the system oversight that is required.

Summary of Serious Incidents (SIs) and Never Events (NE)

Never Event title	Brief details
Insertion of the incorrect intraocular lens (IOL) (1 incident reported)	One patient had an incorrect IOL inserted, where NE criteria were fulfilled. The implanted lens differed to that which was documented on the IOL selection sheet (the surgical plan). The error was identified prior to the patient leaving theatre, and an exchange for the correct lens was undertaken.
Implantation of the incorrect graft material (1 incident reported)	One patient received a tissue graft that was intended for another patient.
Intravitreal injection to the incorrect eye (1 incident reported)	One patient received an intravitreal injection to the incorrect eye. The error was identified whilst the patient was still in the treatment room and the correct eye was injected prior to the patient leaving.

Two further SIs occurred during the year, as set out in the table below:

Serious Incident title	Brief details
Allegation of abuse	A patient alleged that she had been 'poked' by a member of staff whilst a diagnostic test was being performed. In line with the SI Framework, the purpose of the investigation was not to explore the validity of the allegations, but to identify weaknesses in the trust's systems and processes that may lead to adverse events, and to give recommendations to remedy any issues identified.
Follow-up appointment not provided	A patient did not have an appointment booked, following cancellation by the hospital.

All completed SI investigations have associated action plans, which are formally approved by an executive director as part of the report sign-off process. Implementation of the action plan is monitored by the central risk & safety team and the SI panel[8]. Learning 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 2021 to March 2024. Previous reports have included a comparison with data from other acute specialist trusts in England. In September 2023, following the introduction of the Learn from Patient Safety Events (LFPSE) service as a replacement for the National Reporting and Learning System (NRLS), NHS Digital paused the annual publishing of organisational data whilst considering future publications in line with LFPSE. An SPC chart that presents data relating specifically to the quarterly reporting of PSIs has been developed, so that the significance of any increase or decline in reporting numbers can be assessed. Data from previous years has been refreshed.

Reported incidents		
2021/22	2022/23	2023/24
4210	3990	4248

Rate of PSIs reported

The table below presents a summary incident reporting rate for the trust, during the period April 2021 to March 2024. 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.

[8] In March 2024, SI Panel was superseded by the Incident Review Group (IRG).

Reporting period		
2021/22	**2022/23**	**2023/24**
7.52	6.81	7.02

Number of PSIs resulting in severe harm or 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 2021 to March 2024. The trust has a dynamic incident reporting process, and records are continually reviewed and updated. Data from previous years has been refreshed.

Reporting period		
2021/22	**2022/23**	**2023/24**
8	11	6

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.

Reporting period		
2021/22	**2022/23**	**2023/24**
0.19%	0.28%	0.14%

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.

In Quarter 1 2023/24 the trust undertook a re-audit of DoC compliance and compared the results with the previous audit completed during 2020/21. The audit results, which were shared throughout the trust, indicated that the application of DoC would benefit from a period of enhanced scrutiny, as some practices required attention (e.g., some DoC letters were addressed to the GP and copied to the patient), and this additional scrutiny has been provided. Adherence with the individual elements of the 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 on-going basis. Compliance data has continued to be routinely provided to clinical governance committee and quality & safety committee, specifically including the identification of the incidents for which compliance has not yet been achieved. Where non-compliance is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. Actions have been assigned by SI

panel where the need for DoC is identified during the review of an incident. Individual incidents are not closed by the central team until assurance is received from clinical divisions that the DoC has been appropriately applied. This continues to have a positive impact, although the timeliness with which the verbal and written elements of DoC communications are undertaken could still be improved on occasion. Re-audit is due during 2024/25.

The introduction of PSIRF requires modification to a number of trust policies. Policies that currently include DoC requirements will be superseded by a policy that describes the requirements for 'engaging and involving patients, families and staff following a patient safety incident'. The PSIRF guidance does not alter the statutory requirement in relation to DoC. 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.

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; the scope includes not only mandatory 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, for example, 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, and a request for information, by HM Coroner.

During 2023/24 the trust established arrangements to fulfil the National Patient Safety Strategy requirement to have a Medical Examiner (ME) service, the purpose of which is to ensure the provision of independent scrutiny of deaths, and to give bereaved people a voice. The arrangements have been implemented ahead of the statutory requirement to have a ME service being introduced on 9 September 2024. From 1 April 2024, the ME service for the trust is being provided by University College London Hospitals NHS Foundation Trust (UCLH). The UCLH service will cover all Moorfields sites, with 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 prior to the death. The reviews, and inquests, which have taken place have been informed by trust staff and the identified improvements required have been highlighted. Any learning identified has been included in the quarterly learning from deaths report to the trust board.

The following statements meet the requirement set by NHS England and are described against the relevant statement number.

During the period 1 April 2023 to 31 March 2024, zero of Moorfields Eye Hospital NHS Foundation Trust patients died (of which zero were neonatal death, zero were still births, zero were people with learning disabilities and zero had a severe mental illness). This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- Zero in the first quarter.
- Zero in the second quarter.
- Zero in the third quarter.

- Zero in the fourth quarter.

By 31 March 2024, zero case record reviews and zero investigation has been conducted in relation to the zero deaths included above. The number of deaths in each quarter for which a case record review or an investigation was conducted was:

- Zero in the first quarter.
- Zero in the second quarter.
- Zero in the third quarter.
- Zero in the fourth quarter.

Zero deaths, representing 0% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- Zero representing 0% for the first quarter.
- Zero representing 0% for the second quarter.
- Zero representing 0% for the third quarter,
- Zero representing 0% for the fourth quarter.

One case record review took place and one investigation was completed after 1 April 2023 which related to deaths which took place before the start of the reporting period. This number has been estimated using the internal Serious Incident investigation process and the outcome of an Inquest undertaken by HM Coroner.

One, representing 100% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the internal Serious Incident investigation process and the outcome of an Inquest undertaken by HM Coroner. All actions associated with the SI have been implemented and this has been communicated to the deceased patient’s family.

2.5 Statements of assurance from the Board

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 a number of 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 2023/24, 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 2024/25, we will continue with our programme of reviewing the quality of care and delivery of services through our excellence programme and XDU.

The income generated by the NHS services under review in 2023/24 represents the total income generated from the provision of NHS services.

Freedom to Speak up (FTSU) service

During 2023/24, following extensive consultation with staff, Moorfields undertook a full review of its FTSU service. This resulted in the introduction of a new anonymous speak up platform and a successful six-month pilot of a new FTSU champions model in theatres. Also, a new independent substantive lead FTSU Guardian was recruited.

Therefore, for 2023/24, there were five FTSU guardians in place for the majority of the year:

- Dr Ali Abbas, locum consultant, Ealing.
- Derek Scott, health records team leader.
- Amita Sharma, Infection control lead nurse.
- Julia Smythe, ECLO (Eye clinic liaison officer) Croydon.
- Ian Tombleson, director of quality and safety (lead guardian).

The new lead guardian, Princess Cole, started in March 2024.

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 our arrangements. FTSU is viewed as providing additional support for staff should any 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.
- 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. 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 are produced for the trust board and data is also submitted to the National Guardian's office quarterly.

Provision of seven days 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 (08:00 to 20:00) 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 MEH, Microbiology support is available through UCLH microbiologists on a 24/7 basis. Similarly, our testing labs are offer 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 per Schedule 6, paragraph 11b of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in training (England) 2016, the Board receives quarterly reports from the guardian of safe working and an annual report that provides assurance that doctors are safely rostered, and their working hours are compliant with the 2016 TCS. As at the end of quarter 3 in 2023/24, there have been no identified gaps in the rota. Exception reporting has been low, and this reflects trainees' well-being and satisfaction in working conditions.

NHS Doctors and Dentists in Training

Clinical Fellows are locally employed doctors (LEDs) at MEH and are on a unique contract which has been in place for the past decade, and which is not linked to any national terms and conditions of service (TCS). In 2023/24, focus was placed on addressing the immediate challenges faced by the Medical Retina (MR) and Uveitis (UV) services who were most acutely impacted by recruitment and retention issues resulting from the incongruence of the TCS with modern national contracts and local contracts in operation at other NHS organisations. The adoption of the recommendations presented to and agreed by the trust's management executive in September 2023 have provided an interim improvement that allows for focus to be directed to work on the review and reform of the Fellow contract across the next 12 months; which will also feed into the Future Shape of Workforce Programme, which is monitored by the working together excellence board.

Additionally, emphasis will be placed on reviewing the trust's induction and support programme for international medical graduates in line with the national toolkit and actions from the NHSE led programme in 2022/23, which highlighted the notable proportion of International Medical Graduates (IMGs) that form the locally employed doctor workforce.

Participation in clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that Moorfields was eligible to participate in during 2023-24 are as follows:

National Audits

- National Audit of Corneal Graft Outcomes.
- National Ophthalmology Database (NOD) Cataract Audit.
- National Ophthalmology Database (NOD) Age-related Macular Degeneration (AMD) Audit.

National Confidential Enquiries

- No studies were undertaken that were relevant for Moorfields to participate in 2023-24.

The national clinical audits and national confidential enquiries that Moorfields participated in, and for which data collection was completed during 2023-24, 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.

National Audit	Numbers of cases submitted & relevant/eligible
National Audit of Corneal Graft Outcomes	1,216 / 1,520 (80%) *(data from 01/04/2023-31/03/2024)*
National Ophthalmology Database (NOD) Cataract Audit	*23,829 / 21,590 (100%) *(data from 01/04/2022-31/03/2023)*
National Ophthalmology Database (NOD) AMD Audit	**3,294 / 3,717 (88.6%) *(data for patients starting neovascular AMD treatment from 01/04/2021-31/03/2022)*

*NOD received data for 23,829 cataract operations with a record of phacoemulsification and is compared with a denominator of 21,590 recorded in NHS Digital. The NOD team suggested the lower number reported to NHS Digital could be due to system issues, time lags in reporting, or possibly linked to reporting only Moorfields data from the Bedford site. Results are provisional and have not yet been distributed for review by surgeons to check and confirm. Data now aligns to the financial year and information shared is based on the year 2022-23.

**The NOD AMD audit received data from Moorfields (including Croydon and Bedford) for 3,717 naïve eyes starting treatment for neovascular AMD between April 2021 - March 2022. 3,294 eyes were eligible for analysis and 423 were excluded due to the patients' age being <=55yrs at start of treatment (362) or not treatment naïve (61).

NOD numbers are likely to change following a validation period.

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

There were no National Confidential Enquiries (NCE) in 2023-24 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 2023-24, details of current NCE studies were shared at CAEC. Plans for development of processes for NCE transition from child to adult services are in discussion.

Of the 1520 ocular transplant forms received from the NHS Blood and Transplant team for 2023/24, the trust completed and returned 1,216 (80%.) 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 2023, the trust has also submitted several forms received during the previous year. In total during 2023/24, the trust submitted details of 1,488 patients to the NHS Blood and Transplant team.

Whilst no reports have been received from the NHS Blood and Transplant service during 2023/24, 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 second annual report in March 2024 on Age-related Macular Degeneration (AMD) covering the period April 2021- March 2022. Findings will be shared and discussed with the CAEC in May 2024. The sixth and most recent annual report for Cataract Surgery was published in August 2023 and also assessed data from April 2021 – March 2022. Findings were shared and discussed at CAEC in January 2024.

National Audit Report	Discussed	Actions
Trust data compared with national data was published on the NOD website, details of which were presented at the Clinical Audit and Effectiveness Committee (CAEC). The trust scores favourably compared to national results. The sixth annual report of the NOD Audit for Cataract surgery (1 April 2021 to 31 March 2022) was published on 9 August 2023.	Cataract Service	Findings were shared with the Medical Director and Cataract Service. Results were shared and discussed on 18 January 2024 at CAEC.
The second report of Age-related Macular Degeneration (AMD) audit was published in March 2024 and includes details of patients starting treatment for neovascular AMD between 1 April 2021 to 31 March 2022.	Medical Retina Service	Findings were shared with the Medical Director and Medical Retina Service Details will be shared and discussed at CAEC in May 2024.
NHSBT: No reports have been published in 2023-24.	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.

During the period 2023/24, the trust proposed and approved 56 audits assessing national clinical standards/guidelines[9] (many of which have been completed or were re-audits).

The 56 clinical audits derived from national standards and guidelines that Moorfields participated in from 1 April 2023 to 31 March 2024 can be summarised as:

- 3 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).

[9] *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.

- 2 National Service Framework.
- 5 NHS England.
- 6 National Institute for health and Care Excellence (NICE).
- 6 Patient Reported Outcome Measure (PROM).
- 13 Patient Safety First.
- 1 Royal College of Optometrists.
- 2 Royal College of Anaesthetists.
- 8 Royal College of Ophthalmologists (RCO).
- 5 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT). (4 proposals have since been archived)

There were 29 nationally derived audit 'reports' completed and submitted during this time, summarised as:

- 1 National Audits (not part of the National Clinical Audit and Patient Outcomes Programme).
- 2 National Service Framework.
- 3 NHS England.
- 4 National Institute for health and Care Excellence (NICE).
- 4 Patient Reported Outcome Measure (PROM).
- 7 Patient Safety First.
- 1 Royal College of Anaesthetists.
- 3 Royal College of Ophthalmologists (RCO).
- 4 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT).

Participation in clinical research

The National Institute of Health Research (NIHR) Clinical Research Facility (CRF) in Moorfields Eye Hospital ran thirty-eight sponsored research studies and 109 hosted studies, of which over 50% were commercial, in 2023/24. There are currently 56 funded research studies, of which 21 are commercial, being set up with approximately 30 at the concept or grant application stage.

The CRF recruited 3,469 participants in 2023/2024. Total recruitment to studies peaked in 2022 at more than 6,000 due to a number of large observational Covid pandemic related studies as well as operational research studies into patient flow through diagnostic hubs. These studies have now finished with important lessons incorporated into diagnostic hub design and the delivery of ophthalmic care to the large patient populations requiring long-term care.

Our current studies are now mainly interventional requiring more intensive assessment, investigations and long term follow up. Less participants are required to give meaningful conclusions in such studies.

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 MEH continues to attract a pipeline of such high-profile studies.

The National Eye Institute (NEI) funded by the United States Federal Government is the largest funder of ophthalmic research in the world. Moorfields researchers have been invited to collaborate in four large NEI subcontracted research projects to other US Institutions. Moorfields has invested to facilitate such international partnerships with the subcontracted institutions which can require detailed financial, legal, and contractual review to safely manage risk in different legal jurisdictions.

The NIHR and the Department of Health expects Clinical Research Facilities to make the UK as attractive a place as possible for research funded by pharmaceutical companies. Moorfields is developing partnership boards with several industry partners to facilitate research, education, as well as service development. We have also streamlined our set up and research delivery processes to ensure that we can meet the demanding timelines rightly expected by our national & international partners. Recent achievements in this area include £1.2 million study on optimising intravitreal drug therapy and an international multi-site study on a new neuroprotective agent for glaucoma.

Moorfields continues to provide comprehensive research studies across most subspecialty areas of ophthalmology. Examples of existing and new studies include:

- Delivery of more genetic studies in rare and common ophthalmic conditions was a priority in the successful 2022/23 quinquennial National Institute of Health Research (NIHR) Biomedical Resource Centre bid. We have therefore invested in additional specialist staff to facilitate recruitment to local as well as to national Bioresource studies led by Cambridge University.

This year we were successful in bidding for an NIHR £2.1 million infrastructure grant which has allowed investment in new investigative instruments to facilitate both early and later phase studies and to develop new retinal and corneal imaging modalities in collaboration with the UCL Institute of Ophthalmology.

Moorfields currently serves the largest cohort of keratoconus patients in Europe. The European Society of Cataract and Refractive Surgeons awarded a grant to Moorfields investigators of some £400K to deploy know-how and established infrastructure from the INSIGHT Hub Programme to create datasets to enable deep learning analyses for keratoconus. This research has the potential to lead to the development of cost-efficient automated community-based detection of early keratoconus allowing more frequent monitoring of high-risk groups and earlier treatment where clinically indicated.

In 2022/23 MEH was a major recruiter to a new monoclonal antibody study shown to be effective in Thyroid Eye Disease. This trial is now concluding but this experience has led to the development of a pipeline of up to six similar studies on different drugs funded by several international pharmaceutical companies.

Finally, the Medical Protection Society Foundation has recently agreed to fund a study using advanced technology to develop avatars to improve information sharing with patients prior to invasive procedures as well as improve the patient experience.

Commissioning for quality and innovation (CQUIN) framework

Funding arrangements for the 2023/24 CQUINs are part of the national tariff and not separately financed.

Providers were still required to undertake CQUIN schemes proposed and agreed with commissioners from the national list. To keep the funding, the trust was required to report on the agreed CQUINs.

Due to the focus of providers on historical activity levels following COVID 19, the CQUIN process was deemed 'light touch' compared to previous years.

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 2023/24, nor at any time previously.

The trust's most recent CQC inspection took place on 12 September 2023 when the CQC visited Moorfields Private Eye Centre (MPEC). The subsequent report (published: 17 November 2023) gave an overall rating of 'Good' was achieved with 'Good' across each of the five key questions.

In 2023, the new diagnostic and treatment hub at Stratford was opened, with services being withdrawn from Mile End. As part of this process, Stratford was added to the list of trust sites registered with the CQC, and Mile End, and the Ludwig Guttman Centre were removed.

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 procurement of a comprehensive electronic patient record; meanwhile, we support those managing 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. Key to this work will be understanding levels of digital maturity and digital literacy so that the trust is in the best possible position to benefit from the investment and further reduce its IG risks. Meanwhile, engagement with patients and the public continues to be delivered as a core IG activity to meet the trust's duty to be transparent, and to demonstrate that it has engaged stakeholders in the way it manages data by setting out its strategic intent.

The trust has undertaken a review of its management of key systems and processes in information governance, reviewing with stakeholders the method of processing requests for change. Early work includes a refresh of processes supporting prospective researchers and innovators, engaging regulators and NHSE through formal consultation and informally through other forums, to align thinking and working practices, and collaborating with external partners to

deliver interoperability. 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.

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 met all these standards due to improvements IG made to systems, processes, and infrastructure that put the trust in a stronger position. Work is ongoing to build on these improvements to embed the changes within a robust operational framework.

The IG team has continued to put IG quality at the heart of its work through a supportive programme of outreach visits. In this way, better relationships are formed throughout the trust which leads to better support for staff at the clinical interface.

Data quality & audit

Moorfields submitted records during 2023/24 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data (April 23 to February 24). The percentages of records in the published data, which included the patient's valid NHS number, were:

- 99.6% for admitted patient case.
- 99.7% 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.

This year, 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 2023/24.

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 has now been in place for 12 months 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 March 2024. 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 there was an excellent standard of primary and secondary diagnosis and procedure coding. The accuracy rates published in the audit report were:

Audit year	Diagnosis		Procedure	
	Primary	Secondary	Primary	Secondary
DSPT Audit 23/24	100.00%	99.49%	100.00%	99.72%
DSPT Audit 22/23	98.02%	99.4%	98.97%	99.85%
DSPT Audit 21/22	98.5%	99.38%	100%	99.85%
DSPT Audit 20/21	100%	97.20%	100%	100%

The overall findings of the audit demonstrated an excellent standard of clinical coding, with the trust attaining the necessary percentages to meet 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:

- Work with the appropriate software, clinical and administrative teams to create a dedicated hub on Open Eyes (electronic health record) or CITO (electronic document storage platform) for the recording of all current relevant and mandatory secondary diagnosis conditions. This has the dual aim of improving data quality available to those using the systems and of decreasing the amount of time clinical coders spend searching for secondary diagnoses.
- Improve the timeliness of complete, specificity and relevance of procedural and diagnostic clinical information – this will ensure availability and improve quality of documentation at the point of coding within the respective spell.
- Provide coding staff with additional training in the 'Four Step Coding Process' and extraction of relevant co-morbidities and procedures to ensure the accurate translation of clinical information into ICD-10 5th Edition codes and OPCS 4.10 codes.
- Document the specific type of cataract being treated and work towards removing OPCS 4.10 codes from operation sheets as they are unnecessary and introduce the potential for coding errors.

2.6 Priorities for improvement in 2024/2025

The development of this quality account has been led by the director of quality and safety in close liaison with the trust's executive quality and safety leads (the chief nurse and director of allied health professions, and the medical director), in consultation with the chief operating officer.

As described in the statement from our chief executive, the new organisational strategy was launched in 2023/24, and over the next five years we will deliver our vision through our excellence portfolio.

The 2024/25 quality priorities reflect feedback from a comprehensive staff and patient involvement process including discussions at Central Quality Forum, CGC, VLAG, 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 quality improvement principles, ensuring clear, measurable, and SMART objectives for success measurement.

The priorities were presented and discussed at the Clinical Governance Committee, the Quality and Safety Committee, and at the Management Executive. Our host commissioners, NHS Islington CCG, and Healthwatch Islington, have also considered the quality priorities for 2024/25 and are supportive of them.

Moorfields sets out its priorities under the three well-established Darzi headings of patient safety, patient experience, and clinical effectiveness. The priorities set out below are included in the excellence development unit (XDU) programme and will be monitored through the relevant XDU programme board.

The excellence portfolio is made up of five aligned programmes within four boards, with each board having a dedicated executive sponsorship. The four boards are: working together, discover, develop, and deliver, and sustain and scale. The XDU supported the implementation, embedding, and monitoring of a number of the 2023/24 priorities and all the priorities for 2023/24. The XDU will continue in this function for 2024/25.

The XDU ensures there is a consistent approach applied to all the quality priorities across the organisation that includes data driven decision-making, and management of dependencies. In line with the XDU principles, the identified priorities will each have specific metrics to demonstrate and measure performance throughout the year. Moorfields will continue following advice and guidance from NHS Improvement and NHS England to ensure patients continue to receive high quality care as much as possible within current limited resources and capacity which are outside organisational controls as we recover from the pandemic.

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. This quality account has been reviewed by the quality and safety committee and has been finalised as a balanced representation of the trust's priorities across the three areas of patient safety, patient experience, and clinical effectiveness.

The tables below describe the identified priorities, their underlying drivers and how they will be monitored for improvement.

2023/24 Identified priorities – drivers

Classification	Priority	Underpinning drivers						
		Division	Patients (Safer September & VLAG)	Incident priority (PSRIF)	Staff (Q&S workshop, Focus groups)	Risk	Incidents/ Complaints	2023-24 XDU
Safe	Transition and embedding of the National Patient Safety Incident Response Framework (PSIRF)	Y		Y	Y		Y	Y
	Development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)	Y		Y	Y		Y	Y
Patient experience	Certificate of Visual Impairment (CVI)	Y		N/A	Y	Y	Y	Y
	Patient transport	Y	Y	N/A		Y	Y	
	Health inequalities			N/A				Y
	Implementation of patient experience principles	Y	Y	N/A	Y		Y	Y
	Implementation of the patient experience framework	Y	Y	N/A	Y		Y	
	Patient communication	Y	Y	N/A	Y		Y	
	Accessible Information Standard (AIS)	Y	Y	N/A	Y	Y	Y	Y
Effective	Shared decision making - tools and guidance		Y	N/A	Y		Y	
	Shared decision making - staff engagement and empowerment		Y	N/A	Y		Y	

2023/24 Identified priorities – Monitoring and description

Patient safety

Quality priority	Description	Measurement of improvement	Lead
Transition and embedding of the National Patient Safety Incident Response Framework (PSIRF)	PSIRF represents a significant shift in the way the NHS responds to patient safety incidents, focusing on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight. Our PISRF policy and plan were published on the 2 April 2024. and the aim of this project is to build on the work of last year to ensure that the PSRSF principles are embedded across the organisation	• Increase in incident reporting. • Improved safety culture scores on NHS survey • Reduction in moderate harm and above incidents related key safety priority areas.	Julie Nott
Development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)	The development of a learning system will ensure the analysis of aggregate reported patient and staff data looking for improvement opportunities. Most importantly, the mission is that the ability to learn is embedded in our structure and internal processes at every level and reinforced through the culture and behaviours of staff. The project will also focus on implementation of QI principles and recommendations from an external consultation process.	• Impact of actions taken monitored through data (incident trends, complaint etc.) and audit. • Increase in incident reporting and reduction in complaints. • Increased knowledge of events and actions taken to reduce recurrence tested directly or indirectly e.g., via walkabouts and quality rounds. • Increase in % use of LIFEhub webpage.	Kylie Smith

Patient experience

Quality priority	Description	Measurement of improvement	Lead
To improve the process for the allocation of Certificates of Visual Impairment (CVI) to eligible patients.	CVIs are official documents issued to individuals with significant sight loss. This project aims to improve the process and timeliness for issuing CVI to facilitate patient access to support services, benefits, specialised equipment, and educational resources, improving quality of life for the visually impaired.	Number of issued certificates over time	Marco Murro
NEW To improve the experience of patients requiring transport to and from our sites by utilising data in collaboration with our third-party suppliers	Patient and staff feedback have highlighted the need for enhancements in the patient transport process. This project seeks to address these improvements by reviewing and utilizing data provided by our third-party suppliers to drive change.	Under development	To be confirmed
NEW To operationalise the approach developed for routine reporting, review, and utilisation of data on service delivery for health inequalities	This project aims to ensure that health inequalities is data readily accessible to teams to support their programmes of work; whilst also meeting the statutory requirements of NHS organisations.	Suite of standard and additional reporting KPIs adjusted to monitor any health inequalities and variations across cohorts.	Parul Desai
Implementation of patient experience principles	Patient Experience Principles have been developed incorporating the values of kindness, equity, and excellence across the whole patient pathway. This project aims of embed the principles across the organisation to improve the patient experience.	• Service excellence matrix results • Complaints and PALS enquiries • Friends and Family Test • Bespoke KPIs related to improvement projects being driven by local teams.	Robin Tall

Quality priority	Description	Measurement of improvement	Lead
Implementation of the patient experience framework	The aim of this project is to ratify, publish and embed the patient experience framework to support staff to improve patient experience to work towards meeting the three objectives set out in the 5-year patient experience plan.	• Published framework • 5-year delivery plan • Complaints and PALS enquiries • Friends and Family Test • Outputs from the patient experience principles improvement work.	Robin Tall
NEW To review the ways we communicate with our patients.	To meet this aim, we will undertake a review of our existing communication channels (digital and non-digital) to help inform the integration of patient-centred communication into clinical and operational practice, including the new EPR.	Under development	To be confirmed
Continue to embed the Accessible Information Standard (AIS) across Moorfields' network.	Improve the patient experience and care of those with accessible information needs by improving the delivery of accessible information to those that need it. By meeting the Accessible Information Standards, we will ensure that we have a consistent approach for communicating with people who have a disability, impairment, or sensory loss, in line with their individual needs and wishes.	• Proportion of patients with a NEW AIS need recorded out of all patients seen in the month. • Reported patient experience of AIS needs quantitative and qualitative measures from patient survey and expert patient group. • Percentage of patients seen in the month that have an AIS need recorded (before or within 7 days of their attendance) • Out of all patients seen in the month with an AIS need recorded, the percentage of AIS needs recorded as 'No AIS need'.	Laura Brewster

Effectiveness

Quality priority	Description	Measurement of improvement	Lead
NEW To help patients make informed decisions about their surgery	Undertake a review of how we are meeting the NICE guidance to support the surgical excellence programme aimed at improving the way healthcare professionals work together with a patient to reach a decision about care and consent before surgery.	Under development	To be confirmed
NEW To utilise staff shared Decision Making councils to drive staff engagement and empowerment	Support staff engagement and empowerment in the development of shared decision-making councils.	Under development	Mary Masih

2.7 Key indicators for 2024/25

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 is taken to the trust board. Many of the KPIs from previous years are being carried forward, with some updated and removed due to changing reporting requirements both at national and local level. The provisional list of indicators we are focusing on in 2024/25 can be seen in the following tables. As the trust's strategic programmes through the Excellence Portfolio continue to evolve, or if national or local reporting requirements change, metrics may be introduced and updated.

The balance between operational activity, patient safety, and patient experience has been maintained.

In 2023/24, the trust reviewed the presentation of data used in the IPR and following consultation with the board updated the document to report Key Performance Indicator results using NHS England recommended 'Making Data Count' Statistical Process Control (SPC) charts methodology. We are continuing to apply and expand upon this methodology going forward into 2024/25.

2024/25 key indicators

INDICATOR	2021/22 results	2022/23 results	2023/24 target	2023/24 results	2024/25 TARGET
National Indicators					
Cancer 28 Day Faster Diagnosis Standard	93.3%	100%	≥ 75%	92.3%	**≥ 75%**
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat	n/a	n/a	≥96%	100%	**≥96%**
% Patients With All Cancers Treated Within 62 Days	n/a	n/a	≥85%	98.4%	**≥85%**
Reduction of over 18-week pathways	8,842	7,211	n/a	5,962	**n/a**
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks	78.1%	77.9%	≥92%	83.3%	**≥ 92%**
52 Week RTT Incomplete Breaches	395	97	0	144	**0**
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.9%	99.4%	≥95%	98.6%	**≥ 95%**
Maximum 6 week wait for diagnostic procedures	99.0%	99.4%	≥99.0%	99.4%	**≥ 99%**
Mixed Sex Accommodation Breaches	0	0	0	0	**0**

INDICATOR	2021/22 results	2022/23 results	2023/24 target	2023/24 results	2024/25 TARGET
Risk assessment of hospital-related venous thromboembolism (VTE)[1]	98.6%	98.2%	≥ 95%	98.6%	**≥ 95%**
Posterior capsule rupture rate for cataract surgery	1.03%	0.8%	≤1.95%	0.82%	**≤1.95%**
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**
MSSA Rate - cases	0	0	0	0	**0**
Inpatient Scores from Friends and Family Test - % positive	95.0%	95.6%	≥90%	95.9%	**≥90%**
A&E Scores from Friends and Family Test - % positive	92.7%	92.5%	≥90%	92.9%	**≥90%**
Outpatient Scores from Friends and Family Test - % positive	93.3%	93.4%	≥90%	93.6%	**≥90%**
Paediatric Scores from Friends and Family Test - % positive	93.7%	94.3%	≥90%	95.0%	**≥90%**
Freedom of Information Requests Responded to Within 20 Days	95.3%	96.2%	≥90%	65.6%	**≥90%**
Subject Access Requests (SARs) Responded to Within 28 Days	96.0%	95.2%	≥90%	94.4%	**≥90%**
Occurrence of any Never events	2	3	0	2	**0**
Summary Hospital Mortality Indicator	0	0	0	0	**0**
Theatre cancellation rate (non-medical cancellations)	0.7%	1.01%	≤0.8%	1.05%	**≤0.8%**
Number of non-medical cancelled operations not treated within 28 days	18	17	0	23	**0**
Local Indicators					
Total pathways RTT Waiting List	n/a	n/a	n/a	35,656	**≤ 35,656**
Average Call Waiting Time	237 secs	216 sec	≤ 120 Sec	131 Sec	**≤ 120 Sec**
Call abandonment rate	14.5%	17.1%	15%	9.8%	**≤ 15%**
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	1.13%	1.79%	≤ 2.67%	2.17%	**≤ 2.67%**
Endophthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	1	0	0	0	**0**
Percentage of responses to written complaints sent within 25 days	73.5% (Apr-Feb)	70.4%	≥80%	88.6%	**≥80%**

INDICATOR	2021/22 results	2022/23 results	2023/24 target	2023/24 results	2024/25 TARGET
Percentage of responses to written complaints acknowledged within 3 days	99.0%	90.6%	≥80%	97.3%	**≥80%**
National Patient Safety Alerts (NatPSAs) breached	1	0	0	2	**0**
Number of Serious incidents (SIs) open after 60 days[10]	0	0	0	1	**0**
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	-	166	n/a	259	**n/a**
Median Outpatient Journey Times - Non-Diagnostic Face to Face Appointments (Wait at Year End)	n/a	n/a	n/a	97 Mins	**n/a**
Median Outpatient Journey Times - Diagnostic Face to Face Appointments (Wait at Year End)	n/a	n/a	n/a	45 Mins	**n/a**
Overall financial performance vs. Plan (£m) - Year End Position	4.58	5.61	≥0	8.42	**≥0**
Commercial Trading Unit Position vs Plan (£m) - Year End Position	1.17	-1.11	≥0	-0.50	**≥0**
Appraisal Compliance (At time of reporting)	74.9%	70.6%	≥80%	75.6%	**≥80%**
Information Governance Training Compliance (At time of reporting)	93.6%	88.9%	≥90%	90.1%	**≥90%**
Staff Sickness (Rolling Annual Figure)	-	4.7%	≤4%	4.5%	**≤ 4%**
Proportion of Temporary Staff	12.2%	14.5%	No Target	15.5%	**No Target**
Total patient recruitment to NIHR portfolio adopted studies	8,550	5,816	≥ 115 Per Month	211 Per Month (2,532 total year)	**≥ 115 Per Month**
Total patient recruitment to All Research Studies	n/a	n/a	n/a	n/a	**TBC**
Active Commercial Studies (Open + Closed to Recruitment in follow up) (Year End Position)	n/a	n/a	≥44	60	**≥44**
Proportion of patients participating in research studies (as a percentage of number of open pathways)	5.6%	5.9%	≥2%	5.1%	**≥2%**

[10] A new indicator will be developed for the 2024/25 quality account as the trust is transitioning to the patient safety incident response framework (PSIRF) from April 2024.

Part 3: Other information including a statement from our commissioners

North Central London
Integrated Care Board

19 June 2024

Laycock PDC
Laycock Street
London
N1 1TH
0203 198 9743
northcentrallondon.icb.nhs.uk

NHS North Central London Integrated Care Board Statement

The NHS has continued to face significant challenges during 2023/24 as the system focused on recovery from the Covid -19 pandemic, while coping with the impact of Industrial Action, challenges with waiting times to access services, staff shortages and illness. We recognise, and are grateful for, your outstanding leadership and commitment to doing everything possible to keep service users safe, while undergoing significant changes within the senior leadership team at the Trust.

North Central London Integrated Care Board (NCL ICB) has worked closely with the Trust throughout 2023/24, taking a pragmatic approach regarding assurance of commissioned services throughout the year, obtained through regular discussions with key staff within the patient the Trust's patient safety team.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to NCL ICB in May 2024). The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available, a place holder has been inserted.

The quality account clearly sets out progress against the ten quality priorities set out in the Excellence portfolio. It is great to see evidence of co-production with patients, staff, governors, charities and commissioners.

Implementation of the Patient Safety Incident Response Framework (PSIRF) has been a key priority for the Trust this year. PSIRF was implemented in April 2024, accompanied by a PSIRF Policy and plan. This is a key component within the national Patient Safety Strategy and is a requirement for all NHS Trusts to implement from 01 April 2024.

The work on enhancing patient experience for the visually impaired, through developing and implementing a comprehensive training package for clinical and non-clinical staff, is welcomed by the ICB. It is great to see that the Trust continues to build on this work through launching immersive Virtual Reality training within clinical environments, to further improve the experience of patients with sigh loss.

North Central London ICB Chair: Mike Cooke
North Central London ICB Interim Chief Executive Officer: Phill Wells

NCL ICB are supportive of the quality priorities set out by Moorfields for 2023/24, which focus on patient safety, patient experience and reducing health inequalities. We look forward to continuing to work collaboratively with the Trust, and system partners, to improve access and care for all our residents across North Central London boroughs.

Yours sincerely,

Phill Wells
Interim Chief Executive Officer
North Central London Integrated Care Board

North Central London ICB Chair: Mike Cooke
North Central London ICB Interim Chief Executive Officer: Phill Wells

Statement from Healthwatch Islington

We welcome the Quality Priorities focusing attention on continuing to embed the Accessible Information Standard and improving communications with patients.

The feedback we have received about services at Moorfields Eye Hospital over the last year was gathered via an online engagement event we hosted that gave residents the opportunity to share experiences and raise concerns directly with senior staff belonging to the Trust's patient experience and customer care team. We welcome the Trust's commitment to community engagement of this kind.

Feedback from individual service users covered accessibility issues related to visual impairments (the audio description system announcing services located on each floor not being switched on in the lift, lack of contrast making signage hard to read, lighting choices in one particular clinic making it hard to see, text used to describe menu items in the canteen being too small to easily read).

Feedback on patient transport described the frequency of eligibility tests as onerous. The closed nature of the eligibility questions made it difficult for some patients to fully articulate their level of need. One patient who did not qualify for patient transport but had mobility issues reported that they were unable to access services as a result.

It was also felt that it would be useful to consider how actions taken as a result of patient feedback from the Friends and Family Test might be shared beyond the you said/we did signs displayed within the hospital.

We welcomed the fact that, where practical, the Moorfields patient experience and customer care team were able to follow up with individual residents after the event to resolve their issues. This helps make the community engagement feel meaningful and worthwhile to the residents who participate.

Luke Buffery
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