Quality Account 2022/23

(includes Quality priorities for 2023/24)

Our commitment to quality excellence

FINAL v1.0

Contents

Part 1: Statement on Quality

1.1. Statement on quality from the chief executive

I have been at Moorfields Eye Hospital NHS Foundation Trust (MEH) for almost two years, after joining halfway through 2021/22 during a Covid-19 wave. The direct impact of the pandemic has lessened, but we continue to experience the challenges that were present before the pandemic – including increasing demand, which is now augmented by the after-effects of Covid-19.

Moorfields continues to meet these challenges through service transformation and finding new ways to support and treat patients. Our hub model, supported by remote clinical review, continues to grow across the network – reducing the time patients need to spend in clinic.

Another great example of providing excellent care, effectively and efficiently, is the opening of our Cayton Street laser suite as part of a new patient pathway, enabling patients to receive treatment on the same day as their appointment. This minimises delays and reduces patient waiting times.

With huge input from our staff and patients, we also launched our new five-year organisational strategy – working together to discover, develop and deliver excellent eye care, sustainably and at scale. Our strategy commits to all round excellence, making progress in the areas most important to our staff and patients by looking ahead to the opportunities and challenges of a changing world.

Our strategy acknowledges that we need to build on our heritage of expertise in eye care, research, and education and adapt for the future, ensuring we continue to be innovative and add value for our patients. At the very heart of our new strategy, we have reaffirmed our core belief that people's sight matters, and the importance of our refreshed values – excellence, equity, and kindness.

Over the next five years we will deliver our strategic vision through our excellence portfolio, supported by our excellence delivery unit (XDU). The XDU will also monitor the quality priorities described in this account to ensure they deliver sustainable positive change for staff and patients.

I recognise the impact of challenging times on our dedicated and committed staff who have worked so hard to meet the challenges that have been put in front of them. Staff wellbeing

remains a priority at Moorfields, and it is only through caring for our staff that we can continue to provide such excellent ophthalmic care for our patients.

In our recent staff survey, we made areas of progress, however our results are not where we want them to be. I'm committed to ensuring we take action to address feedback and improve the overall experience for all of our staff.

We have started to make progress this year, rolling out our active bystander workshops, our leading with compassion programme for managers, reintroducing our Moorfields' Stars recognition awards, recruiting co-chairs for our three staff networks, and most recently relaunching our dignity at work policy, and bullying and harassment resolution pathway. We want to ensure there is a continuous cycle of improvement so we can not only see positive outcomes in our staff experience journey but that we all feel it in our everyday working lives and team morale.

We remain committed to being a learning organisation and determined to continue to take the learning from the pandemic and other areas as an opportunity to reflect and consider innovative approaches to improvements in clinical care and patient experience.

Testament to this, we have once again achieved excellent clinical outcomes in 2022/23. Additionally, the integrity of our quality governance has remained central to our processes, which provides the organisation with robust assurance over our three key quality areas of patient safety, clinical effectiveness, and patient experience.

Our quality account reflects our quality performance in 2022/23. Overall, we have made good progress with many of our indicators. In areas where we have performed less well, we have plans in place to restore performance as we continue to recover from the pandemic.

Finally, I would like to again pay tribute to our excellent staff. Your commitment, teamwork, and passion are valued and are central to us providing the best care for our patients.

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 2022/23

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 trusts' services by examining the effectiveness of treatment that patients receive, patient safety, and patient feedback about the care provided. The Quality Account 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, which includes patients and the public.

Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2022/23.

At Moorfields, the quality of the services we provide is at the heart of all board decisions. Our strategy, developed in collaboration with our patients and staff, will take us further on our journey towards an overall Care Quality Commission (CQC) outstanding rating. The three key drivers for quality, and the trust's quality structures, create robust arrangements for driving improvement and provide a clear and accountable process for scrutiny, assurance, and delivery of the Quality Account.

The quality of evidence provided in the Quality Account is dependent upon good governance. We have a robust clinical governance structure so we can be sure our evidence of quality is monitored and is matched by our corporate governance systems, neither of which can thrive without the underpinning quality of our information governance. We believe that good care and good governance come hand in hand.

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.

In 2022/23 we introduced the Excellence Portfolio, an executive led framework for change activity across the trust. Assurance for delivery of portfolio projects is provided by Excellence Delivery Unit (XDU). The XDU is responsible for promoting a consistent change method, enabling data driven decision making and proactive management of interdependencies across our change work. This approach draws on good practice methodology and embeds principles of continuous improvement, such as agreeing measures to show impact. In 2022/23, there were 65 projects supported within the Excellence Portfolio.

The Excellence Portfolio is the delivery vehicle for our strategy and is comprised of 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 2022/23, 17 quality-led projects were supported by the Working Together Excellence Programme Board to progress. Examples include Patient Experience Principles, Safety Campaign, and Eye Envoys.

The Eye Envoy programme is aimed at upskilling community nurses in eye health. This project will benefit around 600 service users in eight care homes across Camden and Islington. The three-day course, funded by NHS England/Health Education England, equipped delegates with the knowledge to support people's existing eye conditions and the insight to be alert for deterioration or new sight loss problems. With 80% of people over 60 having some problem with their vision, this new course has the potential to improve the quality of life for large numbers of older people.

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

Planning for 2023/24 Excellence Portfolio has seen two quality projects placed in category 1: Accessible Information Standard, and Freedom to Speak Up. These projects will receive the greatest amount of support, focus and visibility throughout the year. There are 60 projects supported within the Excellence Portfolio in 2023/24. Of those, 15 projects are within the Quality Excellence area, including National Patient Safety Strategy (PSIRF), and Making Every Contact Count. Projects have been aligned with the Quality Account priorities for 2023/24.

August 2022 also saw the launch our upgraded OpenEyes (Version 6) patient record system. OpenEyes is a key clinical system to store patient and care information that is used by over 1,500 colleagues across our network of UK sites. The benefits of moving to version 6 include the ability to see patients' key information in one place and workflow digital automation that creates a better patient journey across our sites.

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 2022/23 priorities

Throughout this period, we have focused on the six key quality priorities described in last year's quality account. We developed these priorities collaboratively with patients, staff, governors, commissioners, and relevant charities. The rationale behind the priorities was based on the progress made with the 2021/22 priorities, as well as staff and patient feedback regarding how we could further improve their experience at Moorfields. During the year, progress to achieve our quality priorities was monitored by the trust's Clinical Governance Committee (CGC), with some[1] priorities also monitored by the newly established Excellence Delivery Unit (XDU) working together and delivery excellence boards.

The trust board approved the six identified priorities, which were based on the three domains of quality: patient safety, clinical effectiveness, and patient experience.

Having set ambitious priority targets, the trust has demonstrated progress across them all. In some areas, full achievement has not been possible. This has been explained in the narrative and some of the priorities will also continue into 2023/24. A summary of the priorities can be found in the table below.

Summary of the 2022/23 quality priorities:

Domain	No	Description	Priority continued from 2020/2021
Patient safety	1	Implementation of the National Patient Safety Strategy*	New
	2	Supporting safer care for patients undergoing invasive procedures	New
Patient experience	3	Embed the Accessible Information Standard (AIS)*	New
	4	Further improve our customer care responsiveness and communications with our patients	New
Clinical effectiveness	5	Reducing health inequalities via 'Make Every Contact Count'*	New
	6	Explore and exploit the full potential of Tendable*	New

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[1] Priorities monitored by the excellence delivery programme and XDU are marked with an * in the associated table.

Improvement achievements against priorities in 2022/23

This section of the quality account highlights achievements against the priorities set for 2022/23.

Patient safety

Quality Domain: Safety
Priority 1: Implementation of the National Patient Safety Strategy (NPSS)
Priority Lead: Julie Nott

Our priority for 2022/23 is: Implementation of the Patient Safety Strategy focusing on:	**Rationale:**
	The National Patient Safety Strategy (NPSS) sets out what the NHS will do to achieve its vision to continuously improve patient safety. Moorfields patient safety strategy encompasses the principles of the national strategy and is being developed using a patient and staff centric approach with patient safety partners, drawn from our patients and carers. Moorfields has patient safety specialists to support and drive this agenda, and they will be key in delivering the new strategy.
• Further developing our culture of speaking up and promoting a safety culture across the organisation.	
• Implementing staff-training requirements outlined in the NHS Patient Safety Syllabus.	**What success will look like by the end of March 2023:**
	All requirements of the National Strategy will be in place and completed within the deadlines set by NHSEI.
	What we will measure and when:
	• Patient safety partners will be recruited ensuring all improvements are fully aligned with patient and service user involvement.
	• Key measures will be developed during implementation. It is anticipated that the patient safety incident response framework will be circulated by NHSEI in June 2022.

Background

Launched by NHS England and NHS Improvement in July 2019, the national patient safety strategy describes how the NHS plans to continuously improve patient safety by building on two foundations, a **patient safety culture,** and a **patient safety system**. Three strategic aims support the development by:

improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)

equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)

designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

What did we achieve to date?

Patient safety partners

Two patient safety partners (patients and carers, who support and contribute to our governance and management processes for patient safety) have been successfully recruited and will join our patient safety committees in 2023/24. They have both been provided with objectives to ensure that the patient voice is central to what we do and included in the development of patient safety strategies.

Patient safety incident response framework (PSIRF)

Implementation of PSIRF is supported by the XDU and monitored by the working together programme board, to which monthly updates are provided. The documentation to support PSIRF was circulated by NHSE in mid-August 2022. We have considered the preparation guide provided by NHSE, with the aim to meet the requirement to implement our patient safety incident response plan (PSIRP) in September 2023. The following tasks have been completed:

- PSIRF is supported by several documents and tools, all of which have been reviewed.
- Early socialisation of PSIRF across the organisation has taken place. This includes identification of why we will be transitioning from the serious incident framework to PSIRF and the timescales for implementation. An NHS England animation has been shared at the chief executive briefing and in various quality and operational forums, including the quality and safety committee.
- Attendance, by multiple members of the wider quality team, at a pan-London webinar and UCLP-led North Central London PSIRF workshop, and multiple national webinars regarding the orientation and diagnostic and discovery phases of implementation.
- The diagnostic and discovery phase has been completed and a gap analysis undertaken to determine the focus of our patient safety incident response plan (PSIRP). This will ensure that resources following the implementation of PSIRF will focus on identified risk areas for improvement.
- Staff survey results have been analysed and used to inform the methodology for our safety culture survey, which will be completed in 2023/24. The aim of the survey is to obtain qualitative and qualitative data (through focus groups) to inform our PSIRP and monitor improvement.

Learn from patient safety events (LFPSE)

LFPSE forms the digital component of the National patient safety strategy. LFPSE is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), to offer better support for staff from all health and care sectors. Although the requirement to move from NRLS is in the final stages of development nationally, trusts have been given the option to delay implementation following feedback from providers. In preparation for the change, we engaged

with Ulysses (Safeguard) and met the requirement to have a test system in place by March 2023. We are confident we will meet the new go-live deadline of September 2023.

Patient Safety Syllabus

The national strategy includes a patient safety syllabus and training programme for the whole NHS. This is designed to help everyone who works in the NHS take all the necessary steps to ensure our patients are safe while they are in our care. The syllabus is not mandatory at this stage, although there is an expectation that all staff should undertake the training, and it forms an integral part of PSIRF. The roll out of the syllabus will be formalised and aligned with the implementation of PSIRF. In the meantime, staff are encouraged to undertake the training as part of the orientation and engagement phase of the PSRIF delivery plan. Currently there is no mechanism to monitor or record who has undertaken the training, however, once the PSIRF training requirements are identified in the diagnostic and discovery phase of the PSIRF implementation, the syllabus will be added to Insight where this can be monitored.

What are the gaps in delivery?

No gaps in delivery have been identified. Project management support has been provided via the XDU programme board to ensure the project stays on track to meet the September 2023 implementation deadline. PSIRF has also been included as a quality priority for 2023/24 and will be monitored by the working together excellence programme board.

| **Quality Domain: Safety** |
| **Priority 2: Supporting safer care for patients undergoing invasive procedures.** |
| **Priority Lead: Andy Dwyer** |

Our priority for 2022/23 is:	**Rationale:**
Supporting safer care for patients undergoing invasive procedures through further development of LOCSSIPs according to National recommendations (NATSSIPs)	The National Safety Standards for Invasive Procedures (NatSSIPs) from NHS England describes the key steps necessary to deliver safe care for patients undergoing invasive procedures and allows organisations delivering NHS-funded care to standardise the processes that underpin patient safety. Local Safety Standards for Invasive Procedures (LocSSIPs) include these steps to harmonise practice, ensuring a consistent approach is taken to the care of patients undergoing invasive procedures across the organisation.
	What success will look like by the end of March 2023:
	Moorfields will have approved and implemented a local Safer Surgery and Invasive Procedures Policy for invasive procedures based on the key steps described in the NatSSIPs document. This policy will provide a standardised process for ensuring the safety of patients following an invasive care pathway.
	What we will measure and when
	• Audit of the intravitreal injection pathway (Q1 2022-23)
	• Identification of leads and invasive pathways across the trust (Q2 2022-23)
	• Development of other invasive pathways to adhere to the standardised practice within the trust policy (Q3-Q4 2022-23)

Background

NatSSIPs have been developed nationally by a multidisciplinary group of clinical practitioners, professional leaders, human factors experts, and lay representatives. They set out key steps to deliver safe care for patients undergoing invasive procedures and enable organisations to standardise the processes that underpin patient safety. Based on the key NatSSIPs steps, we will develop LocSSIPs

to harmonise practice across the organisation, ensuring there is a consistent approach to the care of patients undergoing invasive procedures in any location or on any site.

This objective has been developed to ensure that staff are aware of the key steps to follow when standardising LocSSIPs and supports the development, purpose, and use of trust safer surgery checklists. It will also ensure that the trust is able to consistently benchmark practice across the various sites and services within.

What did we achieve to date?

- Implementation of the theatre LocSSIP has been completed, including a revitalised WHO checklist. This has been accompanied by a modernised WHO audit programme and monitoring process to demonstrate that the LocSSIP has led to improvement.

- Approval and ratification of the new Safer Surgery and Invasive Procedures Policy to replace the previous Surgical Safety Checklist Policy has been completed and disseminated. This policy describes a standardised process for ensuring the safety of patients following an invasive care pathway.

- The Theatre LocSSIP and Safer Surgery and Invasive Procedures Policy, were launched during the trust's Safer September 2022 week-long campaign. Audit data and staff feedback regarding the checklist and the policy are being collected and will be reviewed, in collaboration and consultation with staff, in March/April 2023. Should any improvements be identified, the LocSSIP will be updated to reflect this.

- Three separate audits of the intravitreal injection LocSSIP and associated patient pathway were started to identify good practice and areas for improvement. One audit examining the completion of the current intravitreal injection checklist has been completed and shared with staff. An audit of staff views of the checklist and process, along with an observational audit of practice with associated training are nearing completion. The data collected by these audits will help inform the learning and actions required for the implementation of new LocSSIPs, including a YAG laser LocSSIP.

What are the gaps in delivery?

Delays in the observational audit of the intravitreal injection pathway have postponed overall findings from the associated audits. Findings from adjoining audits have identified the need for better communication and oversight of the checking processes for intravitreal injections, which will be actioned by the trust. The delay in observational audit findings has meant that our aim to introduce a new LocSSIPs in 2022/23 has slowed and will remain a focus for the trust in 2023/24.

Patient experience

Quality Domain: Patient experience
Priority 3: Embed the Accessible Information Standard (AIS)
Priority Lead: Ian Tombleson

Our priority for 2022/23 is to: Embed the Accessible Information Standard (AIS) across Moorfields' network	**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. **What success will look like by the end of March 2023:** • 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. • Develop a trajectory for improvement including measures and metrics into 2023 and beyond. **What we will measure and when:** Example improvement measures from baseline include:

Metric (group)	Frequency
AIS flags on system (PAS / OE)	Monthly
Reported patient experience of AIS needs quantitative and qualitative measures from patient survey and expert patient group.	Bi-annual or quarterly
Reduction in AIS related patient complaints, PALS enquiries and friends and family comments	Bi-annual review

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 sight loss patients.
- 'Strategic' momentum across the trust to improve the patient experience and comply with the standard.

What did we achieve to date?

1) We set up a project steering group, working groups and an expert patient group to ensure that going forward we achieve compliance with the legal requirements of AIS.
2) Using a patient centered approach, built around patient co design using an expert patient group, we have designed a vision that empowers patients in their care by allowing them independent access to their care letters.
3) We have been evaluating how to build effective automated processes to consistently meet the patients' needs in a wide variety of communication formats e.g., braille, transcription to BSL, large font letters, easy read letters, letters in color contrast.
4) Designed a first set of metrics that enable us to demonstrate to progress in identifying and meeting the need for the patient groups mentioned in the standard

What are the gaps in delivery?

We see this as a core priority to support our patients. This is therefore an ambitious project aiming to provide digital solutions to our patients, where it is possible to do so. However, we have not achieved what we wanted this year due to key challenges around technology. In particular, the technology required to support the automation of print production, particularly with respect to flagging AIS needs in our electronic medical record system (OpenEyes). For 2023/24 a project review by the XDU team has reset our approach. We will focus on continuing to build our current manual processes and making these as efficient as possible. We will introduce technological solutions, where possible, with a focus on ensuring our new electronic patient record (EPR) is developed to include AIS functionality. In addition, we will enhance cross-organisational ownership of AIS, which will lead to a practical and deliverable approach to our AIS requirements. This approach will be measured and monitored as it builds over time. Finally, we will drive AIS compliance as part of our culture of support for our patients and we will communicate this widely amongst our staff. AIS therefore forms a quality priority for 2023/24.

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Quality Domain: Patient experience **Priority 4: Further improve our customer care responsiveness and communications with our patients.** **Priority Lead: Jon Spencer and Ian Tombleson**	
Our priority for 2022/23 is to: Further develop a positive customer care focused culture including improving our communications particularly to support our more vulnerable patients	**Rationale:** This builds on the work already achieved, for example, the launch of all staff sight loss training in October 2021. We know that communications with our patients can be inconsistent and that, for example, appointments management needs to improve. **What success will look like by the end of March 2023:** Customer care and effective communication underpin our plans for operational excellence. We will have further embedded our customer care culture by developing customer care principles, which will be used to drive our business to focus on the needs of all our patients and service users, particularly those with sight loss and other vulnerabilities. We will have a plan in place driving improvement in the way we communicate with our patients and how we evidence this is having a positive impact. A Patient Experience Strategy is being developed, which will include communicating with our patients. **What we will measure and when:** - Maintain a regular sight loss awareness campaign with our staff. - Develop a set of customer care principles which will be available to drive improvements centrally and locally. - Develop a set of clear measures to track how well we communicate with our patients. - Launch new virtual reality (VR) training to increase staff awareness and drive better patient/customer care focused behaviours to support vulnerable patients. - Launch our Accessible Information Standard (AIS) project introducing new direct support for patients with AIS needs (quality priority 3)

Background

Our patient experience and communications are inconsistent, and we continue to receive complaints and PALS concerns related to this. Working with a range of stakeholders, Moorfields has developed sight loss awareness training; staff take-up of this training has been excellent. We will build on this by launching immersive VR training to improve customer focus in clinical environments. We are developing a set of patient experience principles which, in line with our values, will drive positive staff behaviours to support all our patients, particularly those who are most vulnerable. A further driver to support our vulnerable patients is to launch our Accessible Information Standard (AIS) project, meeting the requirements of the law and those patients with AIS needs. In addition, further work is taking place to improve our patient communications in key operational areas.

What did we achieve to date?

- **Development of patient experience principles:** We have developed a set of five patient experience principles with our patients and staff, which focus on improving the day-to-day experiences of our patients when they use our services. This includes focusing on empathy and good listening. These principles will be implemented in 2023/24 alongside our staff core behaviours framework.

- **Improving PALS and patient 'facing' service:** During the year an internal audit took place of our complaints and PALS service. The audit was positive indicating the department benchmarked well against the complaints departments of other trusts. Recommendations were made about enhancing performance, remaining patient centered and updating our policy.

- **Virtual reality immersive films:** We have developed several virtual films to help our staff understand how patients with eye conditions and limited sight experience our services, although not at the pace that we anticipated. These films focus on areas where patients need our support In 2023/24, we will use them to inform and educate our staff to improve patient experiences.

- **Ockenden and Kirkup review:** A review of learning from the main themes from the Ockenden review led by the Clinical Governance Committee and has been completed. Themes have been integrated into the review of the PALS service, including putting the views and voices of patients, families, and carers first and ensuring there is full learning from complaints and PALS at all levels of the organisation, particularly in patient facing environments such as wards and clinics.

- **Improving our appointment letters.** Clear and well written appointment letters are key to good communication with our patients. Standard letter templates have been rolled out across clinical services, and a streamlined approach is being developed to support the automatic updating of letter templates with the latest information on issues such as infection, prevention and control.

- **Centralisation of our administration teams.** The first phase of centralisation is underway, providing administration teams in satellite units with greater support and oversight. A significant amount of work has also been undertaken to ensure that such teams receive appropriate communication and customer care training.

- **Booking centre performance:** A key route by which patients contact Moorfields is through our contact and booking centre. Historically performance has been poor with call rate pick up times averaging nearly 7 minutes in September 2022. In 2023 performance improved substantially to 2 ½ minutes in April 2023, with the aim of sustaining this going forwards. The call abandonment rate also achieved the target of <15% for April and May.

- **Patient Portal and DrDoctor update.** The primary way in which the patient portal has improved communication with patients is the roll out of digital outpatient appointment letters. Following the success of a pilot at the Purley site, digital outpatient appointment letters have gone live across the three clinical divisions (South, since 30 August 2022, North, since 12 September 2022 and City Road since the end of September 2022). We are also planning on expanding the roll out to include did not attend (DNA) letters. In total 14,541 digital outpatient appointment letters have been uploaded, with 13,108 patients notified, resulting in over 50% (7,295) of letters being read online. Since going live with digital outpatient appointment letters on 30 August 2022, the South Division have contributed nearly 5,000 letters to this total.

- To better understand the impact of this change on our patient population we sent the following Quick Questions survey to patients in the South Division who would have received their most recent outpatient appointment letters digitally, since going live on 30 August 2022:

"Was receiving and accessing your most recent outpatient appointment letter digitally via the patient portal a positive experience?". The following responses were received:
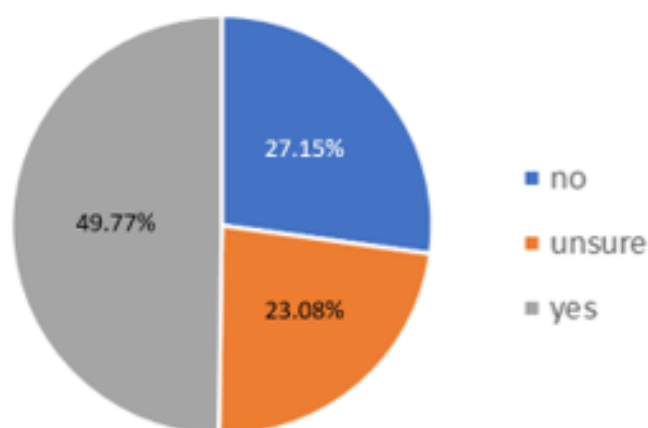
What are the gaps in delivery?

Improving our communications is complex and essential to our day-to-day support for patients and there is much more to do. We continue to do better through a range of mechanisms working in

combination. We will review and monitor these mechanisms and continue to learn to improve. Regular updates will be provided to QSC and Membership Council. Communication continues to be a key focus for the trust and is included in XDU and quality priorities for 2023/24.

Clinical effectiveness and patient outcomes

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Quality Domain: Effective

Priority 5: Reducing health inequalities via 'Make Every Contact Count.'

Priority Lead: Roxanne Crosby-Nwaobi
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Our priority for 2022/23 is to:

Develop systems and processes to reduce health inequalities by working in partnership with our staff to 'Make Every Contact Count'.
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Rationale:

By utilising the principles of Making Every Contact Count (MECC) and our day-to-day interactions with patients to encourage changes in behaviour, we have 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 2023:

Commencing in November 2022, a scoping exercise will take place to understand how this approach will be implemented across the trust, the resources required, and a training programme scoped and developed. This will be completed in partnership with local and national key stakeholders including public health colleagues. Once this has taken place a business case will be developed.

What we will measure and when: It is a challenge to measure the impact of MECC interventions. A MECC evaluation framework will be developed to support implementation:

- A scoping exercise will commence in Quarter 3 (November 2022) to understand the need and how this could robustly be implemented across the trust. This will include an evaluation framework. This will be completed by March 2023.
- A business case will be taken to BCRG in April 2023.
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Background

Many long-term diseases are closely linked to known behavioral risk factors such as tobacco, hypertension, alcohol, being overweight or being physically inactive. Making every contact count (MECC) is an approach to behaviour change that utilises day-to-day interactions with patients to encourage changes in behaviour that have a positive effect on the health and well-being of the individual, but also the wider population.

The expectation is that all NHS organisations will commit to MECC. NHS England included MECC in its 2016/17 NHS Standard Contract Service Conditions which states:
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The Provider must develop and maintain an organisational plan to ensure that staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance

What did we achieve to date?

Smoking is a major risk factor for many pathologies including those related to the eye. The combination of health issues, for example, diabetes and heart disease together with smoking can cause irreversible damage to the small blood vessels in the eyes (Boyd 2020). It is considered good clinical practice to offer basic information and advice on smoking cessation. (BNF 2018, RCN 2019, NICE (NG 209) 2021). A trust-wide audit was conducted to determine the level of completion of smoking status data in OpenEyes for patients attending Moorfields Eye Hospital clinics between 01/09/2021 – 31/12/2021. The Croydon site was excluded as they used Medisoft as their electronic health record. We found that only n= 3268 (3.09%) of patients were asked if they smoke and had their smoking status recorded.

NICE Guidelines (2021) recommend that the information about stop-smoking support and how to access services, including support to temporarily stop, should be provided to people who use secondary care services. The Public Health England Making Every Contact Count (MECC) consensus statement (2016) sets out that "a brief intervention can help communicate to an individual that by them taking positive action, they can reduce their risks for many conditions. A brief intervention can deliver a persuasive message; helping raise an individual's awareness of their risk factors, while contributing to their motivation to act". Therefore, the aim of this priority was to implement a plan of action to ensure that patients are asked about smoking habits at every visit, their answers are recorded appropriately, they have access to smoking cessation advice and services and staff receive the relevant training to ensure this process is accessible to all patients attending MEH.

An operational lead for this project has also been appointed to continue to drive improvement. Since their appointment the team, supported by comms, launched a successful media campaign 'National No Smoking Day. The messaging was present on eyeQ, MEH News, Twitter, and LinkedIn.

What are the gaps in delivery?

Progress continues in the delivery of this priority. The MECC London link was re-launched in April 2023 and the trust's MECC team will liaise with them to determine how we can utilise this system at MEH. The team will also meet monthly to continue to progress this priority and it will be a quality priority for 2023/24, monitored by the working together excellence programme board

Quality Domain: Effective
Priority 6: Explore and exploit the full potential of Tendable.
Priority Lead: Kylie Smith

Our priority for 2022/23 is to: Explore and exploit the full potential of *Tendable* (formally *Perfect Ward*) app	**Rationale:** The use of technology to support the development of change and standardisation is key when considering an amalgamation of data from numerous sources and multiple methodologies. The trust has chosen the 'Tendable' (previously named 'Perfect Ward') application (app) to enhance and standardise the ease and efficiency of quality inspections and audit. This will enable audits and subsequent actions to be progressed quicker and monitored effectively. **What success will look like by the end of March 2023:** We will exploit the potential of Tendable by developing an output and outcomes framework linking the practical usage of Tendable to our audit programme. All staff involved in audits and inspections will have registered and submitted data into the Tendable app. Senior staff will understand how to access and present live analytical data for their departments and teams, providing an immediate understanding of compliance across all sites and departments. **What we will measure and when:** • A new contract will be agreed with the Tendable team (Q1 2022-23) • A structured framework for outputs and outcomes of using the Tendable tool will be developed and linked to our audit programmes (Q3 2022/23) • All departments will have QR codes (Q2 2022/23) • All Tendable data will be linked to a Quality dashboard within Qlik sense (Q2 2022/23) • Senior staff on all sites will have received training on the use of Tendable and how to extract detailed analysis of the data (Q3 2022/23) • At least 10 nursing/quality audits will be successfully undertaken and embedded within Tendable (Q4 2022/23)

Background

The trust currently operates with five divisions, and multiple sites with numerous services and departments within those sites. To assess quality standards across all domains, staff audit all areas by way of observations, documentation reviews, walkabouts and other rounds and risk assessments. These are followed-up by in-depth assessment and analysis of data and detailed reports to share at high-level committees to facilitate change and improvements.

Due to the time taken by staff to develop and present reports, they can often be out-of-date at the time of presentation or dissemination as time and progress has since moved on. Therefore, the assurances provided at senior committees will always reflect events at a given point.

The use of technology via the Tendable app provides live detailed analysis, including uploaded evidence of findings, a summary of actions and improvement advice where evidence of non-compliance is identified. Expanding its use and capability in a structured way will deliver several positive returns in terms of data efficiency and quality, and improved outcomes.

What did we achieve to date?

During 2022/23, a Tendable project group was established to sustain and build on the Tendable implementation work undertaken during COVID-19. Since its formation, the key focus of the group has been to collaborate with Tendable and relevant staff groups to ensure the audit requirements of specific clinical areas have been reviewed. This review identified the need to focus on specific audits already on the Tendable system, including the WHO checklist, resus, and IPC audits. As such, much of the year has been dedicated to ensuring the audit questions for these specific audits provide meaningful outcomes and are mapped to relevant clinical areas and completed as scheduled. This focus has resulted in a significant increase in the number of audits being submitted on the app each month, as outlined in *table 1.*

Table 1; No of audits submitted each month on Tendable.

Number of audits submissions on Tendable each month - starting 01/06/21
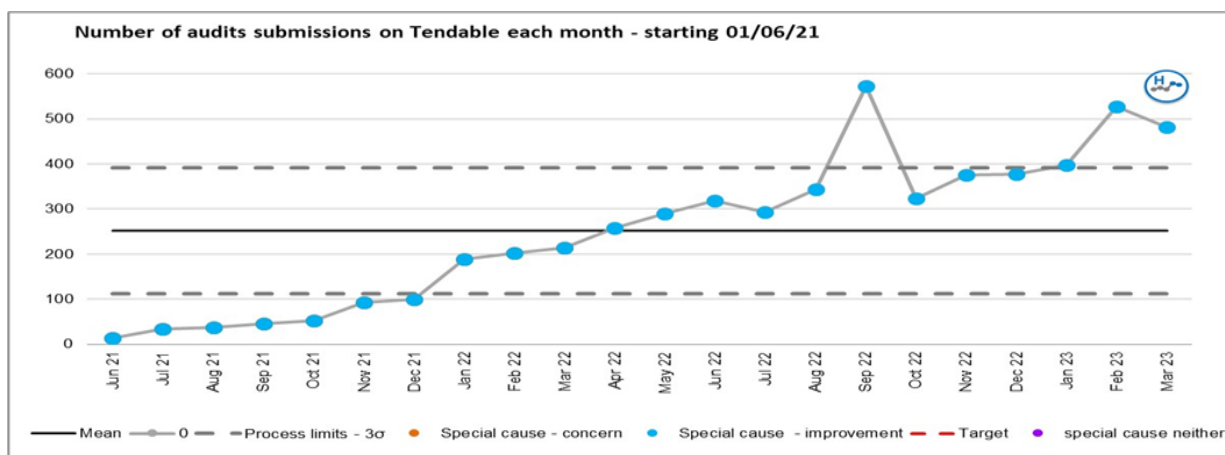
Correct mapping of the 22 audits quality checked in 2022/23 to the 125 clinical areas has demonstrated an increase in the audits submitted within their deadline dates.

Table 2; Percentage of audit deadlines met each month on Tendable.

Percentage of deadlines met each month for audits submissions - starting 01/09/21
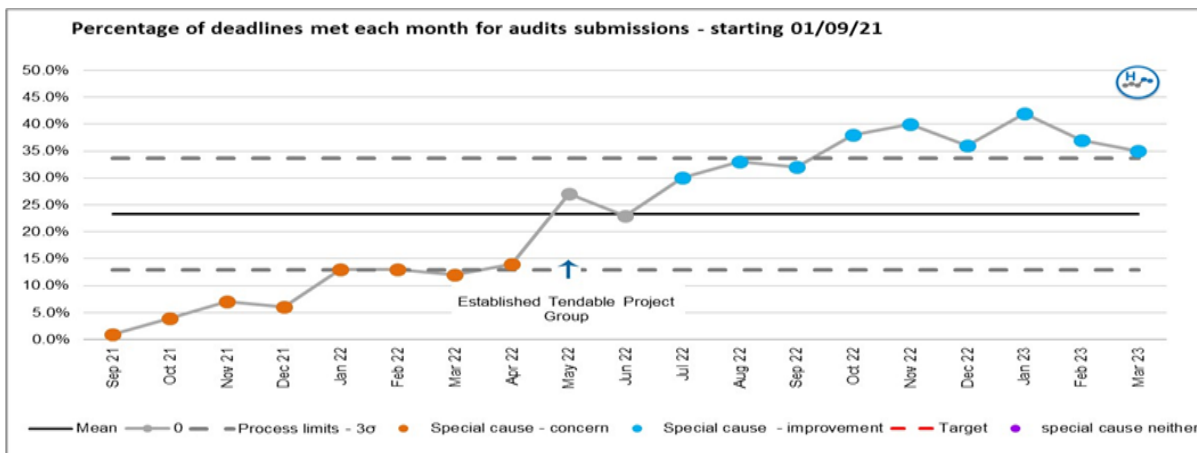
The lessons learned through the working group systematic review of the WHO, IPC, and resus audits, will then be applied to other audits on the system, including the fire audits and quality round audits, before new audits are added to the app.

Other extensive work undertaken in 2022/23 includes:

- Nearly 500 staff approved and registered to use Tendable.
- Weekly Tendable training session in place to support current and new users.
- Fortnightly meetings with audit lead and Tendable to establish the correct mapping of audits to sites.
- Revised WHO safer surgery checklist audits.
- Trial audit champions programme established in theatres, with plans to roll out to wider organisation if successful.
- Peer review process initiated to validate audit results. This process includes the requirement for audits to be undertaken by a senior staff member of another site, when three green audits or three red audits are submitted. The process described in a new Tendable SOP v2.
- Approval and Ratification of Tendable SOP v2, shared widely across the trust and available on eyeQ.
- Tendable project group escalations included as a standing item at the clinical audit and effectiveness committee (CAEC)
- Tendable project joined the excellence delivery unit (XDU)
- Tendable eyeQ page launched, providing a platform for sharing supportive documents and links to training videos.
- Training webinars for staff, focused on audit culture and on the revised WHO checklist audit. These webinars were recorded and are available on the Tendable eyeQ page.
- Development and quality check of Pharmacy audits (Controlled drugs and FP10 audits) moved to the app and outcomes shared in quality reports and forums.

- Tendable analytics shared as a standing item at Ophthalmology and support services (O&SS) and Moorfields North division quality forums, with the aim for this to be a standing item at all forums in 2023/24
  - Accurate mapping of 22 audits quality checked in 2022/23 to 125 clinical areas to ensure robustness of analytics data.
  - Sharing processes for notification reminders to allow staff to receive an alert when audits are due.

Plans for 2023-24 include:

- Quality assurance and mapping of further audits/inspections; including matrons rounds & walkabout inspections & safe storage of medicines.
- Linking of all audit questions against CQC domains to support our CQC self-assessment process.
- Assignment of roles to staff registration to allow for thematic review.
- Expanding divisional representation at the Tendable project group
- Structured format of divisional reports/ presentations using Tendable data
- Develop/train staff on analytics & actions functions.
- Development of a clearer view of benefits for patients and the organisation, including establishing KPIs and outcome measures to monitor improvement.
- Embed the quality assurance structure for the monitoring and review of audit outcomes and of actions following audits.
- Improving percentage of audit completion prior to deadlines

What are the gaps in delivery?

None identified. The trust remains committed to further develop and utilise Tendable to drive improvement. As such, the priority will be continued in 2023/24 and monitored by the working together excellence programme board

2.2 Core clinical outcomes

Progress in 2022/23

The trust's performance against the core outcome standards demonstrates excellent clinical care, with every standard being met (considering 95% confidence intervals) and many being far exceeded. Few DMEK grafts were done for PBK. Accordingly, 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. This is also with the background of the significant mutual aid that the trust has provided to trusts across London, over this period (see page 34 for more detail).

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 2022-2023

Specialty	Metric	Standard	2020/21	2021/22	2022/23
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	1.04%	0.81%	**0.90%**
Cataract	Endophthalmitis after cataract surgery*	<0.04%	0%	0%	**0.01%**
Cataract	Biometry accuracy in cataract surgery*	>85%	92%	93%	**92%**
Cataract	Good vision after cataract surgery*	>90%	89%	90%	**94%**
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	97%	86%	**94%**
Glaucoma	Tube (glaucoma drainage surgery) success*	>80%	92.%	93%	**95%**
Glaucoma	PCR in glaucoma patients*	<1.95%	0.91%	1.2%	**1.3%**
MR[2]	Endophthalmitis after intravitreal anti-VEGF injections*	<0.03%	0.014%	0.006%	**0.012%**
MR	Visual improvement after injections for macular degeneration*	>20%	24.3%	23.9%	**20.6%**
MR	Visual stability after injections for macular degeneration*	>80%	93.4%	92.8%	**91%**
MR	PCR in Medical retina pts*	<4%	1.2%	2.4%	**1.4%**

Specialty	Metric	Standard	2020/21	2021/22	**2022/23**
MR	Time from screening to assessment of proliferative diabetic retinopathy*	80%	80%	87%	**87%**
VR[3]	Success of primary retinal detachment surgery	>75%	84%	85%	**81%**
VR	Success of macular hole surgery*	>80%	89%	90%	**98%**
VR	PCR in vitrectomised eyes*	No published standard	3.3%	2.6%	**2.6%**
NSP	Significant complications of strabismus surgery*	<0.43%	0%	0%	**0.53%**
NSP	Premature baby eye (ROP) screening compliance	99%	99.1%	99.6%	**99.5%**
A&E	Patients seen within 4 hours*	>95%	100%	99.9%	**99.4%**
Ext Dis	PK[4] for keratoconus (2-year survival from NHSBT report) *	See table below	N/A	96%	**96%**
Ext Dis	DALK[5] for keratoconus (2-year survival from NHSBT report) *	See table. below	N/A	98%	**91%**
Ext Dis	DMEK[6] for FED[7] (2-year survival from NHSBT report) *	See table below	N/A	87%	**81%**
Ext Dis	DMEK for pseudophakic bullous keratopathy (2-year survival from NHSBT report) *	See table below	N/A	56%	**59%**
Refractive	Accuracy LASIK (laser for refractive error) in short sight*	>85%	94.5%	N/A	**91.2%**
Refractive	Loss of vision after LASIK*	<1%	0.74%	N/A	**0.12%**
Refractive	Good vision without lenses after LASIK*	≥80%	93.3%	N/A	**94.1%**
Adnexal	Ptosis surgery success*	>85%	93%	100%	**96%**
Adnexal	Entropion surgery success*	>95%	97%	95%	**97%**
Adnexal	Ectropion surgery success*	>80%	98%	100%	**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 sample of cases collected over at least a 3-month period during 2022/23

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

Detailed report of the survival of corneal grafts including confidence intervals (outcomes are after 2 years of follow-up):

	2018/19 grafts	2019/20 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
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
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
DMEK for PBK[8]	- 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

2.3 Performance against key local indicators for 2022/23

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.

2022/23 Key Indicators

INDICATOR	2019/20 results	2020/21 results	2021/22 results	2022/23 Target	**2022/23 results**
PATIENT EXPERIENCE					
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	90.5%	94.7%	97.9%	≥93%	**95.0%**
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	100%	100%	99.1%	≥94%	**96.3%**
Cancer 28 Day Faster Diagnosis Standard	-	87.2%	93.3%	≥75%	**100%**
Over 18-week pathways	-	-	8842	< 8842	**7211**

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[8] pseudophakic bullous keratopathy

INDICATOR	2019/20 results	2020/21 results	2021/22 results	2022/23 Target	**2022/23 results**
52 Week RTT Incomplete Breaches	1	-	395	0 (once activity has normalised)	**97**
Average Call Waiting Time	-	618*	237 secs	≤ 120 Sec	**216 sec**
Call abandonment rate	-	-	14.5%	15%	**17.1%**
Median Clinic journey times in glaucoma and medical retina (mins)	New = 126	New=102	New=81	New=91	**New=84**
Theatre cancellation rate (non-medical cancellations)	0.76%	0.49%	0.7%	≤0.8%	**1.01%**
Number of non-medical cancelled operations not treated within 28 days	11	-	18	0	**17**
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)	3.53%	0%	1.13%	≤ 2.67%	**1.79%**
Posterior capsule rupture rate for cataract surgery	0.85%	0.98%	1.03%	≤1.95%	**0.8%**
QUALITY & SAFETY					
Occurrence of any Never events	2	2	2	0	**3**
Endopthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	-	new	1	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	98.4%	95.2%	95.0%	≥90%	**95.6%***
A&E Scores from Friends and Family Test - % positive	92.6%	94.3%	92.7%	≥90%	**92.5%***
Outpatient Scores from Friends and Family Test - % positive	95.0%	93.2%	93.3%	≥90%	**93.4%**
Paediatric Scores from Friends and Family Test - % positive	96.3%	94.7%	93.7%	≥90%	**94.3%**
Summary Hospital Mortality Indicator	0	0	0	0	**0**
NHS England/NHS Improvement Patient Safety Alerts breached	-	0	1	0	**0**
Percentage of responses to written complaints sent within 25 days	-	88.1%	73.5% (Apr-Feb)	≥80%	**70.4%**
Percentage of responses to written complaints acknowledged within 3 days	-	97.0%	99.0%	≥80%	**90.6%**
Freedom of Information Requests Responded to Within 20 Days	99.2%	95.1%	95.3%	≥90%	**96.2%**
Subject Access Requests (SARs) Responded To Within 28 Days	98.1%	97.9%	96.0%	≥90%	**95.2%**
Number of Serious incidents (SIs) open after 60 days	0	2	0	0	**0**

INDICATOR	2019/20 results	2020/21 results	2021/22 results	2022/23 Target	2022/23 results
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	-	86	-	Data Only	**166**
'ENABLER' Metrics					
Information Governance Training Compliance	-	95.1%	93.6%	≥95%	**88.9%**
Appraisal Compliance	-	78.2%	74.9%	≥80%	**70.6%**
Staff Turnover (Rolling Annual Figure)	-	9.4%*	13.0%	≤15%	**13.75%**
Proportion of Temporary Staff	12.4%	6.7%	12.2%	Data Only	**14.5%**
Overall financial performance (In Month Var. £m)	-	-	4.58	≥0	**5.61**
Commercial Trading Unit Position (In Month Var. £m)	-	-	1.17	≥0	**-1.11**
RESEARCH METRICS					
Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	-	418*	42,733	Data only	**40892**
Proportion of patients participating in research studies (as a percentage of number of open pathways)	-	-	5.6%	≥2%	**5.9%**
Median Time To Recruitment of First Patient (Days)	-	-	KPI accuracy under review not reported	70 days	**Not reported**
Percentage of Commercial Research Projects Achieving Time and Target	61.6%	71.9%	93.6%	≥65%	**66.7%**
CLINICAL EFFECTIVENESS					
% implementation of NICE guidance	100%	97%	100%	95%	**96.6%**
Number of registered and ongoing clinical audits past their target deadline date	1.65%	15.8%	20.7%	≤20%	**17.6% (34/193)**

^ Three month rolling average figure as at end of March 2023

* As at end March 2023

2.4 Performance against 2022/23 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	Performance 2021/22	Target 2022/23	Performance 2022/23	Average for applicable trusts (latest)	Best performing trust (latest)	Worst performing trust (latest)
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]	98.6%	95%	**98.2%**	n/a	n/a	n/a
Waiting Times						
Two-week wait from urgent GP referral for suspected cancer to first outpatient appointment[2]	98.7%	93%	**97.3%**	78.3%	100%	44.8%
Cancer 31-day waits –diagnosis to first treatment[2]	99.1%	96%	**99.3%***	91.76%	100%	75.2%
All 62 days from urgent GP referral to first definitive treatment[2]	100%	85%	**100%***	60.73%	100%	18.7%
Four-hour maximum wait in A&E from arrival admission, transfer or discharge[3]	99.9%	95%	**99.4%**	97.78%	100%	82.7%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks[2]	78.1%	92%	**77.9%**	61.6%	95.2%	15.4%
Maximum 6 week wait for diagnostic procedures[2]	99.0%	99.0%	**99.4%**	71.3%	100%	21.1%
Other						
28-day Emergency readmission rate (over 16 years old) – excluding retinal detachment	1.15%	2.64%	**1.59%**	n/a	n/a	n/a

Description of target	Performance 2021/22	Target 2022/23	Performance 2022/23	Average for applicable trusts (latest)	Best performing trust (latest)	Worst performing trust (latest)
28-day Emergency readmission rate (over 16 years old) –retinal detachment only	4.21%	n/a	**5.12%**	n/a	n/a	n/a
28-day readmission rate (0-15 years old)	0%	n/a	**4.55%**	n/a	n/a	n/a

[1] – National data collection suspended

[2] – Comparison data from NHS Statistical Work Areas – April 2022 – Jan 2023

[3] – Comparison data from NHS Statistical Work Areas – April 2022– Dec 2023

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.

Measure	Target	Q1	Q2	Q3	Q4	Year end 2022/23
18-weeks RTT incomplete	92%	77.8%	76.7%	77.7%	79.6%	**77.9%**
18-weeks RTT incomplete with decision to admit (DTA)	N/A	65.0%	65.2%	67.3%	69.1%	**66.6%**
18-weeks RTT admitted	≥ 90%	58.6%	59.4%	63.7%	61.6%	**60.9%**
18-weeks RTT non-admitted	≥ 95%	69.4%	70.9%	71.4%	73.0%	**71.2%**
New RTT periods (clock starts) all patients	N/A	32,222	32,709	31,934	35,327	**132,192**

The performance measure of the RTT18 incomplete pathway (the key RTT18 performance indicator) across all pathways has increased throughout the year, despite the increase of our overall waiting list numbers. This indicates that, while we have more patients waiting, they are waiting for a shorter amount of time. This has been achieved through rigorous monitoring of patients as well as excellent work and initiatives within the services. We continue to be on course for recovery of our RTT position. A number of checks and balances have also been maintained to provide assurance that patients were not overlooked or missed, in addition to our already rigorous patient safety measures.

The trust has not yet met the national RTT targets overall but is working hard to do so. Some individual areas are meeting the target, and the trust is confident that all areas are reporting accurately. The trust is addressing the issues that are preventing it from meeting the target, such as capacity, host trust capacity, and patient availability. The trust is one of the few trusts close to reaching RTT compliance within London.

The trust has also opened diagnostic hubs at Hoxton, Brent Cross, and Stratford that have allowed us to shorten patient pathways with no compromise in standards of care and provide an overall improvement in patient experience.

Mutual aid

This year, the trust has undertaken a significant amount of mutual aid to trusts across London, such as Royal London, Kingston, Guy's and St Thomas' and Barts Health.

More than 1000 patients have been transferred and treated from these cohorts, assisting London to maintain its waiting times for ophthalmology. These patients are tracked effectively through the combined efforts of the booking center, the services, and the validation team. The trust has been commended at Local ICS meetings for its continued mutual aid support.

Performance indicator data quality

A vital pre-requisite to 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 in ensuring that data is effectively managed from the point of collection, through its lifecycle, until disposal.

The trust continues to utilise the 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 2022/23, with the continued inclusion of a larger range of directly related KPIs published within the Integrated Performance Report (IPR), which was presented to the board each month. 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 process 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 an audit onto the *Tendable* app (previously Perfect Ward) and has been using this for over six 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 performance team has worked closely with the 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 ensured that information capture processes are standardised and adhere to guidance, thereby ensuring accuracy and completeness. We have also established the audit of *paperlite* documents/CITO scanning to

provide the 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 a guidance.

There is also ongoing work with research and other digital projects to support 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) data and working with teams across the trust to support improvements in collection and recording of this vital information; this work has seen our NOK data improve from 10% to 85% in some areas. 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 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.

	2017/18	2019/20	2020/21	2021/22	2022/23
28 days Readmission rate (Adult: 16+)- excluding retinal detachment	3.57%	3.98%	1.74%	1.15%	1.59%
28 days Readmission rate (Adult: 16+)- retinal detachment only	6.27%	6.70%	5.33%	4.21%	5.12%
28 days Readmission rate (Child: 0-15)	2.60%	0.00%	0.00%	0.00%	4.55%

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

2023/24 will see the launch of our 'Patient Experience Principles'. The principles, developed in a co-design project with staff and patients, set out the basis of how we expect to deliver consistently excellent patient experience across the trust. We will continue to engage patients and staff to work together to identify and address issues, and to create excellent patient experience and outcomes. This work is being done alongside development of our core values.

The Vision Loss Advisory Group (VLA) brings together patient and representative stakeholder groups, including Guide Dogs, Royal National Institute of Blind People (RNIB) and London Vision, who meet regularly to discuss how we can better improve the experience of those with sight loss and other vulnerabilities when visiting Moorfields. The group also provides a patient perspective for Accessible Information Standard (AIS) implementation.

Transport

A virtual patient user forum with patient and carer representation was held regularly to discuss the transport service, providing an opportunity to raise issues with the transport provider (DHL/Royal Free hospital). The data for 2021/22 shows that transport provision has been variable and below the standard we require, especially for collecting patients in the afternoon/early evening. Regular representation is made to DHL/Royal Free Hospital (RFH) to address these issues. The introduction of a health care assistant to care for patients waiting for transport, following patient feedback and incidents, has been successful, with further environmental improvements planned for the transport waiting area on the City Road site. We will continue to monitor and drive improvement through 20223/24.

Accessible Information Standard

All trusts as required to meet the Accessible Information Standard (AIS). A project group has been meeting as part of an XDU project to improve how we meet AIS. The work of this project is driven by an expert patient group. Substantial progress has been made about understanding the technological requirements. Workstreams have been focusing on immediate implementation of AIS improvements, and adapting digital systems (PAS, *OpenEyes*) to automate the AIS process

as well as the relevant indicators. The working group has collected data to support improvement and progress in this area, and AIS has been identified as a quality priority for 2023/24.

Digital exclusion

We understand, as we move to more use of digital systems to treat, communicate, and monitor our patients, there is a need to ensure our patients are not digitally excluded from access to our care. A multi-disciplinary Digital Exclusion forum (led by this year's Darzi fellow) was held and discussed ways that patients can be helped to overcome barriers preventing them from engaging with the technology used by Moorfields, such as online consultations or digital consenting (the feasibility of which another group is currently looking at). There was also a session where patients could use technology and identifying potential training needs. We have piloted 'digital pods' where patients attend and receive support for their online consultation, and these have proved successful and have become embedded in day-to-day practice on our Brent Cross site. For 2023/24 we will combine the learning from these studies into a set of principles to support the development of our digital services going forwards.

The 2022/23 complaints and PALS report showed a decrease in complaints and PALS enquiries this year, on average closer to pre-Covid levels. The main themes of complaints remain clinical concerns, staff attitude, communication, and transport. PALS enquiries focus on appointments management and communication. The patient experience and participation committee has updated its terms of reference and meets to discuss patient feedback and what changes and learning will be made as a result.

NHS England Friends and Family Test results (FFT)

During 2022/23, 232,589 (35%) of patients who attended A&E or had outpatient or inpatient appointments responded to a FFT text, with approximately 94% of those indicating they had a positive experience.

FFT Results

FFT Trust results for 2022/23

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	21576	3727	628	381	611	439	27362	71010	92.5%	3.6%	38.5%
Inpatient	12711	1559	149	86	111	254	14870	36637	95.6%	1.3%	40.6%
Outpatient	150341	27811	4086	2034	2119	3966	190357	566518	93.4%	2.2%	33.6%

FFT themed analysis of comments

Face to face consultations

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

Waiting and not being informed of delays were the main issues raised by patients giving scores of 1 or 2 in the trust's 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 trust's Patient Participation and Engagement Committee (PPEC) 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 received a total of 223 complaints in 2022/23, compared to the 298 received the previous year. Clinical concerns continue to be the cause of most complaints, mostly related to delays or failures in 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.

Complaints investigations are undertaken at divisional level and should the complainant remain dissatisfied, or have outstanding concerns, a further review will take place. If they continue to be dissatisfied, a meeting may be offered (if not done earlier) and advice given on contacting the Parliamentary and Health Service Ombudsman (PHSO) for an independent review.

PALS Concerns

PALS received 4,565 enquiries in 2022/23 (5,637 in the previous year). Of these, 135 were compliments, 1,841 were requesting information and 2,589 were concerns. Of the concerns, the largest number related to appointments management, followed by communication issues (including telephone responses), transport 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. The majority of compliments received were through the FFT as noted above.

Complaints performance: Key performance indicators

KPI	Target	2021/22	2022/23
Response <25 days	80%	75%	70%
Acknowledgment <3 days	80%	99%	91%

Re-opened cases: During 2022/23, there were 27 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 was a continuous focus on improving the patient experience of complaints handling and the central teams and divisions continue to work to develop this.

The organisation did not meet their target in 2022/23 for complaint responses. 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 when responding to complaints and PALS enquiries and our responsiveness.

Percentage of staff who would recommend the trust as a provider of care to their family or friends

We value the feedback that we get from our staff; we use this to improve our staff experience by shaping our strategies and informing our action plans. The trust participates in the National Quarterly Pulse Survey (NQPS). However, we quote the response to the Family and Friends Test (FFT) questions from our annual staff survey, since the completion rate for this is higher than the pulse survey.

Monitoring staff engagement and maintaining and improving staff satisfaction is a key part of our strategy to attract, retain and develop great people. The staff survey asks staff to tell us whether they would recommend Moorfields as a place to receive treatment and whether they would recommend it as a place to work.

The results from our most recent staff survey in 2022 show that the majority of our staff are proud to recommend Moorfields as a place for treatment. Meanwhile, almost two-thirds would recommend the trust as a place to work. The Board acknowledges that the score against these questions have deteriorated in recent years and is committed to improving our staff survey results. We are creating trust wide and local action plans to address the feedback and improve the lived experience of our colleagues.

	2020/21	2021/22	2022/23
% staff recommending Moorfields as a place for treatment	88	86.7	85.1
% staff recommending Moorfields as a place to work	70	63.2	62.2
Response rate / (completions)	54% (1184)	54.0% (1232)	50% (1176)

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 continuingly carrying out VTE assessment using the VTE Risk Assessment and Treatment Plan to risk assess. This was implemented three years ago, and we are continuing this practice in our children's hospital.

Patient safety incidents (PSIs)

The incident reporting system has continued to be broadly effective throughout the year, remaining available for use by all staff at all locations, but it is recognised that improvements to the way in which the system is used are possible. Implementation of the NPSS, specifically the elements relating to PSIRF and LFPSE, has been encouraging review of the functionality of the incident reporting system, and the trust has been specifically considering any barriers to incident reporting that the system and incident reporting process may introduce or promote. Some system and process modifications have been made during the year and others will be considered over the coming months, including introduction of the new mandatory requirements required by LFPSE.

The trust has developed statistical process control (SPC) charts as the preferred display for incident data, with further development planned, including provision of a direct overview of patient safety incident reporting in relation to clinical activity. To date, SPC charts that consider

the number of incidents reported and the management of incidents (i.e. the timeliness of investigation and closure) have been introduced. This data is displayed at both trust level and divisional level and the presentation of the information in this format provides the opportunity to readily identify deviations of concern or improvement and to consider the specific reasons for their occurrence. Whilst the trust has not yet achieved pre-pandemic reporting levels, a review of the number of incidents reports submitted over the last 12 months confirms that reporting levels have remained above the mean in each quarter, with no special causes having been identified. Further analysis of the types of incidents reported is required to identify any specific areas of underreporting. This work will inform the development of the trust PSIRP and implementation of PSIRF, in accordance with the requirements of the NPSS. The number of incidents reported has been monitored throughout the year, on a weekly basis, and the clinical divisions are able to challenge local incident reporting rates based on the information that is shared. For most of the year, it was also included in the bi-weekly quality & safety escalation summary, alongside commentary regarding priority areas for focus and improvement, and presented to the risk & safety committee and at quality forums, as a minimum.

In 2022/23, we declared seven serious incidents (SI), three of which were classified as never events (wholly preventable untoward events), which have the potential to cause serious patient harm or death, which are deemed to be serious enough that they should never occur – for example, surgery on the wrong eye muscle, implantation of the incorrect intraocular lens. Of the seven SIs reported during 2022/23, no deadline breaches were recorded, and the trust worked collaboratively with the commissioning support unit (CSU), clinical commissioning group (CCG) and integrated care board (ICB) to ensure that extensions were applied appropriately. At the end of 2022/23, two SI investigations remained on-going with closure scheduled for Q1 2023/24. Robust root cause analysis (RCA) investigations, supported by comprehensive clinical harm reviews where required, were undertaken for all seven SIs, and learning from each incident has been shared across the organisation.

Throughout the year, in anticipation of the implementation of PSIRF, as a replacement for the SI Framework, the trust has encouraged the application of investigation methodologies such as after-action reviews (AARs) and the completion of concise root cause analysis (RCA) investigation reports. The final reports, and the associated learning, has been shared with the other clinical divisions via SI panel.

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 and Moorfields Private Eye Centre (MPEC). In addition to these notification rules, the risk & safety team notifies additional managers and SMEs, as required, and local teams can do the same.

- The trust has a weekly SI panel, chaired by a consultant ophthalmologist, which considers in detail those incidents that fall within the scope of the terms of reference as a minimum, for example, incidents, excluding complications, graded as moderate or above harm and potential never events. An increased focus on shared learning and improvement has been sustained throughout 2022/23.

- Incident reporting training and education has been provided by the risk & safety training throughout the year. This bespoke training has been delivered to individuals or groups and is tailored to meet the specific need of 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 to facilitate the continued monitoring of the numbers of reported incidents, and the subsequent identification of barriers to reporting.
- Completion of a gap analysis being undertaken in preparation for the introduction of PSIRF.
- Completion of a series of safety culture focus groups, during which feedback regarding the incident reporting system will be collated.
- Seeking feedback from users, not involved in the safety culture groups, regarding the barriers to reporting and identifying improvement opportunities.
- Finalising the trust patient safety incident response plan (PSIRP) and implementing all elements of PSIRF.
- Connecting to LFPSE.

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

Never Event title	Brief details
Excisional biopsy of the incorrect lesion (1 incident reported)	A patient, who had been referred because of a suspicious eyelid lesion, had the incorrect lesion removed.
Insertion of the incorrect intraocular lens (IOL) (2 incidents reported)	Two patients had the incorrect IOL inserted, where NE criteria were fulfilled. In both cases, the implanted lens differed to that which was documented on the IOL selection sheet (the surgical plan). On both occasions, the error was identified prior to the patient leaving theatre, and an exchange for the correct lens was undertaken.

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

Serious Incident title	Brief details
Insertion of the incorrect IOL (that did not meet NE criteria)	One patient, in addition to those described above, had the incorrect IOL inserted. The lens inserted was that which had been recorded on the IOL selection sheet but differed from the plan made by the surgeon with the patient.
Error on a device used for performing biometry	The trust became aware that a device used for taking measurements of the eye, to inform the power of IOL required by individual patients, was incorrectly measuring the axial length (AL) of the eye. A comprehensive clinical harm review of 128 patients was conducted, which confirmed that 46 patients had undergone surgery using an inaccurate AL measurement. All 46 patients were contacted and, following review of the patient's record by a consultant ophthalmologist, attended clinic for review or were discharged from the service following a discussion with the patient.
Death of a patient following an elective surgical procedure	A patient became unwell immediately following an elective surgical procedure and passed away two days later. This investigation remains on-going.
Delayed treatment of a paediatric patient	An error in the processing of a referral for a patient resulted in a delay in the diagnosis of a condition and the timely provision of treatment.

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. Learning is shared via various mechanisms, including at divisional quality forums, service (sub-specialty) meetings, via divisional and quality team newsletters 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 2020 to March 2023, where data has been made available. The NHS Digital files are not updated when new data is released, and this accounts for the discrepancy between the Moorfields local record data and that which has been published by NHS Digital for the same period. Trust data, for all three years, has been refreshed since the previous report. The number of PSIs reported at Moorfields has decreased during the financial year 2022/23, in comparison with the data from the previous year. An SPC chart that presents data relating specifically to the reporting of PSIs will be developed, so that the significance of any decline in reporting numbers can be assessed.

	Reported incidents		
	2020/21	2021/22	2022/23
Moorfields (trust local record)	2618	4279	3902
Moorfields (NHS Digital)	2539	****Data not available	****Data not available
National average*	2566	****Data not available	****Data not available
Lowest performing trust**	466	***466	***466
Highest performing trust**	5411	***5411	***5411

*based on the average of 'Acute Specialist trusts' (NHS Digital data)

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21. No new data is available following the merger of NHS Digital and NHS England on 1 February 2023.

**** No new data is available following the merger of NHS Digital and NHS England on 1 February 2023.

Rate of PSIs reported

The table below presents a summary incident reporting rate for the trust, during the period April 2020 to March 2023. 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. These rates are not

comparable against the reporting rates published by NHS Digital, which are calculated per 1,000 bed days.

	Reporting period		
	2020/21	2021/22	2022/23
Moorfields (trust local record)	7.6	7.5	6.8

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 2020 to March 2023. The trust has a dynamic incident reporting process and records are continually reviewed and updated.

	Reporting period		
	2020/21	2021/22	2022/23
Moorfields (trust local record)	9	8	12
Moorfields (NHS Digital)	10	****Data not available	****Data not available
National average*	6.4	****Data not available	****Data not available
Lowest performing trust**	27	***27	***27
Highest performing trust**	0	***0	***0

*based on the average of 'Acute Specialist trusts' (NHS Digital data)

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21. No new data is available following the merger of NHS Digital and NHS England on 1 February 2023.

**** No new data is available following the merger of NHS Digital and NHS England on 1 February 2023.

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.

	Reporting Period		
	2020/21	2021/22	2022/23
Moorfields (trust local record)	0.34%	0.19%	0.31%
Moorfields (NHS Digital)	0.39%	****Data not available	****Data not available
National average*	0.25%	****Data not available	****Data not available

Lowest performing trust**	1.95%	***1.95%%	***1.95%%
Highest performing trust**	0%	***0%	***0%

*based on the average of 'Acute Specialist trusts' (NHS Digital data)

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21. No new data is available following the merger of NHS Digital and NHS England on 1st February 2023.

**** No new data is available following the merger of NHS Digital and NHS England on 1st February 2023.

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. 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 is routinely provided to clinical governance committee and quality & safety committee. Where potential non-compliance with requirements is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. Actions are assigned by SI panel where a 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 action is taken could be improved further.

In Quarter 1 2022/23 the trust undertook a re-audit of DoC compliance and compared the results with the previous audit completed during 2020/21. The audit results 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). The audit findings were shared throughout the trust; however the original audit action plan has been superseded by the issue of the PSIRF supporting guidance 'engaging and involving patients, families and staff following a patient safety incident'. Whilst this guidance does not alter the statutory requirement in relation to DoC, it provides the opportunity for the development of a new policy, of which DoC will be an element. At the point at which the policy is updated, 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.

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

27.1   During the period 1 April 2022 to 31 March 2023, 2 of Moorfields Eye Hospital NHS Foundation Trust patients died (of which 0 were neonatal death, 0 were still births, 0 were people with learning disabilities and 0 had a severe mental illness). This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 0 in the first quarter.
- 0 in the second quarter.
- 2 in the third quarter.
- 0 in the fourth quarter.

27.2   By 31 March 2023, 0 case record reviews and 1 investigation has been conducted in relation to the 2 deaths included in section 27.1. The number of deaths in each quarter for which a case record review or an investigation was conducted was:

- 0 in the first quarter.
- 0 in the second quarter.
- 1 in the third quarter.
- 0 in the fourth quarter.

27.3   0 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:

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

One death that occurred this year is being investigated as a serious incident, but the investigation has not yet concluded and therefore it has not been established if the death was more likely than not due to problems in the care provided to the patient. One death was determined to have not been preventable and no care or service delivery concerns were identified.

27.4 The investigation into the one patient death that occurred in Q3 2022/23 remains on-going. The learning from this incident will be reviewed in line with the trust patient safety incident response plan (PSIRP), which is currently in development, and will inform the quality priority for 2023/24 relating to the management of deteriorating patients.

27.5 The investigation into the one patient death that occurred in Q3 2022/23 remains on-going. The actions are in the process of being agreed and therefore cannot be described.

27.6 The investigation into the one patient death that occurred in Q3 2022/23 remains on-going. The actions are in the process of being agreed, therefore the impact of the actions cannot yet be assessed.

27.7 0 case record reviews and 0 investigations were completed after 31 March 2022 which related to deaths which took place before the start of the reporting period.

27.8 0 representing 0% 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.

27.9 0 representing 0% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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 director of nursing and allied health professions. 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 2022/23, 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 2023/24, 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 2022/23 represents the total income generated from the provision of NHS services.

Freedom to Speak up

All NHS trusts are required to have Freedom to Speak Up (FTSU) guardians and a policy setting out FTSU arrangements. For 2022/2023, there were five FTSU guardians in place:

- Dr Ali Abbas, locum consultant, City Road, St George's, and Croydon
- 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).

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 has a much broader definition than the previous term 'whistleblowing', which was often only used in the most extreme of circumstances and was viewed negatively. FTSU is viewed to provide additional support to staff. 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
- A bullying culture (usually across a team)
- A criminal offence has been committed, is being committed or is likely to be committed
- Concerns about staff well-being
- That the 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 their concern is being 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 – the trust is 100% compliant with this standard, with all patients seeing a consultant level subspecialist within 14 hours of submission.

- Clinical standard 5 – relates to access to diagnostic services. Services are available for microbiology, CT, and ultrasound. MRI is only available on weekends via formal arrangement off-site.
- 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 2021/22, 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 employed at MEH are on a unique contract which is not linked to any national terms and conditions of service (TCS). To address pay equalities, a report was prepared for the trust's management executive in March 2023 which included an options appraisal to address the current Clinical Fellow workforce challenges. The paper detailed the background, context and available short to mid-term options to address long standing challenges, while work progresses to reshape The trust's workforce over the next 12-18 months through the *Future Shape of Workforce Programme*, which is monitored by the working together excellence board (XDU). The paper focused on the immediate challenges facing the Medical Retina (MR) and Uveitis (UV) services, and a further paper will be presented at a later stage to address the wider workforce challenges.

Participation in clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that Moorfields was eligible to participate in during 2022-23 are as follows:

National Audits

- National Audit of Corneal Graft Outcomes
- National Ophthalmology Database (NOD) Cataract Audit

National Confidential Enquiries

- No studies were undertaken that were relevant for Moorfields to participate in 2022-23.

The national clinical audits and national confidential enquiries that Moorfields participated in, and for which data collection was completed during 2022-23, 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
National Audit of Corneal Graft Outcomes	*1,288/1,580 (81.5%)* *(data from 01/04/2022-31/03/2023)*
National Ophthalmology Database (NOD) Cataract Audit	**21,037/19,000 (100%)* *(data from 01/04/2021-31/03/2022)*

*NOD received data for 21,037 operations with a record of phacoemulsification and is compared with a denominator of 19,000 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 2021-22.
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 2022-23 whereby the trust was required to take part or actively contribute data. Any relevant NCE studies are discussed at the trusts bi-monthly Clinical Audit and Effectiveness Committee (CAEC).

Although Moorfields did not qualify for submission for any of the studies in 2022-23, lessons taken from an epilepsy study were shared at CAEC, and a potential study for juvenile idiopathic arthritis that might have required Moorfields input was confirmed as exempt from data submission following discussion with the organiser. Details for both were shared and discussed at CAEC.

Of the 1580 ocular transplant forms received from the NHS Blood and Transplant team for 2022/23, the trust completed and returned 1,288 (81.5%.) 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 2022, the trust has also submitted several forms received during the previous year. In total during 2022/23, the trust submitted details of 1,513 patients to the NHS Blood and Transplant team.

Unfortunately, no reports have been received from the NHS Blood and Transplant service during 2022/23.

The NOD produced a first report in February 2023 on Age-related Macular Degeneration (AMD)*;* however, the most recently published report from NOD for cataract surgery was last issued in April 2022 assessing detail from 2020/21.

National Audit Report	Discussed	Actions
The fifth annual report for NHS or equivalent funded cataract surgery was published by NOD in April 2022.	Cataract Service	The report will be shared with the Medical Director and Cataract Service. Findings from the report were shared and discussed on 13 September 2022 at the Clinical Audit and Effectiveness Committee (CAEC).
NHSBT: No reports have been published in 2022-23.	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

National Audit Report	Discussed	Actions
		and Transplant team as no external reports have been forthcoming.

During the period 2022/23, the trust proposed and approved 52 audits assessing national clinical standards/guidelines[9] (many of which have been completed or were re-audits).

The 52 clinical audits derived from national standards and guidelines that Moorfields participated in from 1 April 2022 to 31 March 2023 can be summarised as:

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

(2 proposals have since been archived)

There were 34 nationally derived audit 'reports' completed and submitted during this time, summarised as:

- 3 National Audits (not part of the National Clinical Audit and Patient Outcomes Programme)
- 1 National Service Framework

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[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.

- 4 NHS England
- 3 National Institute for health and Care Excellence (NICE)
- 3 Patient Reported Outcome Measure (PROM)
- 5 Patient Safety First
- 4 Royal College of Anaesthetists
- 8 Royal College of Ophthalmologists (RCO)
- 3 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT)

Participation in clinical research

In 2022/23, the number of patients recruited to studies was 5,936. This was a decrease from 2021/22, which was an exceptional year with many patients recruited to observational quality of life and Covid related mental health studies as well as the Hercules study. The lessons learned on optimal use of diagnostic hubs in the Hercules study influenced the design and development of the new Moorfields networked site in Stratford which opened in April 2023.

There are currently 82 studies actively recruiting and 64 studies with recruitment completed and now in follow up. Our research pipeline includes 34 studies in "set up", 24 at the "concept" stage and 13 in early discussions with potential sponsors. Not all of these will be judged feasible to progress as research studies.

Some important new studies are particularly intensive involving intravenous infusions and complex treatment protocols for recently introduced drugs. This has involved training to extend the roles of staff to treat and monitor patients requiring such investigational medicinal products [IMP's]. Examples of such trials include:

1. **Teprotumumab for Thyroid Eye Disease.** Thyroid Eye Disease is a serious sight threatening manifestation of a complex systemic condition. Treatment can involve major invasive orbital surgery which can be very demanding for patients and challenging technically. There have been no major treatment improvements for many years. This has now changed. The Moorfields Adnexal service participated in the original Phase 1 "first in humans" trial of a new intravenous agent "Teprotumumab [Tepezza]" published in 2017. This trial demonstrated that Tepezza dramatically reduced the sight threatening and cosmetic consequences of severe TED, reducing the need for major surgery or prolonged high dose immunosuppressive therapy. This drug is now licensed in the USA

though not licensed in Europe or the UK. The Moorfields Adnexal service which has one of the largest cohorts of TED patients in the world has recruited 10 patients as part of a large international study to demonstrate the long-term efficacy of Tepezza. Evidence from this trial will be essential to this drug being made available to patients in the UK.

The Moorfields Adnexal service has also recruited to a trial of another similar agent for TED, which is given orally. We are negotiating with several other pharmaceutical companies to run further TED trials, which is likely to lead to a pipeline of such studies.

2. **Adalimumab for resistant uveitis.** Intraocular inflammation [uveitis] requiring prolonged systemic immunosuppression, with significant side effects, is an important cause of severe visual impairment frequently from a young age.

The drug Adalimumab has been shown to be highly effective in resistant uveitis, with less side effects but the optimal treatment regimen is not yet clear.
Moorfields is the largest recruiter in a complex national multicentre National Institute of Health Research [NIHR] and commercial funded study designed to identify the optimum treatment regimen for this condition.

3. **The development of the 3D-printed prosthetic eye is almost complete "Click2Print".** This has successfully delivered the first major improvement in ocular prostheses in almost 100 years using 3D printing technology. It is the product of a successful collaboration between 3 technology companies, Moorfields Eye Charity, external private philanthropy, Moorfields clinicians as well as the Medicines & Health Regulatory Authority [MHRA]. This new ocular prosthesis is now available to patients as standard NHS care in Moorfields. It will shorten the long waits for prostheses as well as making better use of valuable skilled staff. The lessons learned from taking a research concept from an idea to a service available to patients will be immensely useful in the future in taking projects rapidly from concept to delivery to patients.

4. **The Alexion trial for Geographic Atrophy in Age Related Macular Degeneration** Geographic atrophy is the commonest cause of age-related macular degeneration, is a major public health problem while being currently untreatable. Alexion is a 2-year dose finding global trial of an oral agent for Geographic atrophy (ALXN2040). Moorfields has

recruited the first patient in Europe. This was largely because Moorfields has one of the largest curated data sets of age-related macular degeneration images in the world.

A Clinical Fellow is leading this trial supported by the Clinical Director of the Clinical Research Facility. This is part of our policy to develop new Principal Investigators by giving clinicians early in their careers the opportunity to lead clinical trials.

Research set up and delivery, research governance and safety

1. The UK is perceived by major international pharmaceutical companies and other funders as slow and cumbersome in setting up and delivering research studies. There are multiple reasons for this. The Department of Health and the [NIHR] now expect all biomedical research organisations to improve their set up and delivery times to ensure that the UK continues to attract research and investment by pharmaceutical companies.

The Clinical Research Facility [CRF] support staff have been reorganised into 8 Study Delivery Teams each with a Study Delivery Manager [SDM] to provide Principal Investigators with consistent support from grant application to the completion of studies. Progress against targets is monitored on all trials on a fortnightly basis.

These measures are designed to accelerate the setting up and delivery of trials in Moorfields and ensure that national and international pharmaceutical and academic institutions continue to sponsor and invest in research with Moorfields clinicians.

2. **Research Governance** There is now a separate Research Governance team to ensure that all Information Governance, Legal, and regulatory requirements are met prior to submission for approval to the Health Regulatory Authority, the Medicines & Health Regulatory Authority, and the Regional Ethics Committees. This combined with the relationship we have developed with the MHRA will accelerate the set up and approval of research studies.

3. **A Research Governance half day** was attended by 150 research active clinicians and all research staff in October 2022. The emphasis was on information sharing with patients contributing to clinical trials as well the importance of timely contemporaneous documentation.

The North Thames Clinical Research Network [NTCRN] has asked Moorfields to lead on delivering an extended version of this training to all hospitals in the North Thames in June 2023.

4. **Development of Electronic research files** There is an urgent need to convert to electronic trial site & master files to integrate fully with the trust's electronic patient record system as well as existing NIHR electronic reporting systems. Pharmaceutical companies and other research funding bodies expect this. The Moorfields Clinical Research Facility has invested in software and staff training to convert to electronic records for many trials over the next year.

Commissioning for quality and innovation (CQUIN) framework

Funding arrangements for the 2022/23 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 is required to be registered with the CQC and is currently registered without conditions. The CQC has not taken any enforcement action against the trust in 2022/23, nor at any time previously.

The trust's most recent CQC inspection occurred in September 2022 (City Road Theatres and Well-Led) and was unannounced. The report was published in November 2022, in which the CQC confirmed that the trust retained an overall rating of 'Good' as well as services being rated as 'Outstanding' at City Road. As part of their inspection, the CQC noted several examples where the trust's leadership and management of surgical services helped staff to deliver high-quality eye care to our patients.

In the spring of 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, and Mile End was removed.

Information governance

Information Governance (IG) includes records management, data security, confidentiality, data sharing, freedom of information, and transparency. We look forward to the installation of a comprehensive electronic patient record; meanwhile, we manage processes that rely on multiple electronic systems and paper records to manage data along complex patient journeys where the trust is only one provider. The early work towards bringing in such a system is very welcome, and IG colleagues are providing support to this programme. 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 reduce its IG risks. Meanwhile, small steps have been made towards better engagement with patients and the public as part of the trust's duty to be transparent, and to demonstrate that it has been transparent on the way it manages data.

The trust has undertaken a review of its management of key systems and processes in information governance: there is work underway to improve effective cross directorate working and efficient project pathways. Early work includes a refresh of processes supporting innovators, working alongside the new post of Director of Clinical Safety, 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 external collaboration and learning.

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 did not meet some of these standards by the deadline and was required to complete a programme of work that lasted into this year; the work was completed in December 2022. Improvements to systems, processes, and infrastructure have put the trust in a stronger position to deliver better DSPT outcomes in 2023/24.

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 2022/23 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data (April 22 to January 23). 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. We continue to work on the areas of recommendation made in the 21/22 audit.

There have been no other external audits conducted which have included recommendations regarding data quality related issues, during 2022/23.

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 set up and will meet bi-monthly between the meetings 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 2023. 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:

	Diagnosis		Procedure	
Audit year	**Primary**	**Secondary**	**Primary**	**Secondary**
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:

- Collaborate with the appropriate software, clinical and administrative teams to create a dedicated hub on Open Eyes or CITO for the recording of all current relevant and mandatory secondary diagnosis conditions.
- Work with the relevant clinical and administrative staff to develop a mechanism for improving the visibility of 'nuclear sclerotic cataract' information in the Open Eyes application documentation.

- Provide coding staff with additional training in the 'Four Step Coding Process' to ensure the accurate translation of clinical information into ICD-10 5th Edition codes.
- Advise those filling in primary diagnoses on discharge summaries on the incorrect diagnoses found on discharge summaries in this audit.
- Work towards removing OPCS 4.9 codes from operation sheets as they are unnecessary and introduce the potential for coding errors.

2.6 Priorities for improvement in 2023/2024

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, who are the chief nurse and director of allied health professions, and the medical director, in consultation with the chief operating officer.

As stated in our chief executive's statement, the new organisational strategy was launched in 2022/23, and over the next five years we will deliver our vision through our excellence portfolio.

The account and the associated quality priorities have been developed from a wide range of information about quality from all parts and levels within the organisation. As part of our consultation process, a forum was arranged with our key external stakeholders, including representations from patients and the RNIB. Our staff views were also sought, and the priorities continue to be influenced by CQC's inspection report findings. Our host commissioners, NHS Islington CCG, 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.

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 excellence delivery unit (XDU) has supported the implementation, embedding, and monitoring of a number of our 2022/23 quality priorities and all of the priorities for 2023/24.

The XDU will ensure that 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 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

Quality Account Priority 2023/24	Quality Domain	Excellence programme (XDU)	National initiative	Learning from SIs/ Complaints/ feedback	Themes from patient/staff engagement	Carried over from 2022/23
		Underpinning drivers				
1 Implementation of the National Patient Safety Incident Response Framework (PSIRF)	Safe	✓	✓	✓	✓	✓
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)	Safe	✓	✓	✓	✓	✓
3 Improved care of deteriorating patients		✓	✓	✓	✓	
4 Implementation of patient experience principles	Patient experience	✓		✓	✓	
5 Virtual reality to improve communication project		✓			✓	
6 Patient Portal – Digital Patient Communications		✓	✓		✓	
7 Continue to embed the Accessible Information Standard (AIS) across Moorfields' network		✓	✓	✓	✓	✓
8 Making Better Use of Routine Health Data	Effective	✓		✓	✓	
9 Build further on the work undertaken in 2022/23 to reduce health inequalities via 'Make Every Contact Count'	Effective	✓	✓	✓	✓	✓
10 Patient Initiated Follow Up (PIFU)		✓	✓	✓	✓	

2023/24 Identified priorities – Monitoring and description

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 XDU 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 behaviors 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 webpage.	Working together XDU board
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 XDU 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	Working together XDU board
Virtual reality to improve communication project	Enhancement of the patient experience for the visually impaired 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 access our services who are visually impaired 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 visual impairment (evidence from complaints metrics)	Working together XDU 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 XDU board

Quality priority	Description	Measurement of improvement	Monitoring
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 XDU board

Effective

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 XDU board

Quality priority	Description	Measurement of improvement	Monitoring
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 XDU board
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 XDU board

2.7 Key indicators for 2022/23

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.

Ahead of an in-depth review taking place later this year, the trust has undertaken an interim review of the integrated performance report (IPR) which is presented to the board each month and as a result has retained the existing range of KPIs. The indicators we are focusing on in 2023/24 can be seen in the following tables.

This list of KPIs enables the board to continue to concentrate on the metrics most associated with a return to 'business as usual' Following Covid-19. The balance between operational activity, patient safety, and patient experience has been maintained.

Importantly, the trust has reviewed the presentation of data used in the IPR and following consultation with the board will be updating the document to report Key Performance Indicator results using NHS England recommended 'Making Data Count' Statistical Process Control (SPC) charts methodology.

2023/24 key indicators

INDICATOR	2020/21 results	2021/22 results	2022/23 TARGET	2022/23 results	2023/24 TARGET
National Indicators					
MRSA (rate per 100,000 bed days)	0	0	0	**0**	0
Clostridium difficile year on year reduction	0	0	0	**0**	0
Risk assessment of hospital-related venous thromboembolism (VTE)[1]	98.5%	98.6%	95%	**98.2%**	95%
Two-week wait from urgent GP referral for suspected cancer to first outpatient appointment	97.8%	98.7%	93%	**97.3%**	≥93%
Cancer 31-day waits –diagnosis to first treatment[2]	100%	99.1%	96%	**99.1%**	≥96%

INDICATOR	2020/21 results	2021/22 results	2022/23 TARGET	2022/23 results	2023/24 TARGET
All 62 days from urgent GP referral to first definitive treatment[2]	100%	100%	85%	**100%**	≥85%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.98%	99.9%	95%	**99.4%**	≥95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks	59.7%	78.1%	≥92%	**77.9%**	≥92%
Maximum 6 week wait for diagnostic procedures	64.4%	99.0%	99.0%	**99.4%**	≥99.0%
Local Indicators					
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	94.7%	97.9%	≥93%	**95%**	≥93%
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	100%	99.1%	≥94%	**96.3%**	≥94%
Cancer 28 Day Faster Diagnosis Standard	87.2%	93.3%	≥75%	**100%**	≥75%
Over 18-week pathways	-	8842	< 1680	**7211**	< 7211
52 Week RTT Incomplete Breaches (Targets to become active once activity normalises)	-	395	0	**97**	0
Average Call Waiting Time	618	237 secs	≤ 120 Sec	**216 sec**	≤ 120 Sec
Call abandonment rate	-	14.5%	15%	**17.1%**	15%
Median Clinic journey times in glaucoma and medical retina (mins)	New=102	New=81	New=91	**New=84**	New=91
Theatre cancellation rate (non-medical cancellations)	0.49%	0.7%	≤0.8%	**1.01%**	≤0.8%
Number of non-medical cancelled operations not treated within 28 days	-	18	0	**17**	0
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%	≤ 2.67%	**1.79%**	≤ 2.67%

INDICATOR	2020/21 results	2021/22 results	2022/23 TARGET	2022/23 results	2023/24 TARGET
Posterior capsule rupture rate for cataract surgery	0.98%	1.03%	≤1.95%	**0.8%**	≤1.95%
Occurrence of any Never events	2	2	0	**3**	0
Endophthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	new	1	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	95.2%	95.0%	≥90%	**95.6%**	≥90%
A&E Scores from Friends and Family Test - % positive	94.3%	92.7%	≥90%	**92.5%**	≥90%
Outpatient Scores from Friends and Family Test - % positive	93.2%	93.3%	≥90%	**93.4%**	≥90%
Paediatric Scores from Friends and Family Test - % positive	94.7%	93.7%	≥90%	**94.3%**	≥90%
Summary Hospital Mortality Indicator	0	0	0	**0**	0
NHS England/NHS Improvement Patient Safety Alerts breached	0	1	0	**0**	0
Percentage of responses to written complaints sent within 25 days	88.1%	73.5% (Apr-Feb)	≥80%	**70.4%**	≥80%
Percentage of responses to written complaints acknowledged within 3 days	97.0%	99.0%	≥80%	**90.6%**	≥80%
Freedom of Information Requests Responded to Within 20 Days	95.1%	95.3%	≥90%	**96.2%**	≥90%
Subject Access Requests (SARs) Responded To Within 28 Days	97.9%	96.0%	≥90%	**95.2%**	≥90%
Number of Serious incidents (SIs) open after 60 days	2	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	86	-	Data only	166	TBC
Information Governance Training Compliance	95.1%	93.6%	≥95%	**88.9%**	≥95%

INDICATOR	2020/21 results	2021/22 results	2022/23 TARGET	2022/23 results	2023/24 TARGET
Appraisal Compliance	78.2%	74.9%	≥80%	**70.6%**	≥80%
Staff Sickness (Rolling Annual Figure)	-	-	≤4%	**4.7%**	≤4%
Staff Turnover (Rolling Annual Figure)	9.4%	13.0%	≤15%	**13.75%**	≤15%
Proportion of Temporary Staff	6.7%	12.2%	Data Only	**14.5%**	Data Only
Overall financial performance (In Month Var. £m)	-	4.58	≥0	**5.61**	≥0
Commercial Trading Unit Position (In Month Var. £m)	-	1.17	≥0	**-1.11**	≥0
Proportion of patients participating in research studies (as a percentage of number of open pathways)	-	5.6%	≥2%	**5.9%**	≥2%

Part 3: Other information including a statement from our commissioners

NHS
North Central London
Integrated Care Board

2 June 2023

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

Quality Account 2022/23 - NHS North Central London Integrated Care Board Statement for Moorfields Eye Hospital NHS Foundation Trust

The NHS has continued to face significant challenges during 2022/23 due to the Covid -19 pandemic, and other outbreaks of seasonal illnesses including respiratory viruses, Group A Streptococcus, staff shortages and illness, combined with increased demand for healthcare and industrial action.

North Central London Integrated Care Board (NCL ICB) has worked closely with the Trust throughout 2022/23, taking a pragmatic approach regarding assurance of commissioned services throughout the year, obtained through regular discussions with key staff and attending the Trust's Quality and Safety Committee meetings.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to NCL ICB in June 2023). 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.

Is it encouraging to see that the Trust has made positive progress towards the implementation of the 'National Patient Safety Strategy (PSIRF)' with the successful recruitment of patient safety partners to be a central voice to the development of patient safety strategies. We also note the improvement in communication with patients through digital appointment letters and the significant reduction in call waiting times. We look forward to seeing further improvements through the launch of the 'patient experiences principles' involving staff and patients to further excellent patient experience and outcomes.

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 of our residents across North Central London boroughs.

Name Phill Wells
Job title Chief
Finance Officer
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Email: Phill.Wells@nhs.net

North Central London ICB Chair: Mike Cooke
North Central London ICB Chief Executive Officer: Frances O'Callaghan

Statement from Healthwatch Islington

"We welcome the Quality Priorities focusing attention on embedding the Accessible Information Standard and improving communications with patients.

Healthwatch Islington has not received a great deal of feedback about services provided at Moorfield Eye Hospital over the past year. The feedback we have received concerns the patient transport service provided by DHL, which remains a concern. As such we welcome the recognition that the service has been below the standard that you require. It is good to hear that the introduction of a health care assistant to care for patients waiting for collection from the hospital has been successful. The feedback we have received concerns DHL call handlers failing to book transport onto their systems that they have agreed with patients over the phone, leading in one case to a cancelled operation. We also heard that it was difficult to make a complaint about DHL, the complaints pathway was not adequately signposted. We agree that it is important that regular representation is made to DHL/Royal Free to address shortcomings with the patient transport service. We welcome the fact that you will continue to monitor and drive improvement through 20223/24."

Luke Buffery,
Communications and Impact Manager
Healthwatch Islington