Patient safety incident response plan

Summary

This plan describes how the trust will respond to patient safety incidents, in accordance with the Patient Safety Incident Response Framework (PSIRF) and national reporting requirements.

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Foreword

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. PSIRF is **not** an investigation framework; it does not mandate investigation as the only method for learning from patient safety incidents (PSIs) and it does not prescribe which incidents we must investigate. It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to PSIs.
- Supportive oversight focused on strengthening response system functioning and improvement.

The PSIRF, and specifically this plan, will support the trust to respond to incidents in a way that maximises learning and improvement. Except for incidents that require a nationally mandated response to certain categories of events, such as Never Events, we will be able to:

- Balance effort between learning from responding to incidents and/or exploring issues and our improvement work.
- Broaden the methodologies that we use to learn from PSIs, e.g., clinical audit, thematic analysis.
- Focus our attention on understanding events that we may not have previously had the resource to examine. Our chosen response will not be solely based on harm that has already occurred; we will be able to consider the risk of future harm occurring and then identify how that risk can be reduced across the organisation.
- Further develop our existing learning system and ensure that the output of the proportionate learning responses that we undertake are shared across the organisation and that local improvement opportunities, in areas other than that in which an event occurred, can be considered by teams.

At the heart of the PSIRF is compassionate engagement with patients and staff who have been affected by a PSI. The PSIRF aims to align with the trust 2022-2027 strategic objectives and our quality priorities for 2023/24, and therefore these have been at the forefront of the development of this Patient Safety Incident Response Plan and the associated Patient Safety Incident Response Policy (PSIRP).

A glossary of terms used can be found at Appendix 1.

1. Introduction

This patient safety incident response plan (the Plan) sets out how Moorfields Eye Hospital NHS Foundation Trust (the trust) intends to respond to patient safety incidents over a period of 12 to 18 months. The Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected. It is to be acknowledged that the introduction of the Plan represents a significant change in the way we expect our staff to respond to patient safety incidents. As such, it is acknowledged that it will take time for the new approach to be embedded and to become an integral part of service delivery.

The Plan is underpinned by our trust incident reporting and management policy, the learning framework, and the new trust patient safety incident response policy[1] (PSIRP).

2. Our services

Moorfields Eye Hospital NHS Foundation Trust is a single-specialty trust, which is the leading provider of adult and paediatric eye health services in the UK and is a world-class centre of excellence for ophthalmic research and education. The trust supports the treatment and care of patients with a wide range of eye problems, from common complaints to rare conditions that require treatment not available elsewhere in the UK.

The trust delivers NHS emergency, urgent care, and routine ophthalmic services from multiple number of locations, which are geographically spread across the UK. The lead commissioner of trust services is North Central London Integrated Care Board (ICB). A comprehensive list of sites and services, which is correct at the time of plan approval, is shown in Appendix 2. Many of the NHS services provided by the trust are interlinked with services used in Moorfields Private. For this reason, the Plan does not distinguish between NHS and Private services.

In addition to the main Moorfields Eye Hospital on City Road in London, the trust provides a networked site model of care, comprising Moorfields North and Moorfields South. Within these geographical networks, care is generally sub-divided into five different types of service, ensuring a comprehensive range of eye care provision closer to patients' homes:

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[1] The trust incident reporting policy will be updated to take account of all new arrangements introduced to support implementation of the NHS England National Patient Safety Strategy. A new policy (policy for engaging and involving patients, families & staff following a patient safety incident) is under development and this will supersede the existing 'being open and duty of candour policy'.

Service type	Explanation
Moorfields eye centres (district hubs)	Co-located with general hospital services, eye centres provide comprehensive outpatient and diagnostic care as well as more complex eye surgery and will increasingly serve as local centres for eye research and multidisciplinary ophthalmic education.
Moorfields eye units (local surgical centres)	Eye units provide more complex outpatient and diagnostic services alongside day-case surgery for the local area.
Moorfields community eye clinics (community-based outpatient clinics)	These clinics focus predominantly on outpatient and diagnostic services in community-based locations.
Moorfields partnerships (partnerships and networks)	In this model, the trust offers medical and professional support and joint working to eye services managed by other organisations. The trust also provides clinical leadership to various diabetic retinopathy screening services and to networks across London that deal with retinopathy of prematurity diagnostics.
Moorfields diagnostic hubs	Diagnostic hubs take patients through a series of rapid tests within a 45-minute visit. Patients will only be asked to attend a subsequent hospital visit if the consultant sees something requiring urgent or personal attention following review of the test findings.

3. Defining our patient safety incident profile

The trust has existing processes in place to identify, examine and learn from PSIs. We are committed to improving our processes and strengthening the way in which we learn from all events, including PSIs, and continue to monitor and review the effectiveness of our learning system.

To fully implement the PSIRF, the Trust has completed a review of what types of PSI occur, or may occur, to understand where we need to prioritise our learning resources to

improve. Data from various sources has also been reviewed to inform the selection of PSIs that require a specific learning response (see table 2, section 6).

3.1 Stakeholder engagement

The central quality and safety team has engaged with key stakeholders, over a 12-month period, to inform the Plan. The engagement activities undertaken have been summarised below and described in more detail in Appendix 3 and have included:

- Activities undertaken to support delivery of the PSIRF as a quality priority.
- Communication with the organisation regarding the introduction and purpose of the PSIRF.
- Involvement of our Patient Safety Partners (PSPs).
- Presentation of the Plan and PSIRP at governance meetings, including the trust's Quality and Safety committee and Clinical governance committee.
- Sharing and development of resources made available by NHS England and other NHS organisations.
- Development of a PSIRF implementation group.
- Safety culture focus groups.
- Attendance at networking events, in particular those attended by partnership organisations.

3.2 Data sources

We have reviewed numerous data, from both internal and external sources, to inform the Plan and identify our local incident priorities, as listed below. Where possible we have also considered what the data tells us about inequalities in patient safety.

Internal sources

- Reported incidents (3 years), including incidents reviewed by the Serious Incident (SI) panel – NHS & Private.
- SI and Never Event (NE) investigation reports – NHS & Private.
- Complaints data (as presented in the relevant quarterly reports – Q1 2020/21 to Q4 2022/23) – NHS only.

- PALS data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Friends and Family Test (FFT) data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Claims data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Divisional risk profiles, based on a review of open risks – NHS & Private.
- Staff survey results (2 years) – NHS & Private.
- Junior doctor survey – NHS only.
- Freedom to speak up (FTSU) thematic data – NHS & Private.
- Output of safety culture focus groups – NHS & Private.
- Safety summit output (held for biometry and intraocular lenses (IOLs) and referral management) – NHS & Private.
- Data from quality surveillance processes (e.g., surgical safety checklist audits, pharmacy audits, infection control quarterly reports) – NHS & Private.
- Review of reports to/from specialist risk management committees (e.g., patient falls, resuscitation, medicines management) – NHS & Private.

External sources

- Inquest outcomes, including prevention of future death (PFD) reports.
- Clinical Negligence Scheme for Trusts (CNST) claims scorecards (3 years).
- Healthwatch reports (none of relevance).

3.3 Services covered by the plan

This Plan covers trust UK activity (NHS and Private).

Some departments and services within the trust (e.g., eye bank, pathology, electro-physiology department, contact lens and prosthetics manufacturing) are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. As such, there is a requirement to record non-conformities identified with work processes and systems against certain standards, so that improvement opportunities can be identified and considered as stipulated by these bodies. These non-conformities do

not fall within the remit of this Plan unless a patient is involved or affected, in which case a PSI will be reported on Safeguard (the trust electronic incident reporting system) via the trust incident reporting process and will then be within the scope of this Plan.

4. Defining our patient safety improvement profile

The data outlined in section 3.2, was used to identify our patient safety improvement profile, and used to thematically identify incidents or safety issues appearing in the highest number of sources of safety data. This information was then utilised to inform where there was the greatest opportunity for improvement and learning.

In accordance with NHS England guidance on developing the Plan, we also identified the trust's quality improvement work and quality priorities (set out in the trust's Quality Account 2023).

Our quality priorities form part of our strategic vison and over the next five years the trust will deliver its strategic vision through the excellence portfolio, supported by the trust excellence delivery unit (XDU). The excellence portfolio supports project activity across the trust by:

- Providing a consistent project delivery and reporting framework for projects.
- Driving the use of data for project decision making.
- Supporting the management of interdependencies and assumptions across excellence programmes.

The quality priorities for 2023/24, and the drivers for each, are shown in Appendix 4. A list of the projects included in the Excellence portfolio for 2023/24 can be found in Appendix 5.

In addition to this, the quality, service improvement and sustainability (QSIS) team provide project support and change management expertise to deliver service improvement projects across a variety of services in both clinical and non-clinical areas. The team works collaboratively with colleagues from the department of digital medicine (DoDM) to ensure integration with digital innovation.

To further determine our improvement profile, outputs from safety summits were also reviewed. Safety summits are an emerging improvement response pathway that the trust has used to address systemic safety risks. They bring together a diverse group of stakeholders, to discuss safety issues and develop solutions.

As our learning culture and improvement cycle evolve, we will look to continually embed robust processes which will also link to our excellence portfolio and other improvement work (monitored by committees). Oversight of the improvement work will be through the trust's clinical governance committee and quality and safety committee. This will allow us

to connect, across the organisation, improvement work which delivers against our known risks.

By comparing this improvement work with our patient safety incident profile, and sharing them with key stakeholders for feedback, the trusts local patient safety priorities have emerged, as described in section 6.

5. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Events meeting these requirements are described in the table below:

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incidents meeting the Never Events criteria	Trust-led patient safety incident investigation (PSII) (see glossary for description)	Develop local organisational safety actions and feed these into the most appropriate improvement workstream/consider development of a new workstream	Clinical governance committee
Patient death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	Trust-led PSII	Develop local organisational safety actions and feed these into the most appropriate improvement workstream/consider development of a new workstream	Clinical governance committee

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Death of a person who has a learning disability	Refer for Learning Disability Mortality Review (LeDeR) Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions into the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding adults committee or safeguarding children and young persons' committee, as appropriate (escalations to clinical governance committee)
Child death	Refer for Child Death Overview Panel (CDOP) review Liaise with CDOP as locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding children and young persons' committee (escalations to clinical governance committee)

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
A safeguarding incident in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Respond to recommendations from external referred agency/organisation as required and feed actions into the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding children and young persons' committee or safeguarding adults committee, dependent on PSI (escalations to clinical governance committee)

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incident in a diabetic eye screening (DES) programme	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations from external referred agency/organisation as required and feed action into the most appropriate improvement workstream/consider development of a new workstream.	Clinical governance committee

6. Our patient safety incident response plan: local focus

The table below outlines our local incident priorities developed from the exploration of our data sources and improvement work. It takes account of the resources available to complete proportionate learning responses following a PSI and recognises that further learning is required to inform improvement. The quantity of learning responses required for each PSI incident type or issue will be agreed by our incident review group (IRG). The safety actions will be monitored by the relevant committee, and progress against the actions reviewed and monitored by IRG to ensure the PSIRF standards are met, with oversight provided by our clinical governance committee.

We will not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

It should be noted that the Plan is a starting point, and our learning responses and identification of incident priorities will evolve as PSRIF becomes embedded in the trust. As such, IRG (as will be reflected in the IRG TORs) has the discretion to agree another learning response to that listed in the table, if more appropriate.

As described in section 3.3, the trust provides services that are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. Learning responses will be considered for these services only where a PSI, and not a non-conformity, is recorded.

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Delayed or missed diagnosis of a tumour in a glaucoma patient referred to the neuro-ophthalmology service **(LP01)**	Patient Safety Incident Investigation (PSII)	• A review of our PSIs, previous serious incidents (SIs) and complaints has shown that referral from the glaucoma service to the neuro-ophthalmology service is complex, and there are multiple factors that can contribute to a delay. • Due to the complexity, organisational impact and the number of services involved, a PSII will ensure that a rigorous and in-depth review addressing system factors is undertaken.	Clinical governance committee
Unplanned omission/ deviation to intended care or treatment plan because of the use of hybrid health records/systems **(LP02)**	After Action Review (AAR) or another agreed learning response, if more appropriate	• Some contributory factors related to the use of hybrid records are known. However, PSIs have indicated that more learning will help inform the development of local safety actions. • AAR will support the identification of areas for improvement by understanding the expectations and perspectives of all those involved. Learning from the AARs, will feed into the safety improvement plan, or equivalent, related to the development of a comprehensive electronic patient health record.	Digital clinical safety committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Clinically unacceptable delay in the review/ treatment of a 'follow-up' patient, where the provision of a timely appointment has not been impacted by clinician instruction or known capacity issues **(LP03)**	AAR or another agreed learning response, if more appropriate	• Improvement of our failsafe processes is a trust priority and is on the trust's risk register. The review of our data has highlighted this as an area for improvement. • AAR will support the identification of areas for improvement by understanding the expectations and perspectives of all those involved. New safety actions identified from the AAR will be incorporated in the failsafe and Outpatient Waiting List (OWL) improvement workstream.	Develop and deliver excellence board Oversight and escalations via clinical governance committee
Mismanagement of internal referrals between sites and services and referrals from external providers into the organisation **(LP04)**	Thematic review of PSIs related to referral management	• Reported PSIs, feedback from focus groups and learning from a referral safety summit have evidenced this as an opportunity for improvement. • New safety actions identified from the thematic review of PSIs will be incorporated in the safety improvement plan being developed as part of the ERS (electronic referral service), OpenEyes (OE, electronic patient record) and booking centre improvement workstreams.	Develop and deliver excellence board IT programme board Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Communication of patient information between the trust and external organisations (e.g., letters and referrals relating to continuity of care not sent) **(LP05)**	Thematic review of new PSIs relating to the external communication of information	• Reported PSI, feedback from focus groups, patients, and learning from a referral safety summit have evidenced this as an opportunity for improvement. • A thematic review will allow for a structured approach to identify themes and inform the trust wide safety improvement plan. Clinical governance committee will review the recommendations from the thematic review to determine a mechanism for implementation of the improvement plan.	To be determined by the clinical governance committee following the thematic review
Deviation to intended care or treatment plan resulting in intravitreal injection of the wrong drug and/or to the incorrect eye **(LP06)**	AAR or another agreed learning response, if more appropriate	• Review of PSI near misses and incident data, feedback from key stakeholders and focus groups has identified this as an opportunity for improvement. • Output from the AAR will identify activities, resources and behaviours that will support the development of safety actions and create a trust wide safety improvement plan, if required.	Drugs, therapeutics, and medicines management committee Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Any incident or near miss relating to the application of a laser to a patient **(LP07)**	AAR or another agreed learning response, if more appropriate	• PSI and near misses have been reported relating to the use of lasers. PSIs can have an impact on patient outcomes and vision. • The output from AARs will identify activities, resources and behaviours that will be incorporated in the development of a laser safety improvement plan and/or safety summit.	Laser safety committee Oversight and escalations via risk and safety committee
Delayed recognition of a deteriorating patient **(LP08)**	AAR or another agreed learning response, if more appropriate	• Reported PSIs have identified an opportunity for improvement in the way the trust responds to patient deterioration. • Output from the ARR will quickly identify activities, resources, and behaviours, that will be fed into the 'deteriorating patients' improvement work.	Resuscitation committee Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Delayed processing or review of a diagnostic test or sample leading to a clinically unacceptable delay in treatment **(LP09)**	AAR or thematic review, or another agreed learning response, if more appropriate	• Reported PSI have evidenced this as an opportunity for improvement. • Output from the AAR will identify activities, resources, and behaviours, that will feed into local safety actions. In turn these will feed into the most appropriate improvement workstream/consider development of a new workstream.	Pathology improvement group Radiation protection advisory committee Oversight and escalations: via risk and safety committee
Clinically unacceptable delay, not impacted by known capacity issues, in actioning an outcome of a review of a patient managed through a virtual pathway **(LP10)**	AAR or thematic review, or another agreed learning response, if more appropriate	• Reported PSI have evidenced this as an opportunity for improvement. • Output from the ARR will identify activities, resources, and behaviours, that will feed into local safety actions. In turn these will feed into the most appropriate improvement workstream/consider development of a new workstream.	Develop and deliver excellence board. Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incident(s) which signify an unexpected level of risk and/or potential for learning and improvement **(LP11)**	Assessment by the Incident Review Group to determine if a learning response is required	• To ensure there is a mechanism to add to the Plan as our PSRIF approach develops and new themes emerge.	To be agreed by IRG, depending on the PSI type or issue

Appendix 1: Glossary of terms

Term	Definition/Explanation
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning? It aims to capture learning from these to identify the opportunities to improve and increase occasions where success occurs.
Compassionate engagement	An approach that prioritises and respects the needs of people who have been affected by a patient safety incident.
Duty of candour (DoC)	The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.
Engagement	Everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Term	Definition/Explanation
Everyday work	Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work. Exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences and is central to any learning response conducted to inform improvement. The following tools can be used to explore everyday work: • Observation guide Brief guide to conducting observations • Walkthrough guide Brief guide to walkthrough analysis • Link analysis guide Brief guide to link analysis • Interview guide Guidance on planning and conducting interviews as part of a patient safety incident learning response
Horizon scanning	The horizon scanning tool uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to structure conversations about work as done and emerging patient and staff safety risks Horizon scanning tool
Involvement	Part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.
Multi-disciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Never Event (NE)	Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. A list of NEs can be found here: Never Event list February 2021

Term	Definition/Explanation
Patient Safety Audit (PSA)	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline)
Patient Safety Incidents (PSIs)	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.
Patient Safety Incident Investigation (PSII)	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.
Patient Safety Incident Response Framework (PSIRF)	This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
Patient Safety Incident Response Plan	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.
Patient safety partners (PSPs)	PSPs are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

Term	Definition/Explanation
Systems Engineering Initiative for Patient Safety (SEIPS)	SEIPS is a framework for understanding outcomes within complex socio-technical systems. Patient safety incidents result from multiple interactions between work system factors (i.e., external environment, organisation, internal environment, tools, and technology, tasks, and person(s). SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships. SEIPS quick reference guide and work system explorer
Structured Judgement Review (SJR)	Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.
Thematic review	A thematic review may be useful for understanding common links, themes, or issues within a cluster of investigations, incidents, or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. Top tips for completing a thematic review

Appendix 2: List of sites and medical services (as at January 2024)

	Accident & Emergency	Adnexal	Anaesthetics	Cataract	External disease	General ophthalmology	Genetics	Glaucoma	Intravitreal injections	Medical retina	Neuro-ophthalmology	Ocular oncology	Paediatrics	Private Patients	Refractive laser	Strabismus	Surgery	Urgent Care	Uveitis	Vitreoretinal
Barking Hospital								✓												
Bedford Hospital (South Wing)		✓		✓				✓	✓	✓			✓				✓	✓		
Brent Cross				✓				✓		✓										
Cayton Street				✓														✓		
City Road	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Croydon University Hospital		✓		✓	✓	✓		✓	✓	✓	✓		✓			✓	✓	✓	✓	✓
Ealing Hospital				✓	✓	✓		✓	✓	✓			✓			✓	✓		✓	
Homerton Hospital (Partnership)						✓							✓							
Hoxton								✓		✓										✓
MeiraGTX Hoxton Maze																				
Moorfields Private Eye Centre														✓	✓		✓			
Moorfields Private Outpatient Centre														✓						
Nelson Health Centre						✓		✓		✓										
Northwick Park Hospital		✓		✓	✓	✓		✓	✓	✓			✓			✓	✓			
Parkway Health Centre*																				
Potters Bar Community Hospital				✓		✓		✓	✓	✓			✓			✓	✓			
Purley War Memorial Hospital								✓		✓										
Queen Mary Hospital				✓				✓									✓			
Richard Desmond Childrens' Eye Centre	✓												✓	✓						
Sanderstead Health Centre*																				
St Ann's Hospital			✓	✓				✓	✓	✓							✓			
St Bartholomew's Hospital												✓								
St George's Hospital		✓		✓	✓	✓		✓	✓	✓	✓		✓			✓	✓	✓	✓	✓
Stratford			✓	✓		✓		✓	✓	✓							✓			

- Orthoptist services only.
- This table does not include the support services provided (e.g., orthoptics, optometry, contact lens, imaging, pathology, EDD, prosthetics). For more information regarding these services please contact the ophthalmology and clinical support services (O&CSS) division.

Appendix 3: Detailed stakeholder engagement activities completed to inform our Plan

- For 2022/23 implementation of the National Patient Safety Strategy, including the PSIRF, was introduced as a quality priority for the trust. Delivery against the priority was included for monitoring by the Excellence Delivery Unit (XDU) as a type 1 project (now re-categorised as a type 2) and monthly progress updates were provided to the working together board (jointly chaired by the chief nurse and director of allied health professionals and the director of workforce and organisational development (the function of the XDU is described in more detail in section 4).

- The purpose and expectations of PSIRF were communicated to the organisation in advance of the NHSE launch of the final PSIRF documents in mid-August 2022. The early adopter information was discussed with the caveat that the published versions would contain differences. Routine updates were provided to the risk and safety committee and the clinical governance committee, and National Patient Safety Strategy updates have also been presented to the quality and safety committee as a sub-committee of the trust board.

- Patient safety partners were involved via their membership of our clinical governance committee. One patient safety partner reviewed of our SI responses under SIF to inform the Plan. They were also specifically asked to comment on the safety incident profile and the draft PSIR policy.

- The proposed incident priorities were presented at governance meetings, including the trust's Clinical governance committee for oversight, feedback, and discussion prior to approval.

- The trust welcomed access to the resources made available for use via the NHS Futures platform, and the central quality and safety team has widely advocated such access. For example, the NHS England short animation 'Introducing the Patient Safety Incident Response Framework (PSIRF): A framework for learning' has been shown to staff attending the chief executive briefing, at various department/team meetings and at quality forums. Staff have been afforded the opportunity to share insight or concerns and ask questions regarding PSIRF, either in the forum or on a 1:1 basis.

- Our PSIRF implementation group was first convened towards the end of 2022. Engagement with members of the implementation team continued on an ad-hoc basis, until the implementation group was formally reconvened in Q1 2023/24 to review the output of the diagnostic and discovery phase and to help draft our PSIRP local priorities prior to consultation.

- A significant achievement that PSIRF has enabled for the central quality & safety team was the development of safety culture focus groups to support the diagnostic and

discovery phase of the PSIRP development. A series of focus groups were held across the organisation, and these afforded the team the opportunity to understand any specific concerns that participants may have in relation to patient safety and psychological safety.

- The UCL Partners health innovation partnership has hosted PSIRF events and provided a safe environment in which trust representatives from partnership organisations, including the ICB, networked and sought advice and support from each other. This will also assist with the co-ordination of any cross-system learning responses that are required in the future.

Appendix 4: 2023/24 Quality priority drivers

	Quality Account Priority 2023/24	Quality Domain	Underpinning drivers: Excellence programme (XDU)	National initiative	Learning from SIs/ Complaints/ feedback	Themes from patient/staff engagement	Carried over from 2022/23
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)		✓	✓	✓	✓	✓
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'		✓	✓	✓	✓	✓
10	Patient Initiated Follow Up (PIFU)		✓	✓	✓	✓	

Appendix 5: 2023/24 Excellence portfolio categorisation

The objectives of the excellence programme boards and projects can be found in the tables below. The projects from the IT and Discover Excellence programmes are not included below. This list is subject to change throughout the year.

Programme board	Objective	Excellence area
Working together	We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.	• Workforce • Quality
Discover	We will discover new treatments and clinical pathways for excellent eye care.	• Innovation • Education
Develop and deliver	We will develop our clinical pathways, our physical and digital network, and our operational systems, to deliver reliably excellent eye care.	• Clinical • Network • Operational
Sustain and scale	We will ensure that more people can access excellent eye care sustainably and at scale, reducing waste and inefficiency.	• Enterprise • Sustainability

2023/24 Excellence portfolio categorisation

Type 1

1. Major project (external PMO): Oriel
2. Major project: EPR
3. D&D: Central Sterile Supply Dept. (CSSD) – phase 1&2
4. D&D: Single Point of Access (SpOA) - rollout
5. D&D: Outpatient Waiting List
6. D&D: Brent Cross II
7. D&D: Stratford Hub - phase 1&2
8. WT-Q: Accessible Information Standard
9. WT-Q: EDI strategic priorities (x4)
10. WT-W: Temporary Staffing Provision – bank partners
11. WT-W: E-Roster optimisation
12. WT-W: FTSU
13. WT-W: Agile – phase 1 & 2
14. S&S: Commercialisation Framework
15. S&S: Primary and Community Eye Care Services

Key:

* Projects have not begun reporting via XDU
** Projects have submitted closure reports and transitioned to benefits realisation

Type 2

1. D&D: Surgical Excellence – operational
2. D&D: Inventory Management System (IMS)
3. D&D: Asynchronous and Virtual appointments
4. D&D: Bedford contract renewal and capital works
5. D&D: Development of Clinical Strategy
6. D&D: Failsafe - Implementation phase *
7. D&D: Digital Pre-operative assessment
8. WT-Q: National Patient Safety Strategy (PSIRF)
9. WT-Q: Certificate of Visual Impairment
10. WT-Q: Patient Experience Framework
11. WT-Q: Patient Experience Principles – phase 2
12. WT-W: ESR Optimisation *
13. WT-Q: Health Inequalities Data Analytics
14. WT-Q: Website redevelopment
15. WT-W: Medical Workforce Optimisation
16. WT-W: OD programme
17. S&S: Paperless Campaign
18. D: Education hub @ Ebenezer Street *
19. D&D: Pathology Unit Transfer **
20. WT: Future Shape of Workforce (ON HOLD)
21. D&D: Surgical Excellence – workforce **

Type 3

1. D&D: Digital Remote Consenting
2. D&D: Patient Portal
3. D&D: PIFU
4. D&D: Attend Anywhere – St George's
5. D&D: Follow Up Reduction
6. D&D: Site reviews – Sanderstead / Parkway / Croydon *
7. D&D: New Amin model *
8. D&D: Barking CDC
9. D&D: Robotic Process Automation (ON HOLD)
10. WT-Q: Comprehensive audit tool (Tendable)
11. WT-W: Infrastructure Review – CPD, Apprenticeships and LMS
12. WT-Q: Professional Nurse Advocate
13. WT-Q: Virtual Reality
14. WT-Q: MEC philantrophy culture framework
15. WT-Q: Information Asset Management
16. WT-Q: MEC My Thank You
17. WT-Q: Veterans Aware Accreditation
18. WT-Q: Making Every Contact Count – Smoking Cessation *
19. D: BYOD clinical photography *
20. S&S: Carbon Footprint
21. WT: International Nurse Recruitment **
22. WT: Resuscitation Improvement Project **
23. S&S: Energy Management Phase 1 **
24. S&S: Moorfields Private West End – Outpatients **
25. S&S: Moorfields Private West End – Theatres **
26. S&S: Sustainability Awareness Campaign **
27. S&S: Trust Green Travel Plan **
28. WT: Digital Accessibility / Inclusion **
29. WT: Pathway to Excellence (ANCC) **
30. WT: Eye Envoys **

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