Moorfields Eye Hospital NHS Foundation Trust

NHS

Our commitment to quality excellence

Quality Account 2024/25

(includes Quality priorities for 2025/26)

FINAL v1.0

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Part 1: Statement on quality

1.1. Statement on quality from the interim chief executive

I joined Moorfields Eye Hospital (MEH) as its Interim Chief Executive in January 2025. Since then, it quickly became apparent that MEH is an organisation driven by a strong commitment to ensuring it delivers world-class eye care, leads the way in innovation, and responds openly to the challenges that come with change. As always, its values of excellence, equity, and kindness guide these principles at every stage.

An example of a great quality achievement this year came from our Electrophysiology Department, which became the first in the UK to receive national IQIPS (Improving Quality in Physiological Services) accreditation. This recognition reflects the team's outstanding work in raising clinical standards and delivering safe, high-quality care.

Our excellent clinical outcomes, available in full detail in this report, again indicate that the care we provide is righty top priority for all our staff and this is reflected in the positive perceptions of care and treatment in our staff survey.

In our drive for digital transformation, we made a significant leap forward by awarding a contract to implement the MEDITECH Expanse Electronic Patient Record (EPR) across our 20 plus sites. Once fully in place in 2026, this system will unify patient data and improve the way we coordinate and deliver care, especially across services like accident and emergency (A&E), outpatients, and pharmacy.

We also reached an important milestone in the Oriel Centre development, our central location in Camden. The building's concrete frame was completed in late 2024, and the exterior is making great progress, keeping us firmly on track for opening in 2027. In collaboration with UCL, Oriel will bring together our clinical, research, and education teams under one roof in a purpose-built, modern space.

We continue to embed our Patient Experience Principles. These align fully with our core values and drive everything we do to support our patients. In line with our commitment to continuous improvement and learning, Moorfields has embraced the Patient Safety Incident Response Framework (PSIRF). This approach represents a meaningful shift in how we respond to patient safety incidents, focusing on compassionate engagement, system-wide learning, and a just culture. By adopting PSIRF, we aim to ensure that every incident becomes an opportunity to better understand the complexities of care. Already, our first patient safety incident improvement plans are beginning to drive meaningful change, strengthening our systems and enhancing the quality of care we provide.

We also continued to support public awareness campaigns, including raising awareness of the link between smoking and eye health. National No Smoking Day provided an opportunity to educate patients on how lifestyle choices can impact their vision. Additionally, we made progress on our quality priorities, including significant improvements in the management of Certificates of Visual Impairment (CVI) and in promoting accessible information standards.

Of course, it has also been a year that has prompted honest conversations and self-reflection. In early 2025, we received clear messages from our staff that we need to do more to rebuild trust, strengthen communication, and listen more closely to staff voices.

We take these concerns seriously. In response, the Board opened dialogue with clinical leaders and committed to working collaboratively to address the issues raised. We are taking real steps to improve transparency, support wellbeing, and ensure that every team member feels respected and heard.

As we look ahead, we are proud of the progress we have made and committed to learning from the challenges we have faced. We remain focused on delivering the highest standards of care for our patients, supporting our people, and building a strong future for Moorfields through innovation, collaboration, and compassion.

Peter Ridley
Interim 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 2024/25

At Moorfields, quality remains central to every decision we make. Our trust strategy, shaped in partnership with both patients and staff, guides our commitment to achieving excellence in all aspects of care and service delivery.

The Quality Account serves as a vital mechanism for NHS trusts to demonstrate the quality of care they provide, outline areas for improvement, and report transparently on outcomes. It offers a comprehensive overview of how we assess the effectiveness, safety, and the patient experience of our clinical services, drawing on patient feedback and measurable results.

Our 2024/25 Quality Account reflects on the progress we have made against the priorities and goals set for the previous year. It provides assurance to our patients, stakeholders, and partners that we are delivering high-quality clinical care, while also being candid about areas where improvement is needed and outlining our ongoing commitment to enhancing the quality of our services.

The Quality Account incorporates both the statutory requirements outlined in the Quality Accounts Regulations and the additional reporting expectations set out by NHS England (NHSE). Its purpose is to:

- Promote continuous quality improvement across the NHS
- Enhance public accountability and transparency
- Enable internal review and reflection on the services we provide
- Set out our planned improvements for the year ahead
- Engage with and respond to feedback from patients, the public, and other stakeholders.

The integrity of our Quality Account is underpinned by a strong foundation of governance. Our well-established governance systems uphold accountability and oversight. We have robust information governance and clinical governance practices, reinforcing our belief that high-quality care and effective governance go hand in hand. This approach ensures a transparent, responsive, and continually improving service for everyone who relies on Moorfields.

1.3. Moorfields Eye Hospital's approach to improving quality

At Moorfields, our core belief, people's sight matters, continues to underpin everything we do. Our purpose is to work collaboratively to discover, develop, and deliver outstanding eye care sustainably and at scale.

Throughout 2024/25, our Excellence Portfolio has remained a key framework supporting our quality priorities and improvement initiatives. The Quality, Service Improvement and Sustainability Team (QSIS) has taken the lead in project managing and delivering these improvement initiatives, while the Excellence Delivery Unit (XDU) has provided robust oversight, ensuring a consistent approach to methodology, data-driven decision-making, and the proactive management of interdependencies across programmes.

The portfolio is structured into four aligned programmes delivered across four executive-led boards; Working Together, Discover, Develop and Deliver, and Sustain and Scale, each with dedicated executive sponsorship. This model draws on recognised best practices and embeds key improvement principles, including the use of agreed metrics to assess impact.

In 2024/25, over 40 projects were supported through this approach. The Excellence Portfolio also acts as the delivery mechanism for our organisational strategy, advancing work across nine defined areas of excellence. One of these, Quality Excellence, is sponsored by Sheila Adam, chief nurse and director of allied health professionals.

During the reporting period, the Working Together Excellence Programme Board supported 16 quality-led projects. Notable initiatives included the implementation of our Patient Experience Principles, adoption of the Patient Safety Incident Response Framework (PSIRF), and improvements to the management of Certificates of Visual Impairment (CVI) and Accessible Information Standards (AIS).

We also progressed the development of our quality learning system, which supports continuous organisational learning. In addition, a local improvement process is being established, with a strong focus on this becoming a key area of development for 2025/26. In combination this empowers frontline teams to lead change, embed learning, and deliver localised quality improvements.

Further detail on these initiatives is provided in Section 2.1: Quality Priorities for 2024/25 of this report.

Additional projects across the Excellence Portfolio, such as Surgical Excellence, Outpatient Excellence, and the formation of our Digital Clinical Services Division, are also contributing to quality improvement. Oversight of the Quality Account and the delivery of quality priorities is provided by the Quality and Safety Committee (Q&SC) on behalf of the Board, maintaining accountability and a strong focus on delivering high-quality, safe, and compassionate care.

A plain text version of this Quality Account is available on request.

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 2024/25 priorities

During this time, we concentrated on 11 quality priorities approved by the Board, which were outlined in last year's quality account. These priorities align with the three Darzi domains of quality: patient safety, clinical effectiveness, and patient experience. They were shaped through collaboration with patients, staff, governors, commissioners, and relevant charities. Their selection was also informed by the progress achieved on the 2023/24 priorities, as well as feedback from staff and patients on how to improve their experience at Moorfields.

As part of our consultation process, we held a forum with key external stakeholders, including patient representatives and the Royal National Institute of Blind People (RNIB). We gathered input from staff, and the priorities also reflect insights from incident investigations and ongoing governance and oversight feedback. The trust's host commissioners and other external organisations, such as Healthwatch Islington, reviewed the quality report and expressed support for the priorities. Table 1 provides an overview of the key factors that influenced the selection of these priorities.

Building on the progress made across 2022 to Q4 2024, the quality priorities for 2024/25 were the foundation for the trust's strategy to deliver improvements in patient and service user care, and for achieving compliance with key performance and regulatory requirements.

As previously described, throughout 2024/2025, progress to achieve our quality priorities was monitored by the Excellence Delivery Unit (XDU) and overseen by the Working Together and Develop and Deliver Excellence Boards, as well as the trust's Clinical Governance Committee (CGC).

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

A six-month progress report was presented at the Clinical Governance Committee's meeting in October 2024.

Information for each of the quality priorities, identifying what has been achieved to date and indicating if there are any gaps in delivery, is described below. The information provided sets out the progress with the quality priorities for 2024/25 (1 April 2024 to 31 March 2025). Having set ambitious priority targets, the trust has demonstrated progress across them all. In some areas, full achievement has not been possible. This is explained in the narrative against each of the 2024/25 priorities, and some of the priorities will continue into 2025/26. A summary of the priorities can be found in table 2.

Table 1 - Drivers for inclusion as 2024/25 Quality priority

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

Table 2 - Summary of 2024/25 Quality priorities

Patient safety

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

Patient experience

Quality priority	Description	Measurement of improvement	Lead
To improve the process for the allocation of Certificates of Visual Impairment (CVIs) to eligible patients.	CVIs are official documents issued to individuals with significant sight loss. This project aims to improve the process and timeliness for issuing CVIs to facilitate patient access to support services, benefits, specialised equipment, and educational resources, improving quality of life for those with sight loss.	Number of issued certificates over time.	Marco Murru
NEW To improve the experience of patients requiring transport to and from our sites by utilising data in collaboration with our third-party suppliers.	Patient and staff feedback have highlighted the need for enhancements in the patient transport process. This project seeks to address these improvements by reviewing and utilising data provided by our third-party suppliers to drive change.	• Wait times • Patient complaints and corresponding incidents • Tracking of how long it takes to fix problems and complaints about transport, aiming to make this process faster • Monthly meetings with transport suppliers, focusing on making these meetings regular and productive • Monitoring the accuracy of the data that we use for making decisions and how often we use this information to improve transport services • Patient safety incidents related to transport.	Paul Cartwright
NEW To operationalise the approach developed for routine reporting, review, and utilisation of data on service delivery for health inequalities.	This project aims to ensure that health inequalities data is readily accessible to teams to support their programmes of work; whilst also meeting the statutory requirements of NHS organisations.	Suite of standard and additional reporting KPIs adjusted to monitor any health inequalities and variations across cohorts.	Parul Desai

Quality priority	Description	Measurement of improvement	Lead
Implementation of patient experience principles.	Patient experience principles have been developed incorporating the values of kindness, equity, and excellence across the whole patient pathway. This project aims to embed the principles across the organisation to improve the patient experience.	• Service excellence matrix results • Complaints and PALS enquiries • Friends and Family Test (FFT) • Bespoke KPIs related to improvement projects being driven by local teams.	Robin Tall
Implementation of the patient experience framework.	The aim of this project is to ratify, publish and embed the patient experience framework to support staff to improve patient experience to work towards meeting the three objectives set out in the 5-year patient experience plan.	• Published framework • 5-year delivery plan • Complaints and PALS enquiries • Friends and Family Test (FFT) • Outputs from the patient experience principles improvement work.	Robin Tall
NEW To review the ways we communicate with our patients.	To meet this aim, we will undertake a review of our existing communication channels (digital and non-digital) to help inform the integration of patient-centred communication into clinical and operational practice, including the new EPR.	Patient satisfaction with appointment letters • Clarity and accessibility of content across appointment types • Number of legacy templates in use across the Trust Reduction in template variation (aim: reduce from 300 to 20). • Incorporation of AIS (Accessible Information Standard) principles. • Integration of patient feedback into final letter designs.	Vivindhree Doorgiah

Quality priority	Description	Measurement of improvement	Lead
Continue to embed the Accessible Information Standard (AIS) across Moorfields' network.	Improve the patient experience and care of those with accessible needs by providing accessible information and access to services. As a hospital, we strive to deliver excellent, equitable, and compassionate care to all our patients. We also have a legal duty to provide accessible care, not just to those with sight loss, but to all patients and cares with accessible needs. By meeting the Accessible Information Standards (AIS), we will ensure that we have a consistent approach for communicating with and providing access to services for those with accessible needs, ensuring they have equal and safe access to care.	• 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 FFT, patient survey and expert patient group • Percentage of patients seen in the month that have an AIS need recorded (before or within 7 days of their attendance) • Out of all patients seen in the month with an AIS need recorded, the percentage of AIS needs recorded as 'No AIS need'.	Laura Brewster

Clinical effectiveness

Quality priority	Description	Measurement of improvement	Lead
NEW To help patients make informed decisions about their surgery.	Undertake a review of how we are meeting the NICE guidance to support the surgical excellence programme aimed at improving the way healthcare professionals work together with a patient to reach a decision about care and consent before surgery.	• The proportion of consent forms that are digitally signed in advance of surgery, rather than on paper. • Survey our patients to understand their involvement in shared care decision making. • Data to identify service areas for improvement and to inform the development of SOP and training and education packages.	Ian Newman
NEW To utilise staff shared decision-making councils to drive staff engagement and empowerment.	Support staff engagement and empowerment in the development of shared decision-making councils.	• Number of councils • Staff satisfaction and morale • Participation and engagement levels • Communication effectiveness: Staff perceptions about improvements in interdepartmental communication.	Mary Masih

2.2 Twelve-month progress update

Quality Domain: Safety

Priority 1: Transition and embedding of the National Patient Safety Incident Response Framework (PSIRF)

Priority Lead: Julie Nott

Rationale and background

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents, focusing on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight. Our PISRF policy and plan were published on the 2 April 2024, and the aim of this project is to build on the work of last year to ensure that the PSIRF principles are embedded across the organisation.

What success will look like by the end of March 2025:

There will be an established governance structure in place which fulfils PSIRF oversight requirements and supports the review of potential national and local priorities, including the allocation of an appropriate and proportionate learning or improvement response. Compassionate engagement and support for those involved in, or affected by, a Patient Safety Incident (PSI) will continue to be prioritised.

What we will measure:

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

Background

The PSIRF was launched in August 2022, as a replacement for the Serious Incident (SI) Framework. It promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

What did we achieve to date?

Implementation of PSIRF has continued to be supported by the XDU delivery team and has been monitored by the Working Together Programme Board, to which monthly updates were provided. We have:

- Completed all legacy SI investigations

- Reviewed over 350 PSIs, to consider if they satisfy criteria to be a local or national priority. Approximately 75% have been classified as such.
- Initiated 4 patient safety incident investigations (PSIIs)
- Developed a process for the recording and monitoring of improvement responses
- Adopted an improvement approach to monitoring the effectiveness of our new processes
- Actively participated in the pan-London webinars and UCLP-led North Central London PSIRF workshops.

PSIRF has been included as a trust quality priority for 2025/26. We will undertake the first review of our policy and plan and focus on our improvement responses and completing the associated safety actions.

What are the gaps in delivery?

No gaps in delivery of the project identified. This priority will be included as a quality priority for 2025/26, with a focus on the further development of the learning system below.

Quality Domain: Safety

Priority 2: Development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)

Priority Lead: Kylie Smith

Rationale and background

One of the key principles of the PSIRF relates to ensuring organisational learning following the review of an event and that there is evidence of improvement following the implementation of recommendations. By building an organisational learning system we will have a structured environment or framework to facilitate the acquisition, retention, and application of learning across the organisation. There is also a need to ensure that there are adequate feedback mechanisms within the learning system to enable participants to provide feedback on the response process and suggest areas for improvement. This feedback loop ensures that recommendations following the review of an event are incorporated into future practices and systems.

What success will look like by the end of March 2025:

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

What we will measure:

- Monitoring associated KPIs related to improvement recommendations from the review of multiple data sources
- Staff survey to determine how staff understand the learning from an event
- QR code hits to the feedback survey from safety briefings
- Quality assurance tendable audit and inspections to monitor the learning from events on the shop floor.

What did we achieve to date?

To date, we have focused on developing our learning system, supported by the externally commissioned Moorfields Learning Systems Report. The report highlighted strengths such as robust governance structures for incident reporting, clinical governance, and the use of statistical process control (SPC) charts. It also identified areas for improvement, including communication, the use of patient experience data, and the consistency of safety huddles. As a result, we now have a learning system strategy in place, though further work is needed to embed it fully into governance and other organisational processes.

To support this, we collected data on safety huddles, an integral part of our quality management and learning system, which showed they are not yet standardised across the trust, with variation in how and where they occur and whether learning can be demonstrated. In response, pilots of a new model for safety huddles are underway on Sedgwick Ward, Richard Desmond Children's Eye Centre (both at City Road). MEH Stratford and St Ann's (North Division) are being explored as additional sites. A Standard Operating Procedure (SOP) and charter for huddles have been developed, including how huddles create learning - initial feedback has been positive. Quality improvement principles are being used to adapt and embed these processes based on feedback.

We are also developing simple, practical methods for collecting staff feedback about huddles to support engagement without adding workload. In addition, we have developed a digital PMO (dPMO) tool to monitor progress across our PSIRF work plans, supported by strong governance structures and the XDU team.

What are the gaps in delivery?

While progress has been made in implementing safety huddles across the trust and pilots are underway for a new more robust huddle including learning and guided by an SOP. Ongoing monitoring of improvement is still required. Broadening our Quality Management System (QMS) work to areas outside those already with a QMS is planned but has not commenced and is somewhat dependent on the continuation of safety huddles work, which are a key component. Therefore, the quality learning system will be included as a quality priority for 2025/26.

Quality Domain: Patient Experience
To improve the process for the allocation of Certificates of Visual Impairment (CVIs) to eligible patients.
Priority Lead: Marco Murro

Rationale and background

A CVI formally certifies someone as visually impaired and acts as a referral for a social care assessment by the local authority. Patients are also entitled to financial benefits, equipment, and support from their community enabling them to be as independent as they want to be..

The CVI project aimed to review the process for identifying eligible patients and to determine how many potentially eligible individuals had not yet been assessed, with the overarching goal of improving access to support services and ultimately improving the quality of life for those certified.

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

The project success was aimed at meeting the following objectives:

- To agree the criteria needed to calculate the potentially eligible patients who have not yet been assessed
- To identify potentially eligible patients who have not yet been assessed and carry out the necessary evaluations
- To identify opportunities to streamline the process for CVI registration
- To ensure appropriate steps are in place to prevent delays in identifying eligible patient.

What was measured for improvement?

Unreviewed patients who meet the threshold for severe visual impairment, and therefore meet the criteria for a CVI, as defined as a visual acuity of 6/60 or worse on a monthly basis.

The improved percentage of in-month MEH patients with VA of 6/60 or worse who have an up-to-date CVI status.

The number of Certificates of Visual Impairment (CVIs) issued through the OpenEyes (OE) system over time.

What did we achieve?

- **Funding:** £15,000 funding was approved for overtime to support the team in working on the potential eligible patients who were not reviewed
- **Review:** the team have identified and successfully reviewed all 1,578 patients with a visual acuity of 6/60 or worse in both eyes (highly likely to qualify for CVI registration)
- **Failsafe:** weekly reports are now routinely distributed to the Eye Clinic Liaison Officers (ECLOs). These enable the ECLOs to maintain accurate, up-to-date patient statuses. The data will be regularly reviewed at the monthly divisional quality forums and escalated to the divisional boards
- **Training:** 80 members of staff have been trained on CVI eligibility and on the new process in place. Training is also included in the new staff induction pack
- **Clinical fellows are now actively involved in the process.** They can assess a patient's eligibility, initiate the CVI process, and then hand it over to a consultant for final review and signature, as only a consultant can authorise the approval
- **Communication** with local authorities has been implemented to ensure they are aware of the potential increase in CVIs
- **A targeted email** has been sent to clinical staff to promote awareness of the CVI process and encourage fellows to initiate CVI registrations
- **Engagement** with Glaucoma and Medical Retina service directors has been successfully established
- **Project updates and achievements** have been presented at the National CVIC and the Vision Loss Advisory Group
- **The project was featured at the 'All-Staff Event'** on 4 December 2024 at the Barbican, where a presentation, including a powerful patient story video, highlighted its progress. This event, centred around the theme "Kindness in Healthcare," and provided a valuable platform to share the project's impact and achievements
- **Clinically Governance Poster Competition 2024 –** Won first place, receiving a trophy and a voucher
- **CVI Promotion Week** was successfully delivered, engaging staff through a variety of informative and interactive activities. Highlights included a well-attended Lunch and Learn session with 45 participants, a safety huddle briefing, an engagement stall, and a CVI quiz that attracted 36 participants, with an optometrist winning £50 voucher. To improve accessibility and awareness, a step-by-step guide was provided

- **EyeQ (trust intranet)** updated with key resources
- **Participated in the poster competition at the RCOphth Annual Congress 2025 in Liverpool.**

What are the gaps in delivery?

This project has been successful and has been closed and moved to business-as-usual functions. However, ongoing work continues, including review of failsafe reports and clinician follow up if an excessive delay in issuing a CVI occurs.

We are awaiting the new OpenEyes version to improve system functionality and better support CVI eligibility management, which is due in August 2025.

A review of the ECLO team structure is underway, led by the Deputy Chief Nurse

, with ongoing conversations to ensure robust and sustainable delivery as planned.

Starting on 1 October 2024, ECLOs across the trust have been recording their activities in PAS. It establishes valuable tracking practices.

Quality Domain: Patient Experience

Priority 3: To improve the experience of patients requiring transport to and from our sites by utilising data in collaboration with our third-party suppliers

Priority Lead: Paul Cartwright

Rationale and background

Patient and staff feedback has highlighted the need for enhancements in patient transport. This project seeks to address these improvements by reviewing and utilising data provided by our third-party suppliers to drive change.

The project aims to enhance the experience of eligible patients requiring transport to and from our sites, aligning with the trust's patient experience principles. By utilising data and collaborating with third-party transport suppliers, we will also be embodying the trust values of excellence, equity, and kindness. By integrating these values and principles, the project will enhance the overall patient experience when visiting our sites.

While the regulatory requirements for the transportation of our patients primarily rest with the third-party supplier, it is expected that when an incident or complaint is raised against the service by one of our patients, the third-party supplier meets the standards and requirements set out by the Care Quality Commission (CQC).

This project will support Oriel, our new centre for advancing eye health, by enhancing patient transport experiences and put in place KPIs that will improve operational efficiency that can then be used to determine operational requirements and monitor efficiency post the transition to the new centre. It will also ensure that other sites are monitored where the service is managed via SLAs and that an equitable service is provided at all sites.

What success will look like by the end of March 2025:

- Improve the transport experience for eligible patients traveling to and from Moorfields sites, aligning with the trust's patient experience principles
- This project supports Oriel by enhancing patient transport experiences and establishing key performance indicators (KPIs) to improve operational efficiency, which will guide post-transition transport needs at the new centre
- Utilise data analytics to identify and address inefficiencies in current transport services, in collaboration with third-party transport providers
- The aim is to streamline transport services, reduce wait times, and enhance partnerships with third-party suppliers, ensuring they actively contribute to service improvement initiatives.

The success of this project depends on the cooperation of transport suppliers in providing necessary data for analysis and improvement

What will we measure?

- Waiting times
- Patient complaints and corresponding incidents
- Tracking of how long it takes to fix problems and complaints about transport, aiming to make this process faster
- Monthly meetings with transport suppliers, focusing on making these meetings regular and more productive
- Monitoring the accuracy of the data that we use for making decisions and how often we use this information to improve transport services
- Patient safety incidents related to transport, to ensure that efforts to reduce waiting times and improve satisfaction do not compromise safety.

What did we achieve to date?

To date, we have established a dedicated working group and commenced the process of updating and standardising the Standard Operating Procedure (SOP) for transporting patients across all our sites. We have identified specific pain points - particularly at our network sites - related to the support of patients awaiting transport in host trusts' transport lounges, and we are actively addressing these issues. An audit of transport times at Croydon has been completed to help inform and guide the project. Additionally, we have agreed on a set of key metrics that all sites will monitor to ensure consistency in evaluation. However, despite these developments, progress has been hindered by ongoing challenges in obtaining timely data from host trusts, which has limited our ability to fully implement and assess these metrics. To address this, we are formally writing to senior leaders in relevant trusts to request the necessary data and support for the continued progress of the project.

In the meantime, we are using the success of the presented and circulated data from our third-party supplier at City Rd to inform the monitoring of data at our network sites.

What are the gaps in delivery?

Despite the progress made, key gaps remain in the consistent delivery of data across all sites, particularly from host trusts, which limits our ability to evaluate performance system-wide. There is also variability in how transport processes are managed locally, which underscores the need for more uniform implementation of the revised SOP and agreed metrics. Therefore, this quality priority will continue for 2025/26.

Quality Domain: Patient Experience

To operationalise the approach developed for routine reporting, review, and utilisation of data on service delivery for health inequalities

Priority Lead: Parul Desai

Rationale and background

Tackling healthcare inequalities is not only an NHS priority but also a requirement of the Health And Care Social Act 2022. All NHS organisations are now expected to routinely monitor for any inequalities and unwarranted variations in their services.

The health inequalities data analytics project is how we are working towards meeting these requirements, our trust strategic objectives and core values for excellent and equitable care. Its purpose was to develop a systematic and sustainable approach and an analytical and reporting framework for routine reporting and reviewing healthcare inequalities in the access and uptake of our services.

What success will look like by the end of March 2025:

Using the data we collect in our everyday practice, it has generated new information on how we deliver our services by age, ethnicity, deprivation, need and clinical risk, which can be used to inform planning and service development for actionable change where any unwarranted differences are found. To support this, and subject to internal consultation and validation of the approach and information produced, a dashboard will also be developed to make this information accessible when it is needed and not just in reports e.g. for Site and Service specific reviews, clinical audit, deep dives and trends analyses.

What will we measure?

The analytical and reporting framework defined a suite of standard and additional reporting KPIs adjusted to monitor any health inequalities and variations across cohorts defined by demographic categories, clinical risk and need.

What did we achieve to date?

The utility and validity of the approach and the information generated was affirmed during the recent internal consultation, and a consensus that this should now be taken forward as business-as-usual reporting along the recommended intervals to a range of decision-making levels in the trust. The structures and processes to enable and implement this are currently being taken forward. In addition, with the support of the communications team, we plan to provide updates and feedback to all staff on how we are working towards meeting our core values using the data collected from our routine work.

The benefits of this project have included:

- Leadership for eye health services for reporting on eye healthcare inequalities at trust, Integrated Care Service (ICS) and national level Development of trust data analytical skills beyond performance reporting
- New information generated from routine data to inform service planning and development and monitoring of any unintended consequences / variations on access and uptake of our services.

What are the gaps in delivery?

The project has closed and has delivered a systematic and sustainable approach and defined indicators for routine reporting of healthcare inequalities in access and uptake of our services. Ongoing support, resource and oversight will be needed for the routine reporting of healthcare inequalities, and for developing and maintaining the dashboard on the QlikSense platform.

Quality Domain: Patient experience

Implementation of patient experience principles

Priority Lead: Robin Tall

Rationale and background

Moorfields' patient experience principles were co-designed by staff and patients using a combination of lived experience stories, patient feedback data and workshops. During the principles co-design process, staff and patients shared that, broadly speaking, the experience of care at Moorfields is excellent; however, there were certain areas where improvements could be made.

We explored how the principles could be embedded into the day to day for staff, and how the principles could prompt local improvement projects relating to patient and carer experience. Action labs have taken place to bring these written principles into actionable practice.

Action labs aim to deliver and embed the principles whilst seeking to nurture a culture of improvement, valuing the input, knowledge and expertise of all staff members (including junior staff members; seeking to empower and build confidence). Action labs nurture a culture of sharing improvements and ideas which may be of benefit to other services and sites whilst recognising the bespoke nature of services and service users.

After the successful trial of the action labs, four cohorts of operational teams took part in action labs within a 12-month period from July 2024 to June 2025.

Alongside the action labs, a communications plan was developed for the patient experience principles, aligning with core staff values/behaviours, Shared Decision Making and AIS workstreams.

The patient experience principles and action lab methodology were shortlisted for a national award by the Patient Experience Network in 2024. We expressed that what made this process special was our methodology, embedding of these principles in a practical way.

What success will look like by the end of March 2025:

- 4 action labs will have been completed.
- Teams feeling empowered to make local changes.
- Simple, intuitive change methodology implemented.
- Foundations for a toolkit to support local change across the whole organisation.

What will we measure?

- Service excellence matrix results.
- Complaints and PALS enquiries .
- Friends and Family Test (FFT).
- Bespoke KPIs related to improvement projects being driven by local teams.

What did we achieve to date?

Status: Approved as a type 2 excellence project at working together board. XDU oversight has now closed as the project moves to BAU.

Overview:

- A sound methodology for implementation through action labs.
- Teams delivered multiple local (small) patient experience improvement projects
- Improvement methodology (based around PDSA) put into practice
- Improvement methodology is joined up across the organization (initially linking to PSIRF and then beyond)
- Feedback from all staff about the practical implementation of the principles has been excellent
- The patient experience principles formed part of the Trust's AGM presentation
- Wider implementation of the principles is being extended beyond the project, to link into the Excellence (XDU) portfolio, the development of a set of core behaviours for individuals and teams through the work of the learning and OD teams and to link into core organisational business planning.
- Full set of measures/KPIs to be introduced during wider roll out/linked to implementation of patient experience framework.

What are the gaps in delivery?

Progress has been good. The next phase of delivery in 2025/26 and beyond continues implementation across the organisation alongside the patient experience framework. Full embedding is required including measures and KPIs and monitoring mechanisms.

Quality Domain: Patient experience

Implementation of the patient experience framework

Priority Lead: Robin Tall

Rationale and background

The aim of this project is to ratify, publish and embed the patient experience framework to support staff to improve patient experience to work towards meeting the three objectives set out in the 5-year patient experience plan.

What success will look like by the end of March 2025:

The framework has delivered a number of tools for staff to use to increase patient engagement and broaden the sources of patient feedback, including 15 steps challenge, mystery shoppers and patient engagement user guides. Delivery of further tools will continue through the steering group.

What we will measure:

- Published framework
- 5-year delivery plan
- Complaints and PALS enquiries
- Friends and Family Test
- Outputs from the patient experience principles improvement work.

What did we achieve to date?

- The framework was launched in May 2024.
- This work is being led by the patient experience team. There is a Steering Group overseeing the work.
- Implementation has been broken down into a series of phases
- The first phase has rolled out improved engagement methods and tools across the organization to create a consistent approach. For example, a consistent method of engaging patients and the 15 steps challenge.

Further stages are planned in 2025/26 and beyond to bring the patient voice and perspective into our service approach.

What are the gaps in delivery?

Implementation is running alongside the patient experience principles overseen by a steering group. The priority is to embed what has been achieved so far and introduce measures, KPIs and monitoring mechanisms.

Quality Domain: Patient experience

To review the way we communicate with our patients.

Priority Lead: Vivindhree Doorgiah

Rationale and background:

To meet this aim, we will undertake a review of our existing communication channels (digital and non-digital) to help inform the integration of patient-centred communication into clinical and operational practice, including the new Electronic Patient Record (EPR) system. Following feedback from our governors, we were asked to review and soften the language used in our Did not Attend (DNA) and cancellation letters to make them more empathetic to the patient. The standardisation of Patient Administration System (PAS) letter templates forms part of a wider effort to improve communication, accessibility, and patient experience across the trust. As part of this initiative, new letter templates were presented at the patient participation & engagement committee (PPEC) on 20 September 2024 for feedback. PPEC includes patients, and staff from communications, PALs, and the patient experience team.

What will success look like at the end of March 2025?

Success will be defined by the implementation of a fully standardised set of PAS letter templates, with no more than 20 in active use across the trust. These templates will be designed to reflect patient needs, preferences, and accessibility requirements, using simple, clear, and inclusive language across all appointment types. They will align with clinic-specific information to ensure consistency in patient-facing communication and include enhanced support for particular needs, such as transport guidance and sensitivity to light. Ultimately, success will be measured through positive patient feedback, confirming improved understanding, satisfaction, and a sense of being heard.

What will we measure?

- Patient satisfaction with appointment letters
- Clarity and accessibility of content across appointment types (Face to face, telephone, video)

- Number of legacy templates in use across the trust
- Reduction in template variation (reduce from 300 to 20)
- Incorporation of Accessible Information Standard (AIS) principles
- Integration of patient feedback into final letter designs.

What did we achieve to date?

- A new standardised letter template was developed for all appointment types (Face to face, telephone, and video)
- The template was shared with the PPEC group for review and was well received
- Feedback from patients was overwhelmingly positive, with comments such as: “Thank you for listening to us.”

Specific feedback included:

- Adding transport information to the welcome leaflet (to be reviewed with the transport project team)
- Reordering content in telephone appointment letters for clarity
- Clarifying who initiates telephone contact
- Improving location detail in letters, e.g. “Clinic 1 – City Road”
- Including additional helpful reminders, such as: “Please bring dark glasses if you are light sensitive”
- Suggestions for adding membership information to future versions of welcome materials
- Updates have been made to both video and in-person appointment letters to make them more patient-focused and easier to understand
- Did Not Attend (DNA) letters are now being reviewed and updated based on patient feedback.

What are the gaps in delivery?

While progress has been made, alignment between the new letter templates and the wide range of existing clinic templates remains incomplete. Currently, around 300 letter templates are in use across the trust and reducing and consolidating these into a standardised set of no more than 20 remains a key priority for phase two of this project. Further work is also required to ensure that all templates align with the Accessible Information Standard (AIS) principles, ensuring patient information is fully accessible to all patients. Implementation continues to be challenged by the volume of templates and the diversity of clinic-specific requirements. This work will continue as a quality priority throughout 2025/26 to ensure consistent, patient-centred communication trust wide.

Quality Domain: Patient experience

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

Priority Lead: Laura Brewster

Rationale and background

The AIS is a legal obligation for all healthcare providers, and is extremely important for patients, not just with sight loss but for any patients with specific needs or disabilities who may need information in specific formats or reasonable adjustments made prior to, during, and after their hospital visit. Compliance with AIS is also a requirement within the Care Quality Commission's (CQC) regulatory framework.

The trust has received formal complaints and faced legal challenges related to inadequate provision of accessible information. There have been consistent comments via the Patient Advice and Liaison Service (PALS) highlighting poor customer care linked to a lack of provision for patients with accessible needs.

This project continues the work identified as a quality priority in the 2023/24 Quality Account, aimed at improving the experience and care of patients requiring accessible information and access to support. By providing empathetic and equitable care and meeting the AIS, we will establish a consistent approach to communicating with individuals with accessible needs, such as sight loss or dementia, ensuring communication and access to support services is tailored to their individual needs and preferences.

The work in 2023/24 focused on identifying the necessary processes (Phase 1). The focus for 2024/25 was on implementing these processes to embed AIS compliance across the trust.

What success will look like by the end of March 2025:

As shown in the figure below, the project ran from November 2023 – December 2024 with the following aims:

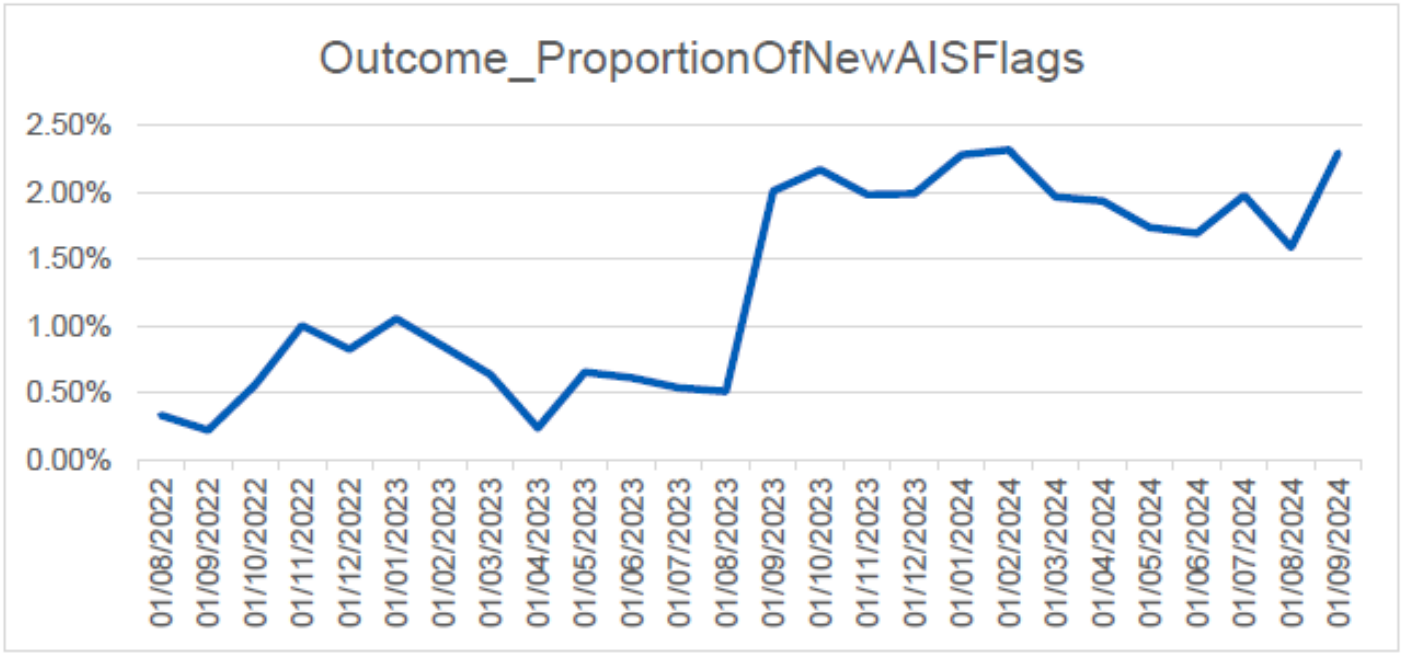
- Create a clear and timebound roadmap for technology changes required to deliver automatic AIS flag recording across all systems
- Create a clear and timebound roadmap for technology changes required to deliver automatic changes to letters and or other methods of communication

- Ensure all (interim or existing) manual processes which enable staff to deliver information to patients in a way that they wish are clearly articulated, including trust-wide access to SOPs, advice & guidance
- AIS training is built into induction training; either as part of existing packages (e.g. leading and guiding) or new packages as required
- Create a patient and staff awareness campaign, which supports widespread knowledge of the AIS requirement and options for action
- Create space on the external facing website and patient screens to advise patients of their options & how they can advise the trust of their preferences
- Update the internal intranet with relevant guidelines for staff to access as required
- Increase awareness of AIS to staff
- Processes for asking patients will be understood, defined and communicated to staff
- The processes for all agreed AIS flags have been developed into an SOP and a training video, both available on eyeQ
- Increase the number of patients with a recorded AIS need on PAS.

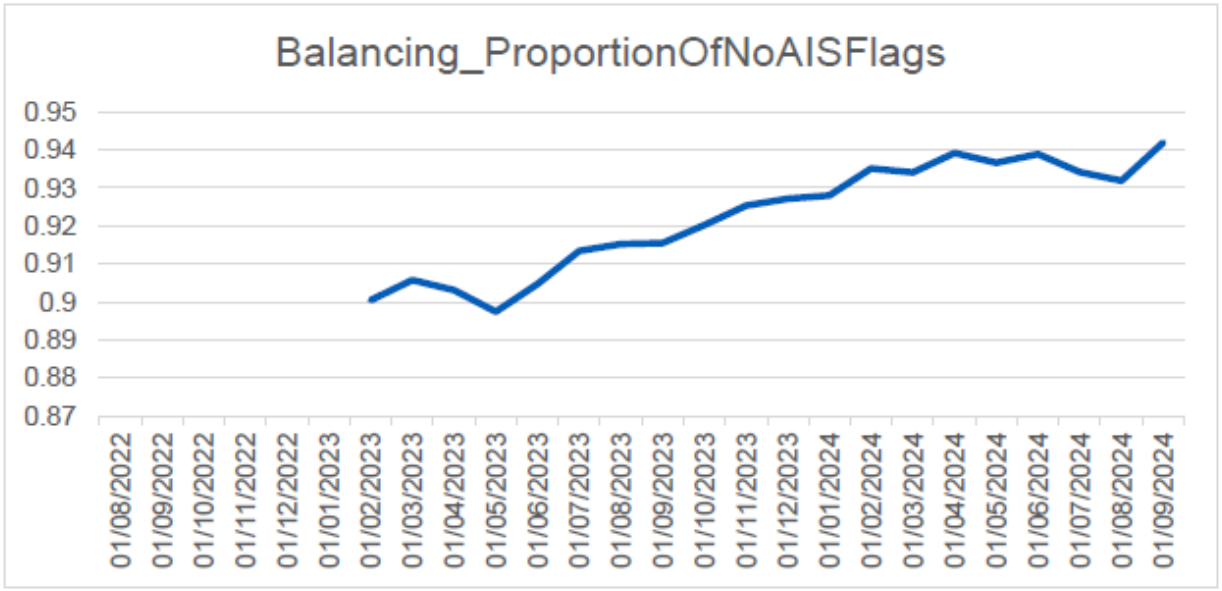
What will we measure?

The graph shows an improvement in the AIS flags that have been recorded on patients' records as a percentage of those seen each month.

Proportion of patients with a NEW AIS need recorded out of all patients seen in the month.



Out of all patients seen in the month and with an AIS need recorded, the percentage of AIS needs recorded as 'No AIS need'



What did we achieve to date?

- Roadmap created for all changes required. Changes to OpenEyes (OE) commissioned and were delivered as part of v9.1. Extensive work completed to rationalise the NHSE list from 72 to 26 AIS flags and standardised across PAS and OE
- Changes to OE commissioned for large font letters in size 24. Automatic changes not possible in PAS for large font. Digital clinic outcome letters have formed part of a separate project (see quality priority for 2023/24 and 2024/25)
- All current processes understood and articulated on the AIS eyeQ page. SOP written and signed off through the Policy and Procedure Review Group (PPRG)
- A video on what AIS is, why it is important and how to action AIS needs created and added to new training on supporting patients with accessible needs. Changes made to PAS registering a patient and PAS basic training. New training on how to add an AIS risk on PAS also created
- Staff awareness campaign over August and September with fortnightly eyeQ articles. Increased staff awareness through clinic pilot. Safer September campaign with Lunch and Learn session, floor walkers at 9 sites, stall at City Rd. Patient campaign with posters in clinics and information on patient screens.

- AIS page on the website created and updated. Inclusion of an AIS statement on patient letters with information on how to inform clinics about their communication needs
- 24 AIS pilot projects have been completed with more than 40 staff involved. 34 staff in the booking/contact centre have been trained. Safer September all staff email from deputy chief nurse was opened by 884 staff, poll on eyeQ was engaged with by 45 staff members. 4 articles were also posted on eyeQ
- Lunch and learn: Communicating with our patients - Accessible information standards: 45 hits on eyeQ
- Delivering accessible care to our patients: 67 hits
- Read our latest safety briefing: Accessible patient communications: 26 hits
- 120 people engaged with at City Rd AIS stalls.

What are the gaps in delivery?

This phase of the project has now closed. However, it is recognised that there are further opportunities to strengthen the accessibility of our outcome and clinic letters. Therefore, this element will be incorporated into the patient letter quality priority for 2025/26.

Quality Domain: Effective

To help patients make informed decisions about their surgery

Lead: Ian Newman, Kylie Smith, Ian Tombleson

Rationale and background

The initial rationale for this priority was to undertake a review of how the trust was meeting NICE guidance in support of the Surgical Excellence Programme, aimed at improving the way healthcare professionals work together with patients to reach decisions about care and consent before surgery. However, when scoping the project and following a review of the NICE guidance related to informed decision-making, alongside the outcome of audits, it was identified that there were significant opportunities to improve our consent processes across four key areas:

- Quality and Governance
- Education and Training
- Equipment and Technology
- Accessibility

The project therefore aimed to address these areas by providing staff with updated training and processes, supported by digital systems, and by revising the Consent Policy and Standard Operating Procedures (SOPs) to include:

- Clearly defined roles and responsibilities across clinical and administrative functions
- Embedding the principles of shared decision-making between patients and healthcare professionals
- Appropriate utilisation of Consent 4 forms, including emergency consent and consent at alternative points in time

What success will look like by the end of March 2025:

- Consent will be a fully digital process for patients who are able to do so. Care and consideration will be made for those with accessible needs, who will still be able to provide consent using alternative methods. The process will be primarily managed through the existing OpenEyes consent functionality and enhanced by the integration of the Concentric digital consent application. Paper-based consent will be significantly reduced, with patients' consent digitally recorded and accessible on the day of surgery.
- The new process will be more efficient, patient-friendly, and streamlined, supported by clear roles and responsibilities outlined in revised policies and SOPs. Staff will be trained to use the digital systems effectively, with appropriate IT infrastructure in place to support the transition. Failsafe reporting will highlight areas where we do not have signed patient consent on record. We will aim to survey patients to understand their involvement in their shared care decision making The consent process will align with the wider Electronic Patient

Record (EPR) programme, ensuring consistency across the trust's digital systems and maximising the use of the best available digital tools for consent.

What will we measure?

- We have established that the vast majority (93%) of digital consent forms are digitally signed by the clinician as technology supports easy clinical signing
- Data suggests a smaller proportion of forms are digitally signed by the patient at time of clinic attendance. Technology and education may be considered limiting factors in this
- OpenEyes data shows this to be ~50% and possibly 33% when we look at sample audit data
- We will continue to monitor the proportion of consent forms that are digitally signed in advance of surgery, rather than on paper
- We will examine the scope to survey our patients to understand their involvement in shared care decision making
- We will use data to identify service areas for improvement and to inform the development of SOP and training and education packages.

What have we achieved?

- Beginning to work with the clinical informatics team to improve digital signature capture methods in clinic via clinical leadership and organic clinical cultural word of mouth
- Leveraging work done around NatSSIPS and the safer surgery checklist to digitise the safer surgery checklist to align digital working practice in theatre to support digital consent process
- Preparation in place to launch Concentric, a digital consent platform, which will improve digital signature capture on record and improve the digital sharing of patient information to improve the informed consent position. The aim is to launch this across the trust in May 2025.
- Building failsafe reporting with a data scientist to understand where individual services, sites, and clinicians stand with respect to digital signature on record in advance of treatment.

What are the gaps in delivery?

It is recognised that there are further opportunities to progress the work already undertaken in relation to this priority. As such, this project will continue as a quality priority for 2025/26.

Key areas of work for the project and quality priority are:

- Moving to a position where the digital patient consent is on record for the majority of patients in advance of their treatment
- Understanding the patient experience around patient involvement in their shared care decision making and working with staff training, education and training in conjunction with patient groups to see how we can improve the patient experience and better involve the patient in their care decision.

Quality Domain: Effective

To utilise staff shared decision-making councils to drive staff engagement and empowerment

Priority Lead: Mary Masih

Rationale and background

In 2020, Pathway to Excellence was introduced to the trust by the then chief nurse and this was then supported by the current chief nurse. Pathway to Excellence Designation was achieved for Moorfields in May 2023.

One of the standards of Pathway to Excellence is shared decision-making and the trust recognises the critical role that shared decision- making councils (SDMCs) play in empowering staff to make local improvements which will in turn positively impact staff health and wellbeing and patient care.

In response to staff survey results over recent years that indicate that employees often felt that their voices were not sufficiently heard or impactful in decision making, Moorfields responded by initiating the introduction of SDMCs across the organisation to help facilitate a platform for multiprofessional teams. The councils are designed to empower our multiprofessional workforce, allowing them to contribute directly and source solutions to making local improvements to their everyday working environment. If successful, then learning can be shared trust wide to benefit other areas.

What success will look like by the end of March 2025:

Empowerment: SDMCs will empower our staff to take ownership of their roles and contribute to meaningful changes, leading to higher job satisfaction and a more engaged workforce.

Innovation: By encouraging creativity and collaboration, SDMCs will drive innovation in patient care and operational practices.

Communication: SDMCs will enhance communication and relationships across all levels of the organisation, ensuring that decisions are informed by diverse perspectives.

Wellbeing: A collaborative work environment promoted by SDMCs will contribute to the overall health and wellbeing of our staff, reducing stress and increasing job satisfaction.

By embedding SDMCs across the trust, we will improve the work environment for our staff but also ensure that our patients receive the highest standard of care. This initiative is crucial in creating a culture where shared decision making becomes business as usual, benefiting both our staff and the patients they serve. Following an initial screening incorporating equality health impact assessments, the Pathway to Excellence

Team has determined that this project does not require a separate equality impact assessment, as it has already been evaluated within the framework of the Pathway to Excellence initiative.

What have we measured?

Number of councils: One of our KPIs is to establish 10 SDMCs by the end of Q2 2025. We have already exceeded this target, with 22 councils active across all divisions and network sites, representing a wide range of multiprofessional teams. We started with 3 in 2023, then rose to 11 in early 2024, then added 11 more between February 2024 and April 2025.

Staff satisfaction and morale: Our recently concluded (February 2025) SDMC audit and direct feedback show that there were improvements in job satisfaction and employee engagement due to the presence of shared decision-making councils.

councils.

Image description: The image is a pie chart that visually represents the outcomes of a certain measure or intervention, categorized by levels of change. It includes five segments, each with a distinct colour and label:

Blue: Significantly Improved – 15 responses

Orange: Somewhat Improved – 7 responses

Green: No Change – 5 responses

Red: Somewhat Worsened – 0 responses

Purple: Significantly Worsened – 0 responses

The chart highlights that the majority of responses indicated improvement, with no reports of worsening outcomes.

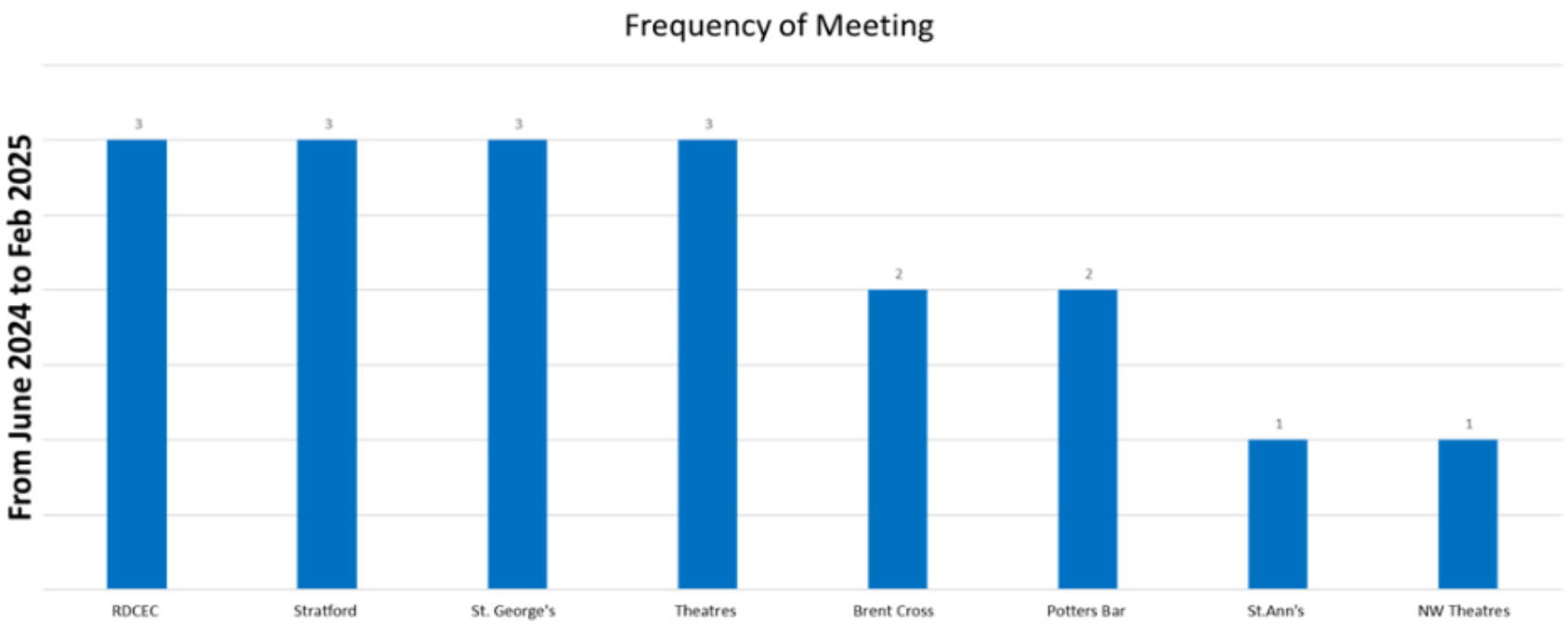
Significantly Improved	15
Somewhat Improved	7
No Change	5
Somewhat Worsened	0
Significantly Worsened	0

Participation and engagement levels: The number of active participants within councils, frequency of attendance at meetings, and involvement in projects. Several articles about the projects and activities of SDMCs are published on eyeQ which has increased awareness. Making teams contact the SDMCs lead with a request to start up their own council.

The bar chart below displays the number of meetings held at various locations between June 2024 and February 2025. The x-axis lists the locations, and the y-axis represents the number of meetings.

- **RDCEC**, **Stratford**, **St. George's**, and **Theatres** each hosted **3 meetings**, making them the most frequently used venues.
- **Brent Cross** and **Potters Bar** each hosted **2 meetings**.
- **St. Ann's** and **NW Theatres** each hosted **1 meeting**, the fewest among all locations.

The chart highlights that meetings were concentrated in a few key locations, with others used less often.



Communication effectiveness: Staff perceptions about improvements in interdepartmental communication and teamwork due to SDMC activities.

What did we achieve to date?

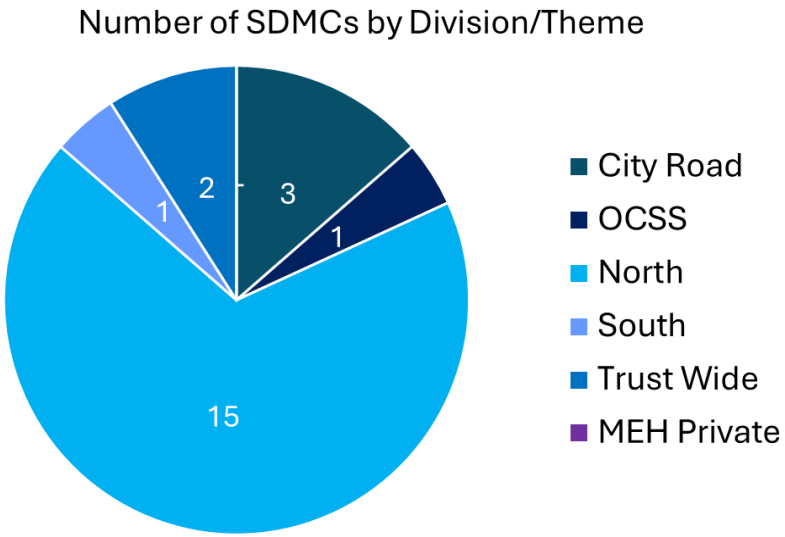
Established councils: Successfully implemented 22 shared decision-making councils across different departments among multiprofessional teams within the trust. Although SDMCs started for frontline nurses, initially, most of the current councils have a good blend of multiprofessional team members.

The pie chart illustrates the distribution of SDMCs (Service Delivery Management Committees) across six divisions or themes. Each segment is color-coded and labelled with the corresponding number of SDMCs:

- **North** – 15 SDMCs (light blue)
- **City Road** – 3 SDMCs (dark teal)

- **Trust Wide** – 2 SDMCs (medium blue)
- **OCSS** – 1 SDMC (dark blue)
- **South** – 1 SDMC (light purple)
- **MEH Private** – No data provided (purple)

The chart highlights that the North division has the highest number of SDMCs, while several other divisions have only one or two. One segment, MEH Private, is included but does not have a value listed.



Positive staff feedback: Initial audits and staff surveys at the 2024 nursing conference indicate significant improvements in staff satisfaction, collaboration, and morale. Some examples of feedback from members of SDMCs are below:

"Great team spirit with high positivity", "Better listening and consideration for others' ideas", "Better patient triage and work up in clinic"

Focus group: A Pathway to Excellence SDMC focus group has been established, comprising direct care nurses (Bands 3 to 6). This group plays a vital role in gathering front line perspectives on the activities and impact of SDMCs across trust sites.

SDMC steering group: A dedicated SDMC steering group has been established to provide targeted support to councils. This group includes representatives from estates, communications, health and wellbeing, and the Friends of Moorfields. The group plays a crucial role in signposting, advising, and offering tailored support to teams based on the needs and scope of each project.

Visible impact: Projects undertaken through SDMCs have resulted in tangible improvements in workflow efficiency, patient care outcomes, and innovation within clinical practices. Examples of such projects are the paperless project at the Richard Desmond Children's Eye Centre (RDCEC), instrumental music in the clinical area at City Road VRE, and the canopy walkway in Bedford.

Increased engagement: Anecdotal evidence suggests higher levels of staff engagement and empowerment, with a marked improvement in staff perception of their voice being heard and valued. More multiprofessional teams are getting interested and contacting the shared decision-making lead to set up a council in their area, including most recently in Orthoptics.

We have actively promoted the SDMC initiative through a wide range of internal and external engagement activities. These include:

- Producing and distributing SDMCs contact cards, which were first launched at the 2024 nursing conference
- Hosting information stands at clinical governance half days to raise awareness
- Attending team huddles, departmental meetings, and quality forums across the organisation
- Conducting one-to-one discussions with staff to encourage participation
- Presenting at NAME UK and the National SDMC Steering Group.
- Publishing several SDMC-related articles and updates on eyeQ.

What are the gaps in delivery?

Time constraints: Many staff members have cited insufficient protected time as a significant barrier to full participation in SDMCs activities. We are continually having discussions with the senior management team to give protected time for council members to carry out their activities. Also, we have modelled setting up a recurrent meeting and putting it on Teams as a reminder in VRE.

Funding and resources: Limited availability of funds and resources for council projects, e.g. provision of refreshments, teaching materials, or necessary equipment. Not all projects require external funding and teams are encouraged to first explore and utilise available local resources before seeking support from external sources.

Communication and awareness: There remains room to further increase awareness and understanding of the purpose, scope, and successes of SDMCs across all sites at the trust.

Consistency and guidance: Variation in the level of understanding, competency, and motivation among individuals leading SDMCs. A need exists for consistent education, training, and leadership development for council leads.

2.3 Core clinical outcomes

Progress in 2024/25

The trust's performance against the core outcome standards demonstrates excellent clinical care, with every standard apart from one being met (considering 95% confidence intervals) and many being far exceeded. Investigations are taking place about why the compliance with retinopathy of prematurity screening overall percentage is lower than target at one of the screening sites. Any variation to the overall figure as a result of this review will be communicated and added to the account at a later date.

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

Table 3 - Trust core clinical outcomes 2024/2025

Specialty	Metric	Standard	2022/23	2023/24	**2024/25**
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	0.90%	0.88%	**0.85%**
Cataract	Endophthalmitis after cataract surgery*	<0.040%	0.010%	0.008%	**0.012%**
Cataract	Biometry accuracy in cataract surgery*	>85%	92%	92%	**93%**
Cataract	Good vision after cataract surgery*	>90%	94%	94%	**94%**
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	94%	92%	**93%**
Glaucoma	Tube (glaucoma drainage surgery) success	>80%	95%	94%	**91%**
Glaucoma	PCR in glaucoma patients*	<1.95%	1.3%	1.4%	**1.1%**
MR	Endophthalmitis after intravitreal anti-VEGF injections*	<0.030%	0.012%	0.009%	**0.007%**
MR	Visual improvement after injections for macular degeneration*	>20%	20.6%	24.1%	**20.8%**
MR	Visual stability after injections for macular degeneration*	>80%	91%	93%	**91%**
MR	PCR in Medical retina patients *	<4%	1.4%	2.2%	**2.3%**
MR	Time from screening to assessment of proliferative diabetic retinopathy*	80%	87%	90%	**92%**
VR	Success of primary retinal detachment surgery*	>85%	81%	92%	**88%**
VR	Success of macular hole surgery*	>80%	98%	92%	**95%**
VR	PCR in vitrectomised eyes*	No published standard	2.6%	N/A	**2.2%**

Specialty	Metric	Standard	2022/23	2023/24	**2024/25**
NSP	Significant complications of strabismus surgery*	<0.43%	0.53%	0.35%	**0.26%**
NSP	Premature baby eye (ROP) screening compliance*	99%	99.5%	99.4%	**93%**
A&E	Patients seen within 4 hours*	>95%	99.4%	98.6%	**98%**
Ext Dis	PK for keratoconus (2-year survival from NHSBT report)*	See table below	96%	100%	**98%**
Ext Dis	DALK for keratoconus (2-year survival from NHSBT report)*	See table below	91%	90%	**98%**
Ext Dis	DMEK for FED[6] (2-year survival from NHSBT report)*	See table below	81%	88%	**90%**
Ext Dis	DMEK for pseudophakic bullous keratopathy (2-year survival from NHSBT report)*	See table below	59%	62%	**70%**
Refractive	Accuracy LASIK (laser for refractive error) in short sight*	>85%	91.2%	90.8%	**94%**
Refractive	Loss of vision after LASIK*	<1%	0.12%	0.72%	**0%**
Refractive	Good vision without lenses after LASIK*	≥80%	94.1%	92.2%	**93.4%**
Adnexal	Ptosis surgery success	>85%	96%	96%	**96%**
Adnexal	Entropion surgery success	>95%	97%	95%	**99%**
Adnexal	Ectropion surgery success	>80%	96%	96%	**98%**

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

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

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

	Jan 2019 – Dec 20 grafts	**Jan 2020 – Dec 21 grafts**	**Jan 2021 – Dec 22 grafts**
PK for KC	- Nationally**: 90.4%** (95% CI: 83.6% - 94.5%). - At MEH**: 96.2%** (95% CI: 75.7% - 99.4%). - No statistically significant difference	- Nationally**: 96.6%** (95% CI: 92.4% - 98.5%) - At MEH**: 100.0%** (95% CI: -) - No statistically significant difference	- Nationally: **94.3%** (95% CI: 89.6% – 96.9%) - At MEH**: 98.4%** (95% CI: 89.1% – 99.8%) - No statistically significant difference
DALK for KC	- Nationally**: 92.5%** (95% CI: 85.8% - 96.1%). - At MEH: **90.8%** (95% CI: 77.1% - 96.5%). - No statistically significant difference	- Nationally: **92.6%** (95% CI: 86.6% - 96.0%) - At MEH: **89.6%** (95% CI: 75.2% - 95.8%) - No statistically significant difference	- Nationally: **96.5%** (95% CI: 92.6% – 98.3%) - At MEH: **98.4%** (95% CI: 89.4% – 99.8%) - No statistically significant difference
DMEK for FED	- Nationally: **83.1%** (95% CI: 78.7% - 86.6%). - At MEH: **81.3%** (95% CI: 70.8% - 88.3%).	- Nationally: **86.4%** (95% CI: 83.2% - 89.1%) - At MEH: **87.5%** (95% CI: 81.3% - 91.7%)	- Nationally: **88.4%** (95% CI: 86.0% – 90.4%) - At MEH**: 89.9%** (95% CI: 85.4% – 93.1%)

	Jan 2019 – Dec 20 grafts	Jan 2020 – Dec 21 grafts	Jan 2021 – Dec 22 grafts
	- No statistically significant difference	- No statistically significant difference	- No statistically significant difference
DMEK for PBK	- Nationally: **68.1%** (95% CI: 56.8% - 76.9%). - At MEH: **58.9%** (95% CI: 38.4% - 74.5%). - No statistically significant difference	- Nationally: **69.9%** (95% CI: 59.8% - 77.9%) - At MEH**: 62.1%** (95% CI: 40.6% - 77.8%) - No statistically significant difference	- Nationally**: 73.0%** (95% CI: 65.6% – 79.1%) - At MEH**: 69.8%** (95% CI: 55.5% - 80.3%) - No statistically significant difference

2.4 Performance against key local indicators for 2024/25

This financial year has seen a continued improvement in the performance of many of our quantitative and qualitative key performance indicators and again this year the trust has achieved the majority of the targets which were set. This is against a backdrop of responding to the NHS ambition to treat more patients, reduce waiting lists and improve the quality of service we provide

Table 5 - 2024/25 Key Indicators

INDICATOR	2021/22 Results	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 results**
National Indicators					
Cancer 28 Day Faster Diagnosis Standard	93.3%	100%	92.3%	**≥ 75%**	80.5%
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat	n/a	n/a	100%	**≥96%**	98.2%
% Patients With All Cancers Treated Within 62 Days	n/a	n/a	98.4%	**≥85%**	98.5%
Reduction of over 18-week pathways (pathways as at end of year)	8,842	7,211	5,962	**n/a**	5,594
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks (performance as at end of year)	78.1%	77.9%	83.3%	**≥ 92%**	83.1%
52 Week RTT Incomplete Breaches	395	97	144	**0**	118[1]
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.9%	99.4%	98.6%	**≥ 95%**	98.0%
Maximum 6 week wait for diagnostic procedures	99.0%	99.4%	99.4%	**≥ 99%**	99.1%
Mixed Sex Accommodation Breaches	0	0	0	**0**	0
Risk assessment of hospital-related venous thromboembolism (VTE)	98.6%	98.2%	98.6%	**≥ 95%**	99.5%

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

Posterior capsule rupture rate for cataract surgery	1.03%	0.8%	0.82%	**≤1.95%**	0.90%
MRSA (rate per 100,000 bed days)	0	0	0	**0**	0
Clostridium difficile year on year reduction	0	0	0	**0**	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	0	0	0	**0**	0
INDICATOR	**2021/22 Results**	**2022/23 Results**	**2023/24 Results**	**2024/25 Target**	**2024/25 results**
MSSA Rate - cases	0	0	0	**0**	0
Inpatient Scores from Friends and Family Test - % positive	95.0%	95.6%	95.9%	**≥90%**	96.4%
A&E Scores from Friends and Family Test - % positive	92.7%	92.5%	92.9%	**≥90%**	93.5%
Outpatient Scores from Friends and Family Test - % positive	93.3%	93.4%	93.6%	**≥90%**	94.8%
Paediatric Scores from Friends and Family Test - % positive	93.7%	94.3%	95.0%	**≥90%**	94.9%
Freedom of Information Requests Responded to Within 20 Days	95.3%	96.2%	65.6%	**≥90%**	86.8% (Apr-Feb)
Subject Access Requests (SARs) Responded to Within 28 Days	96.0%	95.2%	94.4%	**≥90%**	N/A[2]
Occurrence of any Never events	2	3	2	**0**	2
Summary Hospital Mortality Indicator	0	0	0	**0**	0
Theatre cancellation rate (non-medical cancellations)	0.7%	1.01%	1.05%	**≤0.8%**	0.88%
Number of non-medical cancelled operations not treated within 28 days	18	17	23	**0**	10
Local Indicators					
Total pathways RTT Waiting List (pathways as at end of year)	n/a	n/a	35,656	**≤ 35,656**	33,136
Average Call Waiting Time	237secs	216 sec	131 Sec	**≤120 Sec**	162 sec
Call abandonment rate	14.5%	17.1%	9.8%	**≤ 15%**	12.1%
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	1.13%	1.79%	2.17%	**≤ 2.67%**	2.38%
Endophthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	1	0	0	**0**	0

[2] The SAR process is under review and reporting of figures will be reintroduced as soon as possible.

Percentage of responses to written complaints sent within 25 days	73.5%	70.4%	88.6%	**≥80%**	**62.1%**
Percentage of responses to written complaints acknowledged within 3 days	99.0%	90.6%	97.3%	**≥80%**	**76.6%**
National Patient Safety Alerts (NatPSAs) breached	1	0	2	**0**	**0**
INDICATOR	**2021/22 Results**	**2022/23 Results**	**2023/24 Results**	**2024/25 Target**	**2024/25 results**
Number of Incidents (excluding Health Records incidents) remaining open after 28 days (position at year end)	-	166	259	**n/a**	251
Median Outpatient Journey Times - Non-Diagnostic Face to Face Appointments (Wait at Year End)	n/a	n/a	97 Mins	**n/a**	97 mins
Median Outpatient Journey Times - Diagnostic Face to Face Appointments (Wait at Year End)	n/a	n/a	45 Mins	**n/a**	43 mins
Overall financial performance vs. Plan (£m) - Year End Position	4.58	5.61	8.42	**≥0**	-1.27
Commercial Trading Unit Position vs Plan (£m) - Year End Position	1.17	-1.11	-0.50	**≥0**	-1.7
Appraisal Compliance (At time of reporting)	74.9%	70.6%	75.6%	**≥80%**	67.7%
Information Governance Training Compliance (At time of reporting)	93.6%	88.9%	90.1%	**≥90%**	89.5%
Staff Sickness (Rolling Annual Figure)	-	4.7%	4.5%	**≤ 4%**	4.7% (Mar-Feb)
Proportion of Temporary Staff	12.2%	14.5%	15.5%	**No Target**	12.3%
Total patient recruitment to NIHR portfolio adopted studies	8,550	5,816	211 avg per Month 2,532 total year)	**≥ 115 Per Month**	383 avg per month (4,208 Apr-Feb)
Total patient recruitment to All Research Studies (Moorfields site only)	n/a	n/a	n/a	**No set target**	524 avg per month (5,765 Apr-Feb)
Active Commercial Studies (Open + Closed to Recruitment in follow up) (Year End Position)	n/a	n/a	60	**≥44**	58
Proportion of patients participating in research studies (as a percentage of number of open pathways) (position as at end of year)	5.6%	5.9%	5.1%	**≥2%**	3.6%
% implementation of NICE guidance	100%	96.6%	94.5%	**95%**	94.8%

Number of registered and ongoing clinical audits past their target deadline date	20.7%	17.6% (34/193	33.5% (78/233)	**≤ 20%**	13.2% (41/311)

Unless stated, 2024/25 figures are for April 2024 to March 2025, with the position taken as of 7 April 2025

2.5 Performance against 2024/25 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.

Table 6 - National performance measures

Description of target	2024/25 Performance	2023/4		Comparison with applicable trusts (latest)		
		Target	Performance	Average	Best	Worst
Infection control						
MRSA (rate per 100,000 bed days)	**0**	0	**0**	n/a	n/a	n/a
Clostridium difficile year on year reduction	**0**	0	**0**	n/a	n/a	n/a
Risk assessment of hospital-related venous thromboembolism (VTE) [i]	98.6%	≥95%	**99.6%**	89.3%	100%	2.4%
Waiting Times						
Cancer 28 Day Faster Diagnosis Standard [ii]	92.3%	≥ 75%	**81.7%**	76.2%	94.6%	59.2%

Description of target	2024/25 Performance	2023/4		Comparison with applicable trusts (latest)		
		Target	Performance	Average	Best	Worst
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat [ii]	100%	≥ 96%	**98.4%**	91.0%	99.8%	73.6%
% Patients With All Cancers Treated Within 62 Days [ii]	98.4%	≥ 85%	**98.7%**	68.1%	99.2%	31.8%
Four-hour maximum wait in A&E from arrival admission, transfer, or discharge [iii]	98.6%	≥ 95%	**98.0%**	73.9%	100%	51.9%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks [iv]	82.1%	≥ 92%	**82.5%**	65.1%	94.6%	39.1%
Maximum 6 week wait for diagnostic procedures[2]	99.4%	≥ 99%	**99.1%**	78.2%	100%	11.8%

[i] – Comparison data from NHS Statistical Work Areas – April 2024 to Dec 2024
[ii] – Comparison data from NHS Statistical Work Areas – April 2024 to Feb 2025
[iii] – Comparison data from NHS Statistical Work Areas – April 2024 to Mar 2025
[iv] – Comparison data from NHS Statistical Work Areas – Feb 2025, Ophthalmology Service only

Referral to treatment (RTT 18 weeks) performance

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

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

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

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

Measure	Target	Year Start*	Q1	Q2	Q3	Q4	Year 2024/25	Year End*
18-weeks RTT incomplete	≥ 92%	**83.3%**	84.9%	83.1%	82.0%	82.2%	**83.1%**	**83.1%**
18-weeks RTT incomplete with decision to admit (DTA)	n/a	**76.0%**	77.5%	78.4%	80.0%	79.8%	**78.9%**	**79.3%**
18-weeks RTT admitted	n/a		73.3%	75.0%	77.9%	77.9%	**76.0%**	
18-weeks RTT non-admitted	n/a		81.7%	82.0%	82.8%	80.8%	**81.8%**	
New RTT periods (clock starts) all patients	n/a		35,069	33,830	34,007	34,566	**137,472**	

*Year Start is RTT Position on 1 April 2024, Year End is RTT Position on 1 April 2025

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

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

Performance indicator data quality

A vital prerequisite for robust governance and effective service delivery is the availability of high-quality data across all areas of the organisation. The trust requires quality data to support several business objectives, including safe and effective delivery of care, and the ability to accurately demonstrate the achievement of Key Performance Indicators (KPIs). Our data quality policy sets out the specific roles and responsibilities of staff and management to ensure that data is effectively managed from the point of collection, through its lifecycle, until disposal.

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

Data quality continued to be given a high profile in 2024/25, with the continued inclusion of a large range of directly related KPIs published within performance reports and SUS (secondary user Service) dashboards, which are refreshed each month and reported across the trust. These KPIs include:

- Data Quality - Ethnicity recording (outpatient and inpatient)
- Data Quality - NHS number recording (outpatient and inpatient)
- Data Quality - GP recording (outpatient and inpatient)
- Data Quality - Ethnicity recording (A&E)
- Data Quality - NHS number recording (A&E)
- Data Quality - GP recording (A&E).

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

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

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

There is also ongoing work with research and digital projects to drive high quality data, which will continue to be supported through audit and other assurance processes.

The data quality team continued to lead in data improvement for areas such as Next of Kin (NOK); this work has seen our NOK data continue to improve from a previous NOK completeness of 0% - 5% to between 18% - 95%. The data quality working group has the task of monitoring this and other ongoing items on the Data Quality Agenda, this group has representation from across the trust. This group will continue to be at the forefront of Data Quality improvement and assurance as we move into our EPR system.

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.

Table 8 - 28-day emergency re-admission rate

	2020/21	2021/22	2022/23	2023/24	2024/25
28 days Readmission rate (Adult: 16+)- excluding retinal detachment	1.74%	1.15%	1.59%	2.23%	2.48%
28 days Readmission rate (Adult: 16+)- retinal detachment only	5.33%	4.21%	5.12%	4.60%	3.40%
28 days Readmission rate (Child: 0-15)	0.00%	0.00%	4.55%	0.00%	0.00%

* 2024/25 Position taken as of 8 April 2025

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

The successful outputs and outcomes of the patient experience framework project have been described elsewhere in the quality account. 2025/6 will see the rollout of additional tools for staff to use to increase patient engagement and the channels through which patient feedback is gained and actioned. Examples include enhanced use of the FFT and the use of patient stories. The PPEC (patient participation and engagement committee) continues to provide oversight and understand the effectiveness of implementing these tools and changes to improve the patient experience.

Accessible Information Standard

All trusts are required to meet the Accessible Information Standard (AIS). A project group has continued to meet in 2024/25 to drive improvement in this area. This project is a category 1 project monitored by the Working Together Excellence Board, supported by the XDU. Workstreams have been focusing on operational implementation. Staff have been trained about AIS requirements, how to add flags to the system and how to support patients. Delivery mechanisms, such as Braille or enlarged font size letters have been piloted. Work in 2025/26 will focus through a quality priority on specific areas of improvement such as patient letter style and format.

Family and Friends Test (FFT) for patients

During 2024/25, 260,041 (35.5%) of our patients who attended accident and emergency (A&E), or an outpatient or inpatient appointment responded to a FFT text, with approximately 95% of those respondents indicating they had a positive experience.

Table 9 - Family and Friends Test (FFT) trust results for 2024/25

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	21,230	3,571	540	351	602	222	26,516	70,789	93.5%	3.6%	37.5%
Inpatient	13,120	1,394	150	86	113	193	15,056	38,807	96.4%	1.3%	38.8%
Outpatient	177,845	29,181	4,031	2,048	2,084	3,280	218,469	623,644	94.8%	1.9%	35.0%

FFT themed analysis of comments

Face to face consultations

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

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

Complaints and PALS concerns

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

Complaints

The trust received a total of 124 complaints in 2024/25, compared to 149 received the previous year. The drop in the number of complaints received can be attributed to changes made following the introduction of new national guidance on NHS complaints handling, with more cases being resolved using early resolution methods rather than following the formal complaints processes.

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

In line with local strategy following the introduction of new national standards in NHS complaint handling in 2024/25, the trust has had a decrease in formal complaints with the shift to earlier, local resolution. Whilst the number of formal complaints has decreased the number of Patient Advice and Liaison Service (PALS) enquiries increased this year compared to previous years. The main themes of complaints remain clinical concerns, staff attitude, and communication. PALS enquiries generally focused on appointment management and communication. The patient participation and engagement committee (PPEC) continues to meet to discuss patient feedback and what changes and learning is made as a result.

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

PALS Concerns

PALS received 5,593 enquiries in 2024/25 (4,374 in the previous year). Of these, 201 were compliments, 1,739 were requesting information and 3,653 were concerns. Of the concerns, the largest number related to appointments management, followed by communication issues (including telephone responses), transport concerns and questions about clinical care or treatment.

Compliments

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

Response time: The organization did not meet its target in 2024/25 for complaints responses. Performance began well in the first half of the year but deteriorated during the second half for a number of reasons, including staff turnover. An improvement plan is in place, and we are beginning to see improved performance. We will continue to improve our patient focus and responsiveness when responding to complaints and PALS enquiries. The quality of our complaints responses remains high.

Table 10 - Complaints performance: Key performance indicators

KPI (Key Performance Indicators)	Target	2022/23	2023/24	2024/25
Response ≤ 25 days	≥ 80%	70.4%	88.6%	62.1%
Acknowledgment ≤ 3 days	≥ 80%	90.6%	97.3%	76.6%

Venous Thromboembolism (VTE)

Patients admitted to hospital who were risk assessed for venous thromboembolisms (VTE)

Moorfields considers this data is as described for the following reasons:

- All patients admitted for day surgery, or as overnight inpatients have their nursing assessments using our Integrated Care Pathway document. 'VTE Risk Assessment and Treatment Plan' forms part of the risk assessments for all patients admitted.
- Most ophthalmic treatment, or ophthalmic surgery poses low risk for hospital acquired VTE. So far, there have not been any recorded incidents of hospital acquired VTE via our incident reporting systems.
- For those paediatric patients who are between the age of 16 and 18 and are being operated on and admitted onto the paediatric day care ward, rather than admitted via adult wards, we are continually conducting VTE assessment using the VTE

Risk Assessment and Treatment Plan to risk assess. This was implemented five years ago, and we are continuing this practice in our children's hospital.

Table 11 - Venous Thromboembolism (VTE)

Indicator	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 Results**
Risk assessment of hospital-related venous thromboembolism (VTE)	98.2%	98.6%	**≥ 95%**	99.5%

Patient safety incidents (PSIs)

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

We recognise the impact that involvement in an incident can have on both our staff and patients and have been prioritising our work to develop the engagement and support arrangements that are available to those affected. In addition to this, we have been working with our organisational development team to consider the opportunities that exist to further develop our safety culture, so that staff feel comfortable to report and discuss incidents and near misses without feeling that they will be individually blamed or criticised for their occurrence. It is important to us that staff believe that they will be treated fairly, and we recognise that this will contribute to the improved reporting of incidents.

We have continued to use statistical process control (SPC) charts as the preferred display method for incident data, with data being displayed at both trust level and divisional level. Charts which show the numbers of reported incidents, open incidents, and incidents older than 28 days are produced and reviewed monthly as a minimum. Presentation of the information in this format provides the opportunity to identify increases or decreases which concern variation, and areas in which improvement is evident.

Our trust-wide incident reporting data, for both PSIs and non-PSIs, has shown improving variation for the last two years (eight quarters). When the PSI and non-PSI data is charted separately, improving variation is seen for both. This is one of our measures of the successful implementation of the PSIRF.

A focus of trust activity throughout the year, specifically in relation to PSIs, has been the work undertaken in respect of the PSIRF. Our key achievements in respect of this have already been described under section 2.1, 'progress with 2024/25 priorities'. In the first six months of 2025/26 we will review our PSIRF policy, plan, and local priorities, to ensure that they remain reflective of the operational and oversight processes that we have established. Also, we continue to focus on those areas for which there are the greatest opportunities for learning and improvement, and which support the design and implementation of the EPR and our move to Oriel, our new centre for advancing eye health. Our review will involve a repeat of the coordinated review of quality data (including incidents, complaints, PALS concerns, litigation), staff and patient surveys, and concerns highlighted through the Freedom to Speak Up (FTSU) process, that we undertook prior

to PSIRF implementation. For some of our local priorities, we will be harnessing our learning from the reviews that we have undertaken throughout the year and shifting our focus to the reporting of measurable and sustainable improvement.

In 2024/25, we initiated four PSIIs, two of which were classified as never events. Examples of never events that may be relevant to trust activity are surgery on the wrong eye or eye muscle, and implantation of an incorrect intraocular lens (IOL). During the year we have initiated or continued to progress improvements that have arisen from safety summits. One relates to the processes associated with the selection and implantation of incorrect IOLs, which was initiated because of previous never events. Another concerns the delivery and recording of intravitreal injections, which has now been developed as a PSIRF improvement plan. At the end of 2024/25, all four PSIIs remained on-going with closure imminent for two.

In addition to PSIIs, we have specifically promoted the use of after-action reviews (AARs), thematic reviews, clinical audits, and multi-disciplinary team (MDT) meetings as learning responses. We will continue to develop our 'toolbox' of potential responses, exploring proportionate alternatives based on need.

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

- The trust uses an electronic reporting system, which undergoes continual improvement to satisfy the needs of reporters and internal subject matter experts (SMEs). The incident reporting system includes a complex range of notification rules to ensure that the correct managers are notified when an incident is reported, which are reviewed and maintained by the central risk & safety team.
- Functionality exists within the system to monitor PSIRF activity and continues to be developed by both the vendor and the central risk & safety team.
- The system is compliant with LFPSE requirements and will support both local and national safety improvements.
- From March 2024, one month prior to the official launch of the organisation PSIRF policy and plan, the trust piloted the updated governance arrangements for PSIRF oversight. For the entire year, the weekly incident review group (IRG) part one meeting has been the forum at which PSIs that may satisfy the criteria to meet either a national or local priority requirement have been considered. Our local priorities are not dependent on the level of harm that has been sustained, but instead the opportunity to learn, and improve our services. A part two meeting also exists as a forum at which PSIs of concern, including concerns arising from the actual harm impact for an individual or group of patients, also exists. An increased focus on shared learning and improvement has been sustained throughout 2024/25.
- Once every six weeks, the IRG part one meeting is repurposed to be an action and improvement review (AIR) meeting. This is the meeting at which completed learning responses are reviewed and improvement plans are monitored for suitability and sustainability. The AIR meeting also considers IRG activity and is responsible for reporting escalations concerning incidents or emerging risks to the clinical governance committee.

- Incident reporting training and education has been provided by the risk and safety team throughout the year. This bespoke training has been delivered to individuals and or teams and is tailored to meet the specific needs or concerns communicated by the user(s).

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

- Continuing the use, availability, and development of SPC charts, particularly those that will inform the impact of improvement projects associated with the local priorities identified in our PSIRF plan.
- Populating our preferred improvement response implementation monitoring tool with the agreed PSII improvement recommendations and safety actions and developing the associated improvement measures.
- Continuing to adopt a quality improvement approach to the implementation and embedding of our PSIRF plan, to maximise our opportunities for learning and improvement.
- Completing any tasks associated with LFPSE validation, as required by the national team.
- Auditing the occurrence and content of any PSI records that have not been uploaded to LFPSE, to understand why the automated upload has not been effective and modifying our incident reporting system to minimise future occurrence.
- Seeking feedback from users in respect of any changes made to the electronic incident reporting system (Safeguard), to confirm that the change has been a success, and monitoring the impact via existing SPC charts.
- Continuing to review the way in which data entered into Safeguard by the central quality and safety team, relating to PSIRF implementation, provides the trust board with the system oversight that is required.

Table 12 - Summary of Never Events (NE)

Never Event title	Brief details
Injection of Botulinum Toxin (Botox) to the incorrect muscle (1 incident reported)	One patient received a Botox injection to the incorrect muscle in the correct eye. This satisfied the criteria for wrong site surgery. The error was identified shortly after the patient had left the department.
Retained foreign object (1 incident reported)	It was identified that one patient had a retained foreign object following surgery that was undertaken over three years ago. The error was identified when the patient attended an outpatient appointment and disclosed that the retained device had discharged from under his eyelid.

Two further PSIIs were initiated during 2024/25, as described in table 13:

Table 13 - Summary of other Patient Safety Incident Investigations (PSIIs)

PSII title	Brief details
Misdiagnosis of retinoblastoma	A paediatric patient was incorrectly diagnosed following review of ultrasound imaging. Six months later it was identified that a retinoblastoma had been visible in a previous image, but that this had been overlooked.
Delayed review of a Magnetic Resonance Imaging (MRI) report	A patient underwent an MRI scan, and the MRI report identified an incidental finding of a meningioma. There was an approximately seven-month delay in review of the MRI report and a further two-month delay in referral to another provider for specialist review.

All completed PSIIs will have an associated safety improvement plan, which details the safety actions that will be completed.

During 2024/25, the trust completed and approved two legacy serious incident (SI) investigation reports that had been declared during 2023/24, one of which was a never event. We were given permission by North Central London Integrated Care Board (NCL ICB) to apply a systems approach to the investigation and apply PSIRF learning and improvement principles. The nature of the incidents has enabled integration of the improvement recommendations into existing XDU workstreams.

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

Total number of reported PSIs

The table below shows the total number of reported PSIs during the period April 2022 to March 2025. Data from previous years has been refreshed.

Table 14 - Total number of reported Patient Safety Incidents (PSIs)

Reporting period		
2022/23	**2023/24**	**2024/25**
3992	4269	4338

Rate of PSIs reported

The table below presents a summary incident reporting rate for the trust, during the period April 2022 to March 2025. Because Moorfields primarily provides ambulatory care, the organisation calculates a reporting rate based on incidents per 1,000 events. The reporting rates shown have been extracted from the Moorfields quality and safety dashboard. Data from previous years has been refreshed.

Table 15 - Rate of Patient Safety Incidents (PSIs) reported

Reporting period		
2022/23	2023/24	2024/25
5.24	5.24	5.28

Number of PSIs resulting in severe harm or death

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

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

Death (now recorded as fatal as documented on the learn from patient safety events LFPSE service) is if, at the time of reporting, the patient has died and the incident may have contributed to the death.

The table below presents a summary of the total number of PSIs which resulted in severe harm or death that were reported from April 2022 to March 2025. The trust has a dynamic incident reporting process, and records are continually reviewed and updated. Data from previous years has been refreshed.

Table 16 - Number of Patient Safety Incidents (PSIs) resulting in severe harm or death

Reporting period		
2022/23	2023/24	2024/25
11 (1 death)	7	7

Percentage of PSIs resulting in severe harm or death

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

Table 17 - Percentage of Patient Safety Incidents (PSIs) resulting in severe harm or death

Reporting period		
2022/23	2023/24	2024/25
0.28%	0.16%	0.16%

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

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

In quarter two 2024/25, the trust undertook a re-audit of DoC compliance and compared the results with the previous audit completed during 2022/23. The audit results were shared with the clinical governance committee and the quality and safety committee. Whilst quantitatively compliance with the requirement to send DoC letters to patients looked good, the review of the letter content indicated that the quality and tone of letters was inconsistent. For example, some letters lacked empathy suggesting that some staff may perceive it as a tick box exercise. It is recognised that the infrequency with which staff are required to apply DoC at the trust means that support may be required when the need to do so arises. It was also identified that some DoC letters continue to be addressed to the GP and copied to the patient.

Adherence with the individual elements of the process continues to be captured within the electronic incident reporting system, and the risk and safety team and divisional quality partners monitor compliance on an on-going basis. Compliance data has continued to be routinely provided to clinical governance committee and quality & safety committee, specifically including the identification of the incidents for which compliance has not yet been achieved. Where non-compliance is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. In order to improve oversight and compliance with DoC requirements, it has been agreed that clinical divisions will be required to report any DoC non-compliance at executive performance meetings.

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

A re-audit will be undertaken during 2025/26.

Learning from deaths

The death of patients in our care is an extremely rare event. The scope of our learning from deaths policy is deliberately broad to make the best provision for potential learning opportunities. It includes not only mandatory inclusion requirements (for example, an inpatient death, the death of an individual with a learning disability or mental health needs, the death of an infant or child) but also deaths within 48 hours of surgery, deaths of patients who are transferred from a Moorfields site and who die following admission to another hospital, and deaths about which the trust becomes aware of following notification by HM Coroner.

During 2024/25, we finalised our arrangements to fulfil the National Patient Safety Strategy requirement to have a Medical Examiner (ME) service, the purpose of which is to ensure the provision of independent scrutiny of deaths and to give bereaved people a voice. From 1 April 2024, the ME service for the trust has been provided by University College London Hospitals NHS Foundation Trust (UCLH). The UCLH service will cover all Moorfields sites, with referral to the local ME service, where one exists, being co-ordinated and overseen by the UCLH ME service.

The trust has continued to scrutinise patient deaths that have occurred outside of a Moorfields care setting, where there has been interaction with a patient in the days or weeks prior to the death. The reviews which have taken place have been informed by trust staff and the identified improvements required have been highlighted. Any learning identified has been included in the quarterly learning from deaths report to the trust board but has not been detailed below.

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

During the period 1 April 2024 to 31 March 2025, zero of Moorfields Eye Hospital NHS Foundation Trust patients died (of which zero were neonatal death, zero were still births, zero were people with learning disabilities and zero had a severe mental illness). This comprised the following number of deaths, which occurred in each quarter of that reporting period:

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

By 31 March 2025, zero case record reviews and zero investigations have been conducted in relation to the zero deaths included above. The number of deaths in each quarter for which a case record review or an investigation was conducted was:

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

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

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

2.6 Statements of assurance from the Board

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

Review of trust services

During 2024/25, 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 2025/26, 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 2024/25 represents the total income generated from the provision of NHS services.

Freedom to Speak up (FTSU) service

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

If individuals are not happy to raise concerns via these guardians, or their concern is about the guardians themselves, or is at trust board level, these can be raised with Adrian Morris the appointed non-executive director of the trust board responsible for FTSU. Moorfields has a FTSU policy which sets out the scope of the FTSU arrangements. FTSU is provides additional

support for staff should concerns not be resolved locally. Examples of potential FTSU concerns in the policy include, but are by no means restricted to:

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

FTSU guardians ensure that staff concerns are resolved. They also ensure that staff are supported during the period that their concern is addressed, and staff can provide feedback directly to guardians about their experience of how their concern has been resolved.

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

Provision of seven-day services

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

- Clinical standard 2 – trust policy is that consultant review should be arranged within 6 hours of admission during working hours (08:00 to 20:00) and within 14 hours of admission if out of hours.
- Clinical standard 5 – relates to access to diagnostic services. CT and ultrasound are available Monday-Friday with no weekend services. There are some occasional Saturday clinics for ophthalmic imaging, but they are available on an ad hoc basis as the services are required. MRI is only available on weekends via formal arrangement off-site. Whilst not run or administered by MEH, Microbiology support is available through UCLH microbiologists on a 24/7 basis. Similarly, our testing labs are offering a 7-day service so samples can always be sent for testing.
- Clinical standard 6 – the only element that applies is access to emergency surgery which is available on weekdays and weekends.
- Clinical standard 8 – as a single specialty ophthalmology hospital we do not admit patients with high dependency needs so CS8 does not apply.

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

Guardian of safe working

As 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 2024/25, 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

To support NHS England's *Improving the Working Lives of Doctors in Training* programme, we are taking a proactive and structured approach to enhance the experience of our resident doctors — work which is already in progress. This starts at onboarding, where we aim to clearly break down the added value components that contribute to a supportive and high-quality training environment. We are committed to signposting doctors early to key facilities such as rest areas, wellbeing resources, and support services to ensure they feel welcomed and supported from day one. As part of this ongoing effort, we are reviewing rota design to ensure fairness, compliance, and a healthy work-life balance, while strengthening access to mentorship, feedback mechanisms, and professional development opportunities. The recent appointment of a Head of Medical HR in September 2024 marks a significant step forward, providing dedicated leadership to drive these improvements. Our goal is to deliver meaningful, visible changes in time for the August 2025 rotation, ensuring that our doctors in training feel valued, supported, and empowered throughout their time with us.

In 2024/25, a programme of work was commenced to review the contracts of Locally Employed Doctors (also known as Clinical Fellows) employed at the trust and the potential for harmonising the terms and conditions of this cohort of doctor more closely with those of the 2016 TCS for NHS Doctors and Dentists in Training. This work continues to progress with a root and branch review of the Trust's Fellowship programme planned to continue into 2025/26 to inform a final proposal to be taken forward for agreement.

Participation in clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that Moorfields was eligible to participate in during 2024-25 are as follows:

National Audits

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

National Confidential Enquiries

- No studies were undertaken that were relevant for Moorfields to participate in 2024-25.

The national clinical audits and national confidential enquiries that Moorfields participated in, and for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 18 - Participation in clinical audits and national confidential enquiries

National Audit	Numbers of cases submitted & relevant/eligible
National Audit of Corneal Graft Outcomes	1,325 / 1,590 (83.3%) *(data from 01/04/2024-31/03/2025)*
National Ophthalmology Database (NOD) Cataract Audit	*25,933 / (unknown denominator) *(data from 01/04/2023-31/03/2024)*
National Ophthalmology Database (NOD) AMD Audit	**2,421/ 2,824 (85.7%) *(data for patients starting neovascular AMD treatment from 01/04/2022-31/03/2023)*

*NOD received data for 25,933 cataract operations with a record of phacoemulsification but cannot yet be compared with a denominator recorded in NHS Digital due to NHS Digital changes in the order of creating results. The NOD team noted that MEH report very high or 100% case ascertainment and would expect the same for this year.

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 2023-24.

**The NOD AMD audit received data from Moorfields (including Croydon and Bedford) for 2,824 naïve eyes starting treatment for neovascular AMD between April 2022 - March 2023. 2,421 eyes were eligible for analysis and 403 were excluded due to the patients' age being <=55yrs at start of treatment (373) or not treatment naïve (30).

NOD numbers are likely to change following a validation period.

Table 19 - National Confidential Enquiries

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

There were no National Confidential Enquiries (NCE) in 2024-25 whereby the trust was required to take part or actively contribute data. Any relevant NCE studies are discussed at the trust's bi-monthly Clinical Audit and Effectiveness Committee (CAEC).

Although Moorfields did not qualify for submission for any of the studies in 2024-25, details of current NCE studies were shared at CAEC, and a recent NCEPOD report on juvenile idiopathic

arthritis has some relevance/consequence for Moorfields. These patients often experience transitional care from childhood to adulthood.

Of the 1,590 ocular transplant forms received from the NHS Blood and Transplant team for 2024/25, the trust completed and returned 1,325 (83.3%.) 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 2024, the trust has also submitted several forms received during the previous year. In total during 2024/25, the trust submitted details of 1,617 patients to the NHS Blood and Transplant team.

Whilst no reports have been received from the NHS Blood and Transplant service during 2024/25, Moorfields continues to maintain local management and record of data (including submissions to the NHSBT), and this quality account includes the numbers of ocular transplant forms received from NHSBT, and how many have been completed and returned following patient review.

The NOD produced a second annual report in March 2024 on Age-related Macular Degeneration (AMD) covering the period April 2021- March 2022. Findings were shared and discussed at CAEC in July 2024. The seventh and most recent annual report for Cataract Surgery was published in May 2024 and assessed data from April 2022 – March 2023. Findings were shared and discussed at CAEC in November 2024.

Table 20 - National Audit Reports

National Audit Report	Discussed	Actions
The seventh annual NOD report For cataract surgery (1 April 2022 to 31 March 2023) was published in May 2024.	Cataract Service	Findings were shared with the Medical Director and Cataract Service. Results were shared and discussed on 27 November 2024 at CAEC.
The second report of Age-related Macular Degeneration (AMD) audit was published in March 2024 and includes details of patients starting treatment for neovascular AMD between 1 April 2021 to 31 March 2022.	Medical Retina Service	Findings were shared with the Medical Director and Medical Retina Service Details including a summary of Moorfields' results discussed at CAEC in July 2024.
NHSBT: No reports have been published in 2024-25.	Corneal Service	Progress with NHS Blood and Transplant audit data is discussed at CAEC throughout the year. The trust maintains internal processes to monitor data submission to the NHS Blood and Transplant team as no external reports have been forthcoming.

During the period 2024/25, the trust proposed and approved 58 audits assessing national clinical standards/guidelines[3] (many of which have been completed or were re-audits).

The 58 clinical audits derived from national standards and guidelines that Moorfields participated in from 1 April 2024 to 31 March 2025 can be summarised as:

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

  (4 proposals have since been archived)

There were 31 nationally derived audit ‘reports’ completed and submitted during this time, summarised as:

- 2 National Audits (part of the National Clinical Audit and Patient Outcomes Programme)
- 6 National Audits (not part of the National Clinical Audit and Patient Outcomes Programme)
- 1 National Service Framework
- 3 NHS England
- 5 National Institute for health and Care Excellence (NICE)
- 1 Patient Reported Outcome Measure (PROM)
- 8 Patient Safety First
- 1 Royal College of Optometrists

[3] 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.

- 1 Royal College of Anaesthetists
- 1 Royal College of Ophthalmologists (RCO)
- 2 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT).

Participation in clinical research

Research studies

Moorfields Eye Hospital conducted thirty-eight sponsored research studies and 104 hosted studies, of which over 60% were commercial, in 2024/25. There are currently 77 open, funded research studies, of which 23 are commercial, with approximately 78 at the concept or grant application stage. The National Institute of Health Research (NIHR) Clinical Research Facility (CRF) recruited 2,730 participants in 2024/2025. Total recruitment to studies was 5,777, which is an increase of almost 2000 over 2023/2024.

Our current studies are now mainly interventional ones requiring more intensive assessment, investigations and long term follow up. Less participants are required to give meaningful conclusions in such studies. Since 2023/24, the split between commercial and non-commercial studies in our portfolio has risen to 60% commercial, up from 50% commercial.

The NIHR funds research into the most important research questions in ophthalmology and we have invested in grant writing as well as academic statistical support to ensure MEH continues to attract a pipeline of such high-profile studies.

Collaborations

The National Eye Institute (NEI) funded by the United States Federal Government is the largest funder of ophthalmic research in the world. Moorfields were successful in obtaining funding for several studies, funded by sub awards from the National Eye Institute in the USA (NEI). One of these studies, recruited its first patient in March, with a Moorfields patient recruitment target of 40, and a multicentre worldwide target of 438.

The NIHR and the Department of Health and Social Care (DHSC) expects Clinical Research Facilities to make the UK as attractive a place as possible for research funded by pharmaceutical companies. Moorfields has set up partnership boards with several industry partners to facilitate research, education, as well as service development. We are research funded by a range of industry sponsors. The trust has also established a collaboration with a company who have strong relationships and contacts with biotech companies across the USA that could support ophthalmic work in the UK. This collaboration is intended to result in further research from these companies.

Improving our delivery

We developed the Research Management Workflow (RMW) platform in-house to streamline our set up and research delivery processes to ensure that we can meet the demanding timelines rightly expected by our national & international partners. The platform supports research application reviews, covering project costing and setup, grant submissions and contract review and sign off. To date, the platform has processed 303 research projects across all aspects from planning to delivery.

Moorfields Discovery were recently awarded £310,884 from Moorfields Eye Charity (MEC) to support the development of a Grant Application Support Service for Ophthalmology research (GASSO). GASSO will include experts that together can provide all-round support and training to early career researchers in ophthalmology, supporting them to begin or grow their research careers and enabling an increase the number of investigator-led studies and development awards. The funding from MEC is to fully support a trial methodologist and part fund a Director of Clinical Trials and Statistics for two years.

The new questionnaire-based study (SIBA) looks to evaluate patient experience and attendance rates in digital eye clinics in London funded by Health Systems Partner, Roche, Ltd. The study has a target of 1,568 and was opened in December 2024. The study has already recruited almost a third of its target with 572 recruits to date.

Our recently opened commercial ocular oncology study has recruited its first patient. The target was one patient; however, we have agreed with the sponsor to continue recruiting. The treatment of Choroidal Melanoma has not changed fundamentally for many years and the development of drug treatments for this condition is long overdue. Moorfields, as the largest centre for Choroidal Melanoma treatment in the UK is well placed to offer these treatments to patients should the drugs be shown to deliver better outcomes than current treatment.

Interventional Uveitis studies in rare diseases are notoriously difficult to recruit to and frequently have an intensive treatment and assessment regime. We are pleased to report that the SANDCAT study, a global multi-centre study investigating the use of a new monoclonal antibody in the treatment of intra-ocular inflammation, has exceeded its recruitment target.

We have been improving the Research Opportunities at Moorfields (ROAM) platform, developing the next version of the application based on stakeholder feedback. ROAM increases the visibility of research activities to patients; records consent to contact and allows us to understand representativeness of those who interact with the platform to inform patient engagement and involvement activities. In 24/25, 221 patients were registered onto the ROAM platform, taking the total number of registrants to 3,690.

Funding applications

We were successful in an investigator-initiated trial funded by Alcon. This will allow the exploration of Direct Selective Laser Trabeculoplasty (DSLT) as a treatment option to reduce intraocular pressure (IOP) in eyes with ocular hypertension. This treatment option is intended to be less damaging and more comfortable than the currently used SLT. The trial will recruit 50 patients and will investigate over 12 months IOP reduction compared to baseline (when patients were recruited onto the trial).

We were awarded 3 NIHR project grants over the last financial year. One is an EME grant which is being led by Moorfields and will recruit 250 patients with proliferative diabetic retinopathy over 25 sites from across the UK onto a study that will compare efficacy and safety of rapid surgical intervention for patients with retinal bleeds to the current standard of care where surgical intervention is offered as a last resort.

For the other two projects, Moorfields are collaborators on the award. In one project, Moorfields is collaborating with Ufonia Limited, a company developing next-generation technology to automate routine clinical conversations. Moorfields is the sole patient recruitment site on the project and intends to recruit 800 patients to the study over 10 months.

Three Moorfields employees were directly awarded funding to pursue research careers. Two of these were in the advanced category (NIHR Senior Clinical Practitioner Research Award) and from ophthalmology research areas typically under-represented, and one was in the early career category (Pre-doctoral Clinical and Practitioner Academic Fellowship). Moorfields BRC were also successful in being awarded funding to support researchers (early and advanced) in under-represented areas of ophthalmology (nursing, visual electrophysiology and paediatric ophthalmology) in preparing competitive NIHR career funding applications. Funds have been allocated to seven individuals who are being provided with time from clinical commitments to undertake research activities, training and mentorship.

Equality and diversity

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

Quality review

During 2024/2025, the quality management system continued to be improved with the introduction of three new Standard Operating Procedures (SOPs) and 21 new templates. Standard two-year reviews of 25 SOPs were conducted and in addition to these standard reviews, 13 SOPs were updated to align with new regulatory guidance or to refer to the new templates. In January 2025, the standard review cycle was changed from every two years to every three years.

As per the internal audit schedule agreed by the Quality Review Group, four internal audits were carried out. Two process audits, the IMP accountability audit and informed consent audit reviewed two and four studies respectively against the internal SOPs, study protocols and regulatory requirements. The audit of the Reading Centre in January 2025 focused on two studies and a study specific audit was carried out in February 2025.

The proposed corrective and preventative action (CAPA) plans addressing the internal audit findings were approved as satisfactory. Effectiveness checks are now carried out to provide assurance the implemented preventative actions have been successful. Two effectiveness checks of previous preventative actions were conducted during the period and resulted in additional changes to the processes and or templates used by the operational teams to help prevent further recurrences of the issues seen during the audit. Training on the updated processes and templates was provided.

The CRF received notification, via the sponsor of a commercial trial, of a potential FDA site inspection expected to take place in August or September 2024. Following the notification, inspection training for the team was carried out in May and July, however, Moorfields were not one of the non-US sites selected for an FDA inspection in the end. A sponsor’s audit of a different commercially sponsored clinical trial was hosted by the CRF in October with the associated CAPA plan agreed with the sponsor in December 2024.

One serious breach was reported to the trust via the internal incident reporting system and to the Research Ethics Committee (REC) which approved the study. The CAPA plan for this incident has been completed now and confirmation the REC consider the breach closed is expected.

The safety reporting compliance reports received from the pharmacovigilance (PV) team confirm all reports were submitted to the regulatory authorities and REC with the required timeframes. An internal pharmacovigilance audit is scheduled for 2025 to provide assurance on compliance with other PV requirements.

The research induction programme developed in collaboration with three other UCL affiliated CRFs is progressing well. Moorfields CRF hosted the May 2024 and February 2025 sessions and a new topic, Study Coordination, was trialled during the February 2025 session.

The Moorfields Cells for Sight facility is being decommissioned. The Cells for Sight team, R&D and Moorfields Eye Bank are currently working with the Human Tissue Authority (HTA) to ensure the records are archived appropriately and in accordance with the HTA's requirements.

Commissioning for quality and innovation (CQUIN) framework

Funding arrangements for the 2024/25 CQUINs are part of the national tariff and not separately financed.

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

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

Registration with the Care Quality Commission (CQC)

The trust must be registered with the CQC and is currently registered without conditions. The CQC has not taken any enforcement action against the trust in 2024/25, nor at any time previously.

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

Information governance

Information Governance (IG) includes records management, data security, confidentiality, data sharing, freedom of information, and transparency. We have supported the work on the procurement of a comprehensive electronic patient record; meanwhile, we support those managing processes that rely on multiple electronic systems and paper records to process data along complex patient journeys where the trust is one of many providers. Engagement with patients and the public continues to be delivered as a core IG activity to meet the trust's duty to

be transparent. We worked with patient representatives on the Public and Patient Experience Committee (PPEC) to review principles around managing data and looked at ways to present the Trust's patient privacy notice.

Further work to support prospective researchers and innovators has been undertaken internally and there is good visibility through new reporting. This work included engaging external partners on ideas to improve processes.

The volume of work generated by the increasing rate of digitisation, and ongoing support, thereafter, has been appreciated by colleagues as we contribute to the various strategic improvement programmes. The trust is supporting its IG team members with their own personal and professional development by ensuring there is protected time for professional development and training.

The CQC is clear that safety of patient data is a patient safety matter. The data security and protection elements of information governance are driven by standards set down in the NHS Operating Framework as measured by compliance with the Data Security and Protection Toolkit (DSPT). Last year, the trust met all these standards due to improvements IG made to systems, processes, and infrastructure that put the trust in a stronger position. Work is ongoing to build on these improvements as the trust completes the tougher internationally aligned cyber assessment framework.

The IG team has continued to put IG quality at the heart of its work through a supportive programme of outreach visits and shadowing of our consultants and senior clinicians; a solid foundation for joint working which leads to better support for staff at the clinical interface.

Data quality & audit

Moorfields submitted records during 2024/25 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data (April 24 to January 25). The percentages of records in the published data, which included the patient's valid NHS number, were:

- 99.7% for admitted patient case
- 99.7% for outpatient care
- 97.7% for accident and emergency care.

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

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

In 2024/25, the trust has not been subject to the Data Quality and Performance Management audit.

There have been no other external audits conducted which have included recommendations regarding data quality related issues, during 2024/25.

We have continued to hold the amalgamated Information Management and Data Quality Working Group (IMDQG) to ensure a better constructive interaction between the two related issues. This group continues to meet every two months and discusses core data quality areas, including audit results. A Data Quality working group has now been in place for 24 months and continues to meet bi-monthly and feed back into this group and other trust forums. Evidence of data quality will continue to be provided for the trust DSPT submissions.

Clinical coding

Moorfields was subject to the annual clinical coding audit as part of the Data Security and Protection Toolkit (DSPT) during March 2025. 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:

Table 21 - Clinical Coding

	Diagnosis		Procedure	
Audit year	Primary	Secondary	Primary	Secondary
DSPT Audit 24/25	99.5%	98.4%	100%	99.5%
DSPT Audit 23/24	100.00%	99.49%	100.00%	99.72%
DSPT Audit 22/23	98.02%	99.4%	98.97%	99.85%

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

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

Below are the key recommendations made from these audits:

- Continue collaboration with clinical divisions, administrative leads and relevant software teams to work towards streamlining, and improving the accuracy and relevancy of, comorbidity documentation
- Continue ongoing efforts to improve the documentation of primary diagnoses on discharge summaries, particularly where cataracts are concerned, in close collaboration with relevant clinical divisions. Immediate effect and ongoing
- Explore the introduction of a validation process to verify the accuracy of 'active' and 'historic' diagnoses listed within scanned documentation on CITO.

2.7 Priorities for improvement in 2025/2026

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

Our organisational strategy was launched in 2023/2024, and over the next five years we will deliver our vision through our excellence portfolio.

The 2025/2026 quality priorities reflect feedback from a comprehensive staff and patient involvement process including discussions at Central Quality Forum, Clinical Governance Committee (CGC) and the Vision Loss Awareness Group (VLAG), as well as patient feedback during Safer September. The development process also involved staff engagement and patient representative sessions, business planning, and discussions at various committee meetings. The priorities have been aligned with the trust's strategic objectives and will be implemented using quality improvement principles, ensuring clear, measurable, and SMART objectives for success measurement.

The priorities were presented and discussed at the Clinical Governance Committee, the Quality and Safety Committee, and at the Management Executive. Our host commissioners, NHS Islington CCG, and Healthwatch Islington, have also considered the quality priorities for 2025/2026 and are supportive of them.

Moorfields sets out its priorities under the three well-established Darzi headings of patient safety, patient experience, and clinical effectiveness. The priorities set out below will be monitored through the relevant programme boards or committees for oversight.

The Quality and Safety Committee, on behalf of the Board, takes responsibility for overseeing the development and delivery of the Quality Account and quality priorities. 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.

Table 22 – 2025/26 quality priorities: drivers

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

Table 23 - 2025/26 quality priorities: descriptions

Heading	Status for 2025-26	Priority	Priority description	Rationale / Problem statement
Effective	Rescope from 2023/2024 priority	Patient Initiated Follow Up (PIFU) (Quality priority in 2023/2024)	To roll out Patient Initiated Follow-Ups (PIFU) pathways across viable services, enabling patients to initiate follow-up appointments within agreed timescales, and to continue the work undertaken in 2023/2024.	•Some patients currently lack the ability to book follow-up appointments when they need them e.g. when experiencing changes in their condition. As a result, many are routinely scheduled for follow-up appointments they may not actually need, which can waste clinical capacity and delay access for others. •Not all services that could benefit from a Patient-Initiated Follow-Up (PIFU) approach are currently adapted to support it. This misalignment with the NHS transformation strategy and national planning guidance may limit the potential improvements in efficiency and patient-centred care that PIFU can offer.
Safe	NEW	Failsafe	To ensure a consistent and safe approach to A&V service delivery across the organisation by monitoring failsafe processes and evaluation under the oversight of the A&V Oversight and Development Group, supporting decision-making, promoting best practices, and addressing pathway sustainability	There is a need to evaluate and standardise the processes and effectiveness of current practices and address capacity challenges within Asynchronous and Virtual (A&V) pathways. This will help ensure that pathways can meet demand, focus on safety and are improved, without compromising the quality of service

Heading	Status for 2025-26	Priority	Priority description	Rationale / Problem statement
Safe	Phase II of 2024/2025 priority	Safety and Experience learning system (previously Learning System)	To further develop a learning system that aligns with PSIRF principles and improvement standards, which strengthens the processes for learning from incidents, complaints, and PALS feedback, promotes clear and consistent mechanism for sharing learning from events, and foster strong partnerships across divisions.	There is a need to embed learning from PSIRF responses to foster a learning culture and implement quality improvement and learning quality management system principles across the organisation.
Experience	Phase II of 2024/2025 priority	Patient experience principles	To provide a structured approach to achieve the trust-wide goals in relation to monitoring and improving patient experience.	•There is a need to further embed improvement principles across the organisation, ensuring that local changes are monitored for impact and that the work is sustained over time. • There is a need to support the facilitation of customer care requirements as outlined in national and NHS reform guidance, ensuring that these standards are met and maintained.
Experience	Continuation of 2024/2025 priority	Patient Transport (2024/2025 quality priority)	To improve the experience and patient safety of eligible patients requiring transport to and from our sites.	•Transport is a consistent concern raised through complaints and incidents. •Removes variation across sites regarding transport services and data availability. •Addresses gaps in data related to third-party suppliers and KPIs. •Without data, implementing and monitoring effective changes to the transport service will be challenging.

Heading	Status for 2025-26	Priority	Priority description	Rationale / Problem statement
Effective	NEW	Referral management optimisation (including eRS improvement)	To continue to build on the standardisation of triage and eRS processes, as well as improving the management of referrals to our services	•There is some inconsistency regarding triage across the organisation that needs to be better understood in order to improve processes, where possible. •To enhance triage efficiency there will need to be some streamlining of workflows, benefiting both patients and healthcare teams.
Experience	NEW	Quality of patient letters comms and AIS (includes AIS Phase 2)	To improve the communication with our patients by improving our appointment letters (accuracy, frequency, numbers) Ensure all patient letters are AIS compliant. Building on phase 1, consider what aspects of the AIS process should be improved in parallel	•The implementation of Accessible Information Standard (AIS) principles is required to ensure effective communication and accessibility for all patients. •There is a need to address patient complaints and feedback regarding clinic locations and communication. •The review of letters is required to support Moorconnect processes and for clinic management in Oriel.
Effective	Rescope of 'To help patients make informed decisions about their surgery' 2024/2025 priority	Consent optimisation	Continue to improve consent processes across quality & governance, education & training, equipment, technology and accessibility. This will continue to take forward the shared decisions about surgery quality priority from 2024/2055	•Consent processes are not currently being used to support patient flow and reduce delays and inefficiencies. •There is a need to ensure that shared decision-making and clear information is shared with patients
Effective	NEW	Scan for safety and IMS optimisation	To build on the work completed to enhance patient safety, and meet national traceability requirements and reduce the risk of incorrect implants	There is a need to address safety recommendations following a serious incident investigation and never event related to lens selection and processes The organisation needs to comply with National Traceability Requirements to ensure adherence to national traceability standards.

2.8 Key indicators for 2025/2026

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

The trust is currently undertaking a review of our integrated performance report (IPR) which is produced each month and is taken to the trust Board. A provisional list of KPIs (Key Performance Indicators) we are focusing on in 2025/2026 can be seen in the following tables, many of which have been carried forward from previous years, however we expect this to change over the next financial year for several reasons, including the changing reporting requirements at both national (DHSC and NHS England) and local level (ICB), and as the trust's strategic programmes through the Excellence Portfolio continue to evolve.

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

In 2023/2024, the trust reviewed the presentation of data used in the IPR and following consultation with the board updated the document to report Key Performance Indicator results using NHS England recommended 'Making Data Count' Statistical Process Control (SPC) charts methodology. We are continuing to apply and expand upon this methodology going forward into 2025/26.

Table 24 - Provisional 2025/26 key indicators

INDICATOR	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 Results**	**2025/26 TARGET**
National Indicators					
Cancer 28 Day Faster Diagnosis Standard	100%	92.3%	≥ 75%	80.5%	≥ 80%
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision to Treat	n/a	100%	≥96%	98.2%	≥ 96%
% Patients With All Cancers Treated Within 62 Days	n/a	98.4%	≥85%	98.5%	≥ 85%
Reduction of over 18-week pathways (pathways as at end of year)	7,211	5,962	n/a	5,594	Reduction in line with 18-week trajectory
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks (performance as at end of year)	77.9%	83.3%	≥ 92%	83.1%	Monthly Trajectory, 87.6% by March 2026
52 Week RTT Incomplete Breaches	97	144	0	118	0

Four-hour maximum wait in A&E from arrival admission, transfer, or discharge	99.4%	98.6%	≥ 95%	98.0%	≥ 95%
INDICATOR	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 Results**	**2025/26 TARGET**
Maximum 6 week wait for diagnostic procedures	99.4%	99.4%	≥ 99%	99.1%	≥ 99%
Mixed Sex Accommodation Breaches	0	0	0	0	0
Risk assessment of hospital-related venous thromboembolism (VTE)	98.2%	98.6%	≥ 95%	99.5%	≥ 95%
Posterior capsule rupture rate for cataract surgery	0.8%	0.82%	≤1.95%	0.90%	≤ 1.95%
MRSA (rate per 100,000 bed days)	0	0	0	0	0
Clostridium difficile year on year reduction	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	0	0	0	0	0
MSSA Rate - cases	0	0	0	0	0
Inpatient Scores from Friends and Family Test - % positive	95.6%	95.9%	≥90%	96.4%	≥ 90%
A&E Scores from Friends and Family Test - % positive	92.5%	92.9%	≥90%	93.5%	≥ 90%
Outpatient Scores from Friends and Family Test - % positive	93.4%	93.6%	≥90%	94.8%	≥ 90%
Paediatric Scores from Friends and Family Test - % positive	94.3%	95.0%	≥90%	94.9%	≥ 90%
Freedom of Information Requests Responded to Within 20 Days	96.2%	65.6%	≥90%	86.8% (Apr-Feb)	≥ 90%
Subject Access Requests (SARs) Responded to Within 28 Days	95.2%	94.4%	≥90%	N/A[4]	≥ 90%
Occurrence of any Never events	3	2	0	2	0
Summary Hospital Mortality Indicator	0	0	0	0	0
Theatre cancellation rate (non-medical cancellations)	1.01%	1.05%	≤0.8%	0.88%	≤ 0.8%
Number of non-medical cancelled operations not treated within 28 days	17	23	0	10	0

[4] The SAR process is under review and reporting of figures will be reintroduced as soon as possible.

INDICATOR	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 Results**	**2025/26 TARGET**
Local Indicators					
Total pathways RTT Waiting List (pathways as at end of year)	n/a	35,656	≤ 35,656	33,136	Reduction in line with 18-week trajectory
Average Call Waiting Time	216 sec	131 Sec	≤120 Sec	162 sec	≤120 Sec
Call abandonment rate	17.1%	9.8%	≤ 15%	12.1%	≤ 15%
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	1.79%	2.17%	≤ 2.67%	2.38%	≤ 2.67%
Endophthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis measures not achieving target)	0	0	0	0	0
Percentage of responses to written complaints sent within 25 days	70.4%	88.6%	≥80%	62.1%	≥80%
Percentage of responses to written complaints acknowledged within 3 days	90.6%	97.3%	≥80%	76.6%	≥80%
National Patient Safety Alerts (NatPSAs) breached	0	2	0	3	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days (position at year end)	166	259	n/a	251	Reduction in open incidents
Median Outpatient Journey Times - Non-Diagnostic Face to Face Appointments (Wait at Year End)	n/a	97 Mins	n/a	97 mins	No set target
Median Outpatient Journey Times - Diagnostic Face to Face Appointments (Wait at Year End)	n/a	45 Mins	n/a	43 mins	No set target
Overall financial performance vs. Plan (£m) - Year End Position	5.61	8.42	≥0	-1.27	≥ 0
Commercial Trading Unit Position vs Plan (£m) - Year End Position	-1.11	-0.50	≥0	-1.7	≥0
Appraisal Compliance (At time of reporting)	70.6%	75.6%	≥80%	67.7%	≥ 80%
Information Governance Training Compliance (At time of reporting)	88.9%	90.1%	≥90%	89.5%	≥ 90%
Staff Sickness (Rolling Annual Figure)	4.7%	4.5%	≤ 4%	4.7% (Mar-Feb)	≤ 4%
Proportion of Temporary Staff	14.5%	15.5%	No Target	12.3%	Reduction in Temp Staffing

INDICATOR	2022/23 Results	2023/24 Results	2024/25 Target	**2024/25 Results**	**2025/26 TARGET**
Total patient recruitment to NIHR portfolio adopted studies	5,816	211 Per Month (2,532 total year)	≥ 115 Per Month	351 average per month (4,208 total year)	≥ 115 Per Month
Total patient recruitment to All Research Studies (Moorfields site only)	n/a	n/a	No set target	5,765	No set target
Active Commercial Studies (Open + Closed to Recruitment in follow up) (Year End Position)	n/a	60	≥44	58	≥44
Proportion of patients participating in research studies (as a percentage of number of open pathways) (position as at end of year)	5.9%	5.1%	≥2%	3.6%	≥2%
% implementation of NICE guidance	96.6%	94.5%	95%	94.8%	≥ 95%
Number of registered and ongoing clinical audits past their target deadline date	17.6% (34/193	33.5% (78/233)	≤ 20%	13.2% (41/311)	≤ 20%

Part 3: Other information

Statement from North Central London Integrated Care Board

nclhealthandcare.org.uk

NHS
North Central London
Integrated Care Board

02 June 2025

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NHS North Central London Integrated Care Board Statement

Moorfields Eye Hospital NHS Foundation Trust

North Central London Integrated Care Board (NCL ICB) has worked closely with Moorfields Eye Hospital NHS Foundation Trust throughout 2024/25, taking a pragmatic approach regarding assurance of commissioned services throughout the year; obtained through regular discussions with key staff within the Trust.

We recognise, and are grateful for, your outstanding leadership and commitment to doing everything possible to keep service users safe, now and in the future, while navigating the significant changes within how the NHS currently operates.

We confirm that we have reviewed the information contained within the draft Quality Account, shared with us in May 2025. The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available a place holder has been inserted.

The Trust's "Excellence Portfolio" sets out a clear framework supporting the quality priorities and improvement work overseen by the Quality, Service Improvement and Sustainability Team (QSIS), and Excellence Delivery Unit (XDU). We note the work undertaken by the Trust to implement the Patient Safety Incident Response Framework (PSIRF), alongside the implementation of the Accessible Information Standards (AIS), and the concerted focus on supporting continuous learning.

We recognise the challenges experienced by patients with visual impairments and sight loss, particularly those patients that require support to travel to the hospital to attend their appointments and are supportive of the work undertaken by the Trust to improve the experience of those using patient transport services.

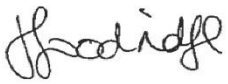
One of the priorities last year focused on reviewing existing communication channels to improve patient-centred communications, making the language in 'Did Not Attend' and cancellation letters 'softer'. While progress has been made throughout the year, we acknowledge that further work is required to align the new letter templates with existing clinic templates. We note that this priority will be progressed further in 2025/26.

We have reviewed the quality priorities identified by the Trust for the coming year, in particular, the

work to comply with the National Traceability Requirements by improving traceability of implanted medical devices. This is a key area of focus for the Trust, building on the work improve patient safety and implement the recommendations following a serious incident investigation and never event related to lens selection and processes.

We look forward to seeing the outcome of this work throughout the coming year.

Yours sincerely,



Jenny Goodridge
Acting Chief Nursing Officer
NHS North Central London ICB

Statement from Healthwatch Islington

Healthwatch Islington has not received any feedback about services provided at Moorfield Eye Hospital over the past year.

We welcome the Quality Priorities focusing on improving the experience of patients, with particular reference to priorities for: embedding the Accessible Information Standard; using patient transport services to and from your sites (patients in Islington have given feedback to Healthwatch on this issue in previous years); and ensuring that the Trust has better access to health inequalities data.

Luke Buffery
Communications and Impact Manager
Healthwatch Islington

Appendix 1: Glossary

A&E	Our **Accident and Emergency** team offers A&E treatment for urgent, sight-threatening problems and issues that cannot wait for a routine appointment with a GP.
AAR	An **After-Action Review** is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
AIS	**Accessible Information Standard** is a legal right of patients to be supported and empowered in their care by accessible information
BAU	**Business As Usual** is the usual operations of the Trust
CAEC	The **Clinical Audit and Effectiveness Committee** meets bi-monthly to discuss progress of the clinical audit and effectiveness programme across the trust.
CGC	The **Clinical Governance Committee** meets bi-monthly to discuss and present a variety of governance, clinical risk, and quality related topics.
CoO	The **College of Optometrists** is the professional, scientific and examining body for optometry in the United Kingdom
CQC	The **Care Quality Commission** is the health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation** is a payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in high quality care for all (the NHS next stage review report) of an NHS where quality is the organising principle.
CRF	Since 2007, the NIHR Moorfields **Clinical Research Facility** has pioneered the translation of laboratory discoveries for the benefit of patients with eye conditions.
CVI	**Certificates of Visual Impairment** are official documents issued to individuals with significant sight loss.
Deep Dive	A **Deep Dive** is a detailed analysis, investigation, or examination of a topic.
DHSC	The **Department of Health and Social Care** is a ministerial department of the Government of the United Kingdom. It is responsible for government policy on health and adult social care matters in England, and oversees the English National Health Service (NHS)
DNA	Where a patient **Did Not Attend** an appointment of admission. Was Not Brought (WNB) / Could Not Attend (CNA) / Refusal to attend for appointments or admission are connected
DoC	**Duty of Candour** is open, honest and transparent communication with patients, their families and carers following a patient safety event.
DoLS	**Deprivation of Liberty Safeguards** ensures people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests.
DSPT	The **Data Security and Protection Toolkit** is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

ECLO	**Eye Clinic Liaison Officers** provide advice and information about services outside the hospital for patients living with sight loss. ECLOs are available to offer emotional support and practical advice to all patients at Moorfields, their families and carers.
EDI	**Equality, Diversity, and Inclusion**: the trust is committed to providing an environment where people feel valued, included and empowered and where intolerance and discrimination in all its forms is eliminated.
EPR	An **Electronic Patient Record** system is a digital platform that brings all patient information, from medical history to results of investigations and medications prescribed, together in one place.
FFT	The **Friends and Family Test** aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.
FoI	The **Freedom of Information** Act 2000 provides a right of access to a wide range of information held by public authorities, including the NHS.
FTSU	**Freedom to Speak Up** is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon.
GIRFT	**Getting It Right First Time** is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.
ICB	**Integrated Care Boards** are NHS organisations responsible for planning health services for their local population.
IMDQG	The **Information Management and Data Quality Working Group** oversees the validation of the standards and integrity of the information management processes, ensures the trust adheres to external NHS information and data standards and provides governance and assurance of an appropriate level of data quality across the trust.
IPR	The **Integrated Performance Report** highlights a series of metrics regarded as Key Indicators of Trust Performance and covers a variety of organisational activities within several directorates including Operations, Quality and Safety, Workforce, Finance and Research.
IRG	The **Incident Review Group** is the forum where incidents which potentially fulfil our criteria as a local or national priority are reviewed and actioned accordingly.
KPI	A performance indicator or **Key Performance Indicator** is a type of performance measurement. KPIs evaluate the success of an organisation or of a particular activity in which it engages.
LED	**Locally Employed Doctors** are employed by trusts on local terms and conditions, so they are usually non-permanent posts and do not have nationally agreed terms and conditions.
LFPSE	The **Learn from Patient Safety Events** service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare.
LIFE	**Learning and Improvement Following Events**: Sharing learning following an incident, complaint, claim or other event is essential to create a culture in which workers feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or affects their experience in the workplace.
MAST	**Mandatory And Statutory Training:** statutory training is required by law, and mandatory training is determined by the organisation based on local risk assessments and training needs analysis.

ME	**Medical Examiners** are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.
MECC	**Make Every Contact Count** enables the delivery of consistent and concise health and wellbeing information and encourages individuals to engage in conversations about their health at scale across organisations and populations.
MEH	**Moorfields Eye Hospital** NHS Foundation Trust.
MRI	**Magnetic resonance imaging** is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
NatPSA	**National Patient Safety Alerts** are notices from NHS England that share information about risks that can cause serious harm or death. They set out what health or care organisations need to do to reduce the risk.
NCP	**New Citizenship Project** is an external partner, to work with the patient experience team to develop Patient Experience Principles.
NE	**Never Events** are patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
NEI	**National Eye Institute** funded by the United States Federal Government is the largest funder of ophthalmic research in the world.
NHSBT	**NHS Blood and Transplant** is responsible for the supply of blood, organs, tissues and stem cells. It collects and supplies blood to hospitals in England and is the organ donation organisation for the UK.
NHSE	**NHS England** leads the NHS in England.
NICE	**National Institute for Health and Care Excellence**: a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money.
NIHR	The **National Institute of Health Research** funds research into the most important research questions in ophthalmology .
NIHR	The **National Institute for Health and Care Research** is the major funder of clinical, public health, social care and translational research.
NOD	The **National Ophthalmology Database** collects data on cataract surgery performed in England and Wales and provides individual surgeons, healthcare providers and the public with benchmarked reports on performance, with the aim of improving the care provided to patients.
NOK	**Next of Kin** refers to a person's closest living relative(s).
NRLS	The **National Reporting and Learning System** is designed to collect information on safety incidents to enable analysis and generate learning to improve the state of care.
OpenEyes	**OpenEyes** is Moorfield's electronic heath record system.
Oriel	A joint project between Moorfields Eye Hospital, UCL and Moorfields Eye Charity. **Oriel** is our new centre for eye care, research and education.
OWL	The **Outpatient Waiting List** is a virtual waiting list for patients who require a follow-up appointment more than six weeks ahead of their last appointment.

PALS The **Patient Advice and Liaison Service** offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

PEP The **Patient Engagement Portal** (DrDoctor)improves and increase the speed and efficiency by which the Trust and patients can communicate with each other with regards to specific administrative and clinical functions.

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

PLACE This is the **Patient Led Assessment of Care Environment.**

PPRG The **Policy and Procedure Review Group** has governance oversight for all the Trust's policies and procedural documents (such as clinical guidelines and standard operating procedures).

PROM **Patient-reported Outcome Measures** are used to assess the quality of healthcare experiences, focusing on patients. These measures help the Trust make informed changes to their services.

PSI **Patient Safety Incidents** are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare.

PSII **Patient Safety Incident Investigations** are undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

PSIRF **Patient Safety Incident Response Framework** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP The **Patient Safety Incident Response Plan** sets out how the Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of the work to continually improve the quality and safety of the care provided.

PTL A **Patient Tracking List** is an established, forward-looking, management tool that can be used by the NHS to help achieve and sustain short Referral to Treatment and diagnostic waits.

QSC The **Quality and Safety Committee** is a formal committee of the board and provides assurance on matters concerning quality, health and safety.

RCO The **Royal College of Ophthalmologists** is an independent professional body who set the standards and examinations for ophthalmologists, and provide surgical skills training, as well as services to those who have completed their training.

RCoA The **Royal College of Anaesthetists** is the professional body responsible for the specialty of anaesthesia throughout the United Kingdom.

RNIB The **Royal National Institute of Blind People** is a UK charity that offers information, support and advice to people in the UK with sight loss.

RSC The **Risk and Safety Committee** has responsibility for ensuring that risk management policy, systems and process are in place across the organisation.

RTT **Referral to Treatment**: the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

SAR	Data protection legislation gives individuals the right to request access to personal data held on them by organisations. This is known as a **Subject Access Request**
SBAR	This stands for **Situation Background Assessment Recommendation**, and is a key element of the incident review process
SDMC	The **Shared Decision-Making Council** is part of the joint process in which healthcare professionals work together with patients and people to reach a decision.
SI	**Serious Incidents** include acts or omissions in care that result in unexpected or avoidable death or injury resulting in serious harm - including those where. the injury required treatment to prevent death or serious harm.
SPC	NHS England recommended 'Making Data Count' **Statistical Process Control** charts methodology.
TCS	**Terms and Conditions of Service** for NHS Doctors and Dentists in training (England) 2016
Tendable	**Tendable** is a smart inspection application (app) that replaces the manual pen and paper aspects of collecting data assessing outcomes and improving quality for audits and inspections across clinical areas.
UCLH	**University College London Hospitals** NHS Foundation Trust comprises University College Hospital, University College Hospital at Westmoreland Street, the UCH Macmillan Cancer Centre, the Royal National ENT and Eastman Dental Hospitals, the Hospital for Tropical Diseases, the National Hospital for Neurology and Neurosurgery, the Royal London Hospital for Integrated Medicine, and the Royal National Throat, Nose and Ear Hospital.
VLAG	The **Vision Loss Advisory Group** is a key patient participation group.
XDU	The **Excellence Delivery Unit** supports us to achieve our five-year organisational strategy by providing a framework for projects.