



Patient safety incident response plan

Summary

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

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Foreword

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

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

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

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

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

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



1. Introduction

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

The Plan is underpinned by our trust incident reporting and management policy, the learning framework, and the new trust patient safety incident response policy¹ (PSIRP).

2. Our services

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

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

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

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



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

3. Defining our patient safety incident profile

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



To fully inform our PSIR plan, the Trust has completed a review of what types of PSI occur, or may occur, to understand where we need to prioritise our learning resources to improve. Data from various sources has also been reviewed to inform the selection of PSIs that require a specific learning response (see table 2, section 6).

3.1 Stakeholder engagement

Prior to the initial adoption of PSIRF in April 2024, the central quality and safety team engaged with key stakeholders, over a 12-month period, to inform development of the Plan. The comprehensive engagement activities undertaken to inform the initial development and the review of our plan are summarised below and described in more detail in Appendix 3:

- Activities undertaken to support delivery of the PSIRF as a quality priority.
- Communication with the organisation regarding the introduction and purpose of the PSIRF.
- Involvement of our Patient Safety Partners (PSPs).
- Presentation of the Plan and PSIRP at governance meetings, including the trust's Quality and Safety committee and Clinical governance committee.
- Sharing and development of resources made available by NHS England and other NHS organisations.
- Establishment of a PSIRF steering group, along with a number of working groups.
- Safety culture focus groups (note, this has not been repeated for the review).
- Attendance at networking events, in particular those attended by partnership organisations.

We have undertaken a number of further activities in order to develop our revised list of local priorities, as described in this plan. These activities include, but are not limited to:

- Review and consideration of the incidents reported and considered by the Incident Review Group (IRG) over an 18-month period.
- Improvement responses initiated over an 18-month period, progression against these, and the need to further inform the safety actions that are required.
- The existence of on-going and proposed improvement plans (e.g., those described as quality priorities, those that form part of the transformation portfolio, those registered as continuous improvement initiatives either as a local improvement or



as a project overseen by the quality, service improvement and sustainability (QSIS) transformation team).

- PSIRF annual review workshop.
- Review of feedback and learning captured during various trust meetings.

3.2 Data sources

Prior to the initial adoption of PSIRF we reviewed numerous internal and external data sets to inform the Plan and identify our local incident priorities. These are as listed below. Where possible we have also considered what the data tells us about inequalities in patient safety. We have used some of these data sources to inform the 2025/26 update to our plan.

Internal sources

- **IRG and IRG action and improvement review (AIR) meetings and data relating to the 2024/25 local priorities.** This includes completed learning responses (e.g., patient safety incident investigation reports (PSIIs), after action reviews (AARs), thematic review) and on-going improvement plans.
- **Reported incidents (3 years), including incidents reviewed by the Serious Incident (SI) panel – NHS & Private.** During our latest review, we have supplemented the knowledge we gleaned in the pre-PSIRF review, with both the incidents that have been reviewed by IRG and also those that have not met the criteria as a local priority.
- **Serious Incidents (SIs)² and Never Event (NE) investigation reports - NHS & Private.** NE reports have been considered during this review.
- **Complaints data (as presented in the relevant quarterly reports – Q1 2020/21 to Q4 2022/23) – NHS only.** A formal review was not undertaken during the 2025 update process. Divisions were asked to consider any themes arising from complaints during their review of the proposed local priorities.
- **PALS data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.** This data was not formally considered during the 2025 review.

² The Serious Incident (SI) Framework ceased to be applied following the implementation of the PSIRF in April 2024. SI investigation reports are no longer created and are therefore not considered in reviews now.



- **Friends and Family Test (FFT) data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.** This data was not formally considered during the 2025 review.
- **Claims data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.** This data was not formally considered during the 2025 review.
- **Divisional risk profiles, based on a review of open risks – NHS & Private.** This information was considered during the 2025 review.
- **Staff survey results (2 years) – NHS & Private.** This data was not formally considered during the 2025 review.
- **Junior doctor survey – NHS only.** This data was not formally considered during the 2025 review.
- **Freedom to speak up (FTSU) thematic data – NHS & Private.** This information was considered during the 2025 review.
- **Output of safety culture focus groups – NHS & Private.** This data was not formally considered during the 2025 review.
- **Safety summit output (held for biometry and intraocular lenses (IOLs) and referral management) – NHS & Private.** The output from a safety summit considering intravitreal injections and a quality summit to review follow-up outpatient waiting list (FOWL) management and oversight took place during 2024 and 2025.
- **Data from quality surveillance processes (e.g., surgical safety checklist audits, pharmacy audits, infection control quarterly reports) – NHS & Private.** Audit is recognised as a rich source of data within the trust. In addition to the audits registered on Safeguard (the trust integrated risk management system), Tendable is used to electronically collect data, assess outcomes, and improve quality for audits and inspections across clinical areas.
- **Review of reports to/from specialist risk management committees (e.g., patient falls, resuscitation, medicines management, digital clinical safety) – NHS & Private.** This information was considered during the 2025 review.

Potential external sources of information for consideration (as appropriate)

- Inquest outcomes, including prevention of future death (PFD) reports.
- Clinical Negligence Scheme for Trusts (CNST) claims scorecards.



- Care Quality Commission (CQC) reports.

3.3 Services covered by the plan

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

Some departments and services within the trust (e.g., eye bank, pathology, electro-physiology department, contact lens and prosthetics manufacturing) are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. As such, there is a requirement to record non-conformities identified with work processes and systems against certain standards, so that improvement opportunities can be identified and considered as stipulated by these bodies. These non-conformities do not fall within the remit of this Plan unless a patient is involved or affected, in which case a PSI will be reported on Safeguard (the trust electronic incident reporting system) via the trust incident reporting process and will then be within the scope of this Plan.

4. Defining our patient safety improvement profile

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

In accordance with NHS England guidance on developing the Plan, we also identified the trust's quality improvement work and quality priorities (set out in the trust's Quality Account 2024/25).

Our quality priorities form part of our strategic vision and over the next five years the trust will deliver its strategic vision through the transformation portfolio, supported by the trust performance improvement team (PIT). The performance improvement portfolio supports us to achieve our five-year organisational strategy by focussing on optimising current operations, making them more efficient and effective. It is organised through four executive-led boards, aligned to our strategic objectives.

The performance improvement portfolio supports project activity across the trust by:

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



The quality priorities for 2025/26, and the drivers for each, are shown in Appendix 4. A list of the projects included in the performance improvement portfolio for 2025/26 can be found in Appendix 5.

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

To further determine our improvement profile, outputs from safety summits were also reviewed. Originally termed safety summits, and now quality summits, they are an improvement tool to inform the incident response pathway that the trust has used to address systemic safety risks. They bring together a diverse group of stakeholders, to discuss safety issues and develop solutions collaboratively.

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

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



5. Our patient safety incident response plan: national requirements

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

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



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



Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
<p>A safeguarding incident in which:</p> <ul style="list-style-type: none"> babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years old) are in receipt of care and support needs from their local authority the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence 	<p>Refer to local authority safeguarding lead</p> <p>Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards</p>	<p>Respond to recommendations from external referred agency/organisation as required and feed actions into the most appropriate improvement workstream/consider development of a new workstream</p>	<p>Safeguarding children and young persons' committee or safeguarding adults committee, dependent on PSI (escalations to clinical governance committee)</p>



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



6. Our patient safety incident response plan: local focus

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

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

It should be noted that the Plan is a starting point and learning responses, and identification of incident priorities, may evolve as more is understood about the incident and other trust data. As such, IRG (as reflected in the IRG TORs) will assign the learning response, but also has the discretion to agree another learning response, if more appropriate.

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

Any learning response agreed at IRG must be one described in our PSIR plan or listed in the PSIRF.

Our local priorities that have been removed or amended during this review have been retained in the list that follows. **The first column describes the outcome of our 2025 review.**

Given that digital systems underpin many of our processes and will continue to grow as our virtual hospital and pathways develop, all incidents with a digital element must be shared with the digital clinical safety team and its associated governance process. The director of digital clinical safety is a member of IRG, and the digital clinical safety team reports to CGC.



Status (2025/26 local priority list)	Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
REMOVED (see new LP12)	Delayed or missed diagnosis of a tumour in a glaucoma patient referred to the neuro-ophthalmology service (LP01)	Not required – removed priority.		
REMOVED – no longer a local priority	Unplanned omission/ deviation to intended care or treatment plan because of the use of hybrid health records/systems (LP02)	Not required – removed priority.		
AMENDED	Clinically unacceptable delay in the review/ treatment of a ‘follow-up’ patient, where the provision of a timely appointment has not been impacted by clinician instruction (LP03)	As determined at IRG	<ul style="list-style-type: none"> Improvement of our failsafe processes is a trust priority and is on the trust risk register. The review of our data has highlighted this as an area for improvement. AAR will support the identification of areas for improvement by understanding the expectations and perspectives of all those involved. New safety actions identified from the AAR will be incorporated in the failsafe and Outpatient Waiting List (OWL) improvement workstream. 	Develop and deliver board Oversight and escalations via clinical governance committee



Status (2025/26 local priority list)	Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
RETAINED	Mismanagement of internal referrals between sites and services and referrals from external providers into the organisation (LP04)	As determined at IRG	<ul style="list-style-type: none"> • Reported PSIs, feedback from focus groups and learning from a referral safety summit evidenced this as an opportunity for improvement. • New safety actions identified from the thematic review of PSIs will be incorporated in the safety improvement plan being developed as part of the ERS (electronic referral service), OpenEyes (OE, electronic patient record) and booking centre improvement workstreams. 	Develop and deliver board IT programme board Oversight and escalations via clinical governance committee
REMOVED – no longer a local priority	Communication of patient information between the trust and external organisations (e.g., letters and referrals relating to continuity of care not sent) (LP05)	Not required – removed priority.		



Status (2025/26 local priority list)	Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
AMENDED	Deviation to intended care or treatment plan resulting in intravitreal injection of the wrong drug or wrong dose (LP06)	As determined at IRG	<ul style="list-style-type: none"> Review of PSI near misses and incident data, feedback from key stakeholders and focus groups has identified this as an opportunity for improvement. Output from the AAR will identify activities, resources and behaviours that will support the development of safety actions and create a trust wide safety improvement plan, if required. 	Drugs, therapeutics, and medicines management committee Oversight and escalations via clinical governance committee
REMOVED – no longer a local priority (review at IRG part 2 and re-escalate to IRG part 1 if required)	Any incident or near miss relating to the application of a laser to a patient (LP07)	Review at IRG part 2 and re-escalate to IRG part 1, if required.		
REMOVED – no longer a local priority (review at IRG part 2 and re-escalate to IRG part 1 if required)	Delayed recognition of a deteriorating patient (LP08)	Review at IRG part 2 and re-escalate to IRG part 1 if required.		
REMOVED (see new LP12)	Delayed processing or review of a diagnostic test or sample leading to a clinically unacceptable delay in treatment (LP09)	Removed priority - See LP12.		



Status (2025/26 local priority list)	Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
REMOVED – no longer a local priority. Amalgamated with LP03	Clinically unacceptable delay, not impacted by known capacity issues, in actioning an outcome of a review of a patient managed through a virtual pathway (LP10)	See LP03 improvement route.		
AMENDED	Incident(s) which signify an unexpected and high level of risk and/or potential for considerable learning and improvement (LP11)	As determined at IRG	<ul style="list-style-type: none"> To ensure there is a mechanism to add to the Plan as our PSRIF approach develops and new themes emerge. 	To be agreed by IRG, depending on the PSI type or issue
NEW	Delayed or missed diagnosis resulting from availability of or accessibility to diagnostic imaging or pathology test results (LP12)	As determined at IRG	<ul style="list-style-type: none"> Reported PSIs have evidenced this as an opportunity for learning and ongoing improvement. Output from an AAR, or other learning response, will identify activities, resources, and behaviours, that will feed into local safety actions. In turn these will feed into the most appropriate improvement workstream/consider development of a new workstream. 	To be agreed by IRG, depending on the PSI type or issue



Appendix 1: Glossary of terms

Term	Definition/Explanation
After Action Review (AAR)	<p>AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.</p> <p>It is based around four questions:</p> <ul style="list-style-type: none"> • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning? <p>It aims to capture learning from these to identify the opportunities to improve and increase occasions where success occurs.</p>
Compassionate engagement	<p>An approach that prioritises and respects the needs of people who have been affected by a patient safety incident.</p>
Duty of candour (DoC)	<p>The duty of candour requires registered providers and registered managers (known as ‘registered persons’) to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines ‘notifiable safety incidents’ and specifies how registered persons must apply the duty of candour if these incidents occur.</p>
Engagement	<p>Everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.</p>



Term	Definition/Explanation
Everyday work	<p>Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work. Exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences and is central to any learning response conducted to inform improvement.</p> <p>The following tools can be used to explore everyday work:</p> <ul style="list-style-type: none"> • Observation guide Brief guide to conducting observations • Walkthrough guide Brief guide to walkthrough analysis • Link analysis guide Brief guide to link analysis • Interview guide Guidance on planning and conducting interviews as part of a patient safety incident learning response
Horizon scanning	<p>The horizon scanning tool uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to structure conversations about work as done and emerging patient and staff safety risks</p> <p>Horizon scanning tool</p>
Involvement	<p>Part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.</p>
Learning and improvement action meeting (LIAM)	<p>A structured, time-limited rapid meeting involving front-line staff and those who can influence actions discussing a recent patient safety incident or cluster of incidents. The discussions help facilitate the investigation of the incident by ensuring that the circumstances of events are understood and the teams involved have been provided with support and an opportunity to contribute to the investigation findings.</p>
Multi-disciplinary team (MDT) review	<p>An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.</p>



Term	Definition/Explanation
Never Event (NE)	<p>Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.</p> <p>A list of NEs can be found here: Never Event list February 2021</p>
Patient Safety Audit (PSA)	<p>A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline)</p>
Patient Safety Incidents (PSIs)	<p>Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.</p>
Patient Safety Incident Investigation (PSII)	<p>PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.</p>
Patient Safety Incident Response Framework (PSIRF)	<p>This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.</p>
Patient Safety Incident Response Plan	<p>Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.</p>
Patient safety partners (PSPs)	<p>PSPs are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.</p>



Term	Definition/Explanation
Quality summit	<p>A quality summit is a structured, multidisciplinary meeting convened to:</p> <ul style="list-style-type: none"> • Review findings from one or more significant patient safety incidents or a thematic review. • Consider data from various sources across safety, experience and effectiveness. • Facilitate shared learning across teams and departments. • Agree on system-level improvements and actions to prevent recurrence.
Systems Engineering Initiative for Patient Safety (SEIPS)	<p>SEIPS is a framework for understanding outcomes within complex socio-technical systems. Patient safety incidents result from multiple interactions between work system factors (i.e., external environment, organisation, internal environment, tools, and technology, tasks, and person(s)). SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships.</p> <p>SEIPS quick reference guide and work system explorer</p>
Structured Judgement Review (SJR)	<p>Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.</p>
Thematic review	<p>A thematic review may be useful for understanding common links, themes, or issues within a cluster of investigations, incidents, or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.</p> <p>Top tips for completing a thematic review</p>
Walk through, talk through	<p>A walk-through (or talk-through) is a structured exercise used to analyse a task, process, environment, or proposed change. It aims to uncover discrepancies between how work is imagined (design or policy) and how it is actually done in practice.</p>



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

	Accident & Emergency	Adnexal	Anaesthetics	Cataract	External disease	General ophthalmology	Genetics	Glaucoma	Intravitreal injections	Medical retina	Neuro-ophthalmology	Ocular oncology	Paediatrics	Private Patients	Refractive laser	Strabismus	Surgery	Urgent Care	Uveitis	Vitreoretinal
Barking Hospital																				
Bedford Hospital (South Wing)																				
Brent Cross																				
Cayton Street																				
City Road																				
Croydon University Hospital																				
Ealing Hospital																				
Homerton Hospital (Partnership)																				
Hoxton																				
MeiraGTX Hoxton Maze																				
Moorfields Private Eye Centre																				
Moorfields Private Outpatient Centre																				
Nelson Health Centre																				
Northwick Park Hospital																				
Parkway Health Centre*																				
Potters Bar Community Hospital																				
Purley War Memorial Hospital																				
Queen Mary Hospital																				
Richard Desmond Childrens' Eye Centre																				
Sanderstead Health Centre*																				
St Ann's Hospital																				
St Bartholomew's Hospital																				
St George's Hospital																				
Stratford																				
<ul style="list-style-type: none"> - Orthoptist services only. - This table does not include the support services provided (e.g., orthoptics, optometry, contact lens, imaging, pathology, EDD, prosthetics). For more information regarding these services please contact the ophthalmology and clinical support services (O&CSS) division. 																				



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

- For 2022/23, implementation of the National Patient Safety Strategy, including the PSIRF, was introduced as a quality priority for the trust. It remains a quality priority, alongside development of a quality management learning system.
- The purpose and expectations of PSIRF were communicated to the organisation in advance of the NHSE launch of the final PSIRF documents in mid-August 2022. Since implementing the PSIRF in April 2024, routine updates have continued to be provided to the risk and safety committee, clinical governance committee, and the quality and safety committee as a sub-committee of the trust board. Learning and improvement information is now shared in multiple forums, on both a scheduled and ad-hoc basis.
- Patient safety partners have continued to be involved through membership of our clinical governance committee and the PSIRF steering group.
- The development of proposed changes to our local incident priorities has been informed through feedback collated following a number of engagement exercises. Staff have been afforded the opportunity to share insight or concerns and ask questions regarding PSIRF, either in the forum or on a 1:1 basis.
- The PSIRF implementation group, renamed the PSIRF steering group, was formally reconvened in Q1 2023/24 to review the output of our initial diagnostic and discovery phase and to help draft our initial PSIRP local priorities prior to consultation. The steering group continues to meet and oversees and implements a focused programme of work establishing a foundation for a comprehensive risk management system and a risk-based approach to patient safety incidents, aligned with PSIRF Standards.



Appendix 4: 2025/26 Quality priority drivers

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



Appendix 5: Performance improvement categorisation

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

Programme board	Objective	Transformation area
Working together	We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.	<ul style="list-style-type: none"> • Workforce • Quality
Discover	We will discover new treatments and clinical pathways for excellent eye care.	<ul style="list-style-type: none"> • Innovation • Education
Develop and deliver	We will develop our clinical pathways, our physical and digital network, and our operational systems, to deliver reliably excellent eye care.	<ul style="list-style-type: none"> • Clinical • Network • Operational
Sustain and scale	We will ensure that more people can access excellent eye care sustainably and at scale, reducing waste and inefficiency.	<ul style="list-style-type: none"> • Enterprise • Sustainability



Major MEH change programmes and projects for 25/26

Live Project
£ Potential Financial benefit
IT enabled
Quality Priority

Develop & Deliver:

Surgery (SRO Kathryn Lennon, programme manager Gerry Hanna)

Pre-Assessment operating model	Consent optimisation (including digital remote consent)	Theatres and anaesthetics operating model	Inventory Management System (IMS) phase 2, incl Medical Devices Outcome registry	Clinical Sterile services
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Outpatient and Diagnostic (SRO Victoria Banks, programme manager Merel Reinink)

Patient-initiated follow-up roll out (PIFU)	Relocation of City Road asynchronous diagnostics	Synchronous diagnostics scheduling and workforce implementation	Oriel paediatric services outpatient transformation	Vitreo-Retinal Target Operating Model	External Target Operating Model	Oriel adult services outpatient transformation	Adnexal Target Operating Model (Incl Crosscoper trial)
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Admin and Operations (SRO Jack Wooding, programme manager Tina Haigh)

Care Coordination System (Powered by MEH FDP)	Check-in / Check-out (Oriel Admin Model)	Virtual review model (Oriel Admin Model)	Patient Support services operating model	Digital patient letters
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Access and Referrals (SRO Lydia Salice)

Single Point of Access clinical model	Advice and Guidance
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Network – North Sites (SRO Natalie O’Shea)

Bedford Contract Transition (phase 2)	St Anns transformation	Ealing Theatre Re-Provision and Paediatrics Expansion
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Quality & workforce priority projects

Leadership Development Programme	MEH Agile working policy including workforce and cultural change	One Granary Street	PSIRF Learning system implementation	Equality, diversity and inclusion Leadership and culture	Equality, diversity and inclusion Fair opportunities for all	Equality, diversity and inclusion Data driven change	Launch MEH People and OD Strategy [not PCOD]	Manager Self Service for Employee Staff Records (ESR)	Embedding Values
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ICT Transition programme

Rhapsody	Identity access management
Data warehouse	CoLo & Clinical Services

IT Operational Projects

Network Decommission	Print management	Windows 11 Migration	Microsoft Defender	Athena Reading Centre	Zeiss Upgrade
Friends & family test	Intouch patient kiosks	Private Computcare phase 2	A&E videocams	Heyex 2 Upgrade	

Oriel joint workstreams

People/Culture Org Development (PCOD) Workstream	Arts & heritage	Wayfinding	Tissue centre
Oriel Smart Hospital	Oriel ICT Infrastructure	Education	Innovation Centre

MoorConnect EPR programme

Training	Technical delivery	Design	Data usage
Data management	Go-live & handover	ADAPT	Paper record scanning

