Moorfields Eye Hospital NHS
NHS Foundation Trust

Clinical Quality and Safety Performance Report

Quarter 2 and Quarter 3 2014/5

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TMB 24th March 2015

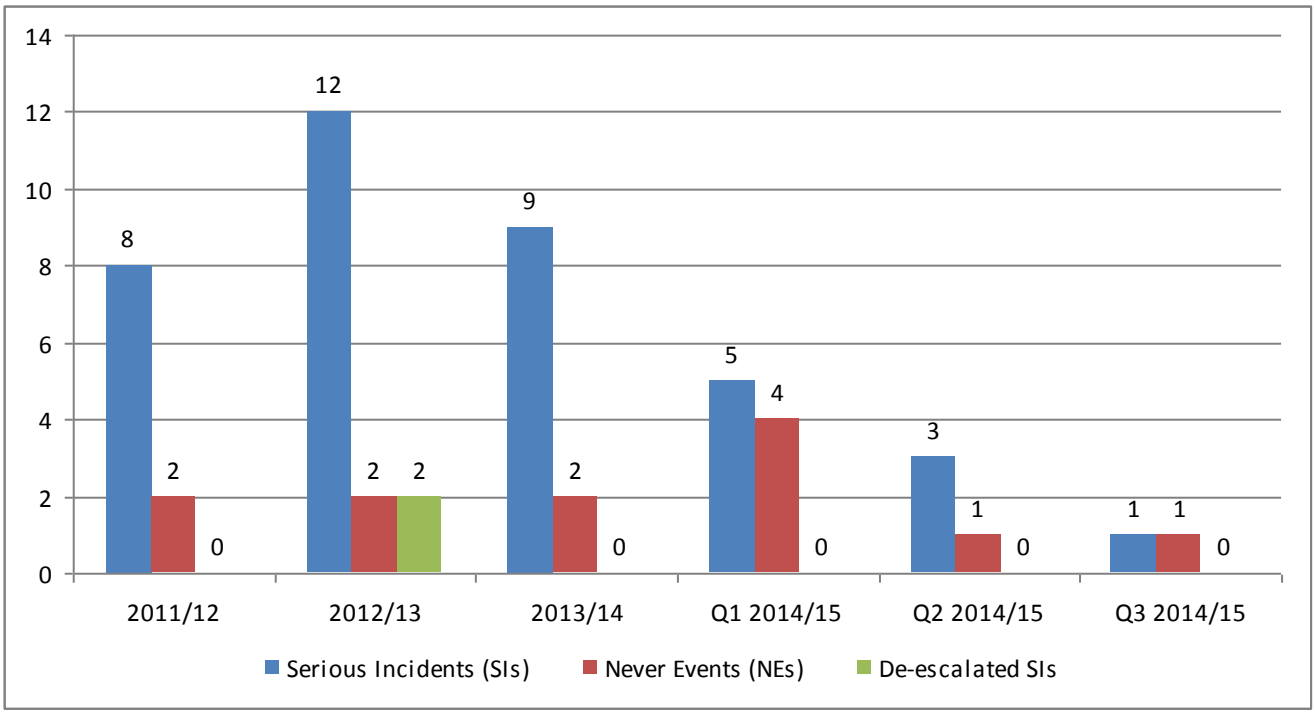
Action:

- **For information**
- **For consideration** ✓
- **For decision**

1. Patient Safety:

a. Incidents and claims

Serious Incidents (SIs) and Never Events (NEs)



In Q2 and Q3 14/15 a total of 4 SIs and 2 NEs were reported with no requests made for downgrades:

Q2 14/15

- Eye bank flood
  The flood occurred as a result of both heavy rainfall and equipment failure (a solenoid valve failed to open and, as a consequence, the sump was filled with high temperature condensate and the pump seized). It was not the first flood that had occurred in this area. No patient harm occurred, but the service had to be relocated for a period of time and donor tissue was lost. The investigation concluded that there is a need to relocate the eye bank from the basement to another floor and consideration of potential options for relocation is on-going;

- Delayed endophthalmitis diagnosis (received as a claim)
  The Trust only became aware of this incident following receipt of a letter of claim (i.e. it was not reported as an incident in December 2012 when the incident occurred and no subsequent complaint was made). The investigation is on-going although it is acknowledged that there was a failure to make the correct diagnosis;

- Lost to follow-up, Glaucoma
  The patient was last reviewed in a City Road glaucoma clinic in 2007, at which time he was asked to discontinue his medication to both eyes as the intraocular pressure (IOP) was adequately low. The incident is currently being investigated;

- Retained post operative foreign object (trochar cannula) NEVER EVENT

Medical and nursing staff failed to detect a trochar cannula was still in the eye whilst performing the surgical instrument count, and the patient was discharged home with the cannula in situ. It was later detected by the patient, who presented at A&E. The investigation has concluded and a number of agreed actions for better instrument nomenclature and counts are in the process of being implemented;

Q3 14/15

- Lost to follow-up, Glaucoma
  The patient was last seen at Barking in 2003 when new medication was prescribed. The patient did not attend the next two scheduled appointments and it appears that there was no communication with the patient's GP regarding the non-attendance. The incident was detected when the patient was re-referred following an appointment with a high street optometrist;

- Implantation of the incorrect IOL (St George's), NEVER EVENT
  This incident is still under investigation, but it appears that the error occurred for the same reason as the four NEs at Bedford, i.e. an undetected and unexpected change in the layout of the data pertaining to different lenses on the biometry printout. The surgeon selected the lens from the data box positioned on the "usual" part of the page, which would normally pertain to the most common lens type, and therefore chose the wrong lens strength. An action plan, which has been developed in response to 6 previous wrong IOL implantation incidents occurring from March 2014 onwards, has generated many actions across the whole of the organisation including revision of the 3 key clinical guidelines relating to IOL selection and implantation, simplification of the IOL checking process in theatres, an audit of compliance with guidelines, and a number of actions for the Clinical Technical Services department to achieve standardisation of process across the Trust;

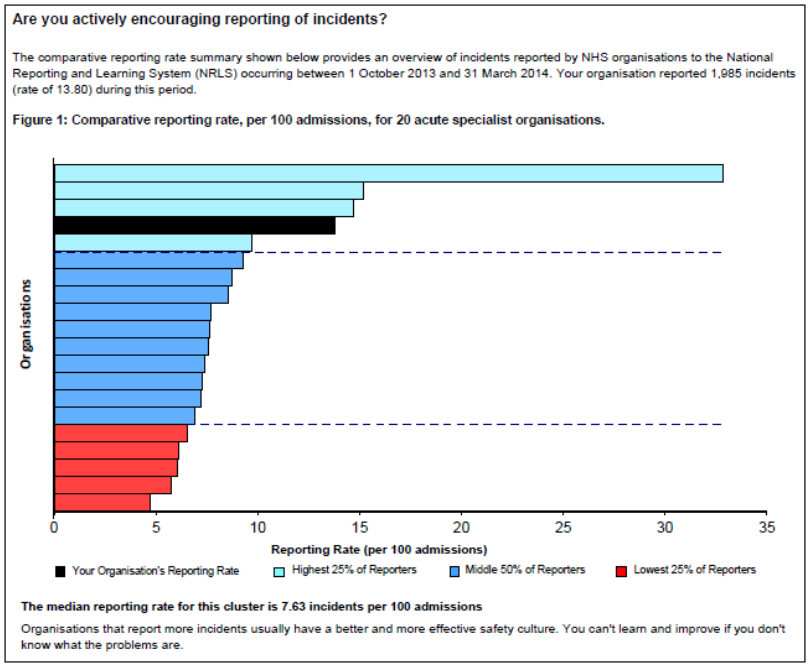
The table below shows the number of incidents that have been reported in previous years and over the first 3 quarters of 2014/15. It can be seen that the year to date (YTD) reporting figure of 5242 incidents for 2014/15 has already exceeded the total number of incidents reported over the whole of 2013/14.

Indicators	11/12	12/13	13/14	14/15			YTD
				Q1	Q2	Q3	
Patient Safety Incident (PSI)	828	1199	3400	1371	1624	1314	4078
Non-PSI	286	287	325	88	83	60	231
Incidents in the web-holding file[1]	-	-	10	42	138	522	712
Total incidents	1114	1486	3735	1501	1845	1896	5242
Serious incidents (SIs)	8	12	9	5	3	1	9

[1] A completed incident form is submitted to the web-holding file (WHF) in the first instance. It remains in the WHF until such time that the investigation is complete and the manager closes the incident. At the point at which it is merged into the 'live' file, the R & S department performs a data quality check. Incidents in the WHF have not been submitted to the National Reporting and Learning Service (NRLS) unless an SI/NE. The data in the table is correct as on 2nd March 2015. For this reason there is a small variation between the numbers shown in this report and the aggregate data report (i.e. this data has been extracted more recently)

Never events (NEs)	2	2	2	4	1	1	6

The table below, extracted from the most recent NRLS report (September 2014 covering period 1st October 2013 to 31st March 2014), indicates that Moorfields' reporting culture continues to improve over time. Moorfields reported 7.63 incidents per 100 admissions, which places the Trust in the top 5 specialist acute Trust reporters. In the previous report the Trust demonstrated a recorded reporting rate of 7.55 incidents per 100 admissions, and was in the top 10 reporters and in the report before that a reporting rate of 3.1 incidents per 100 admissions placed the Trust in position 19 out of 20.



Review of the Q2 & Q3 data (excluding web holding file data) gives the following headlines:

- Incident reporting numbers are proportional to site activity: 1537 (52.2%) were reported from City Road and 644 (21.9%) from St George's
- In Q1 14/15 the Trust declared an SI in relation to multiple failures associated with RTT18, that is the management of referral to treatment waiting times, which resulted in a number of patients waiting more than 18 weeks before they started their treatment. The SI investigation included a clinical harm review of the 5223 patients who had waited for more than 18 weeks before commencing their consultant-led treatment between 1st April 2013 and 31st March 2014; and a prospective review of patients who would breach the 18 week threshold before commencing treatment. Multiple operational changes have been introduced to address the issues and ensure RTT 18 rules are appropriately followed for all patients and sites. In Q3, 9 incidents were classified as an 'admission delay/failure' compared with 32 in Q2
- 1788 (60.7%) of the 2944 incidents reported in the 6 month period relate to health records. In Q2 14/15, following an extensive period of review and planning, the health records library was 'closed'. This significant change meant that staff members from the clinical services were no longer responsible for accessing the library to pull and prepare records in advance of clinics. Now library staff pull and prepare ('prep') the health records centrally and then make these available to clinic clerks in advance of the clinic. Introduction of the new system failed, in Q2 and Q3, to have a positive impact on record availability. In direct response to the continuing

risks in relation to record availability two events have happened. The Health Records Steering Group (HRSG) has been replaced by the Health Records Project Group (HRPG), which has different terms of reference, more frequent meetings and more multidisciplinary and senior staff presence, with a remit to resolve the continued difficulties with records; and the Compliance Team undertook an extensive 'deep dive' review of the health records function which was presented to the Quality & Safety Committee in February and identified a number of significant issues and is working with operational staff to produce a comprehensive action plan which will support the work of the HRPG.

Claims and Litigation

The NHSLA was notified of claims relating to Moorfields as detailed below:

Claim type	Number of new claims advised 2013/14	Number of new claims advised Q1 2014/15	Number of new claims advised Q2 2014/15	Number of new claims advised Q3 2014/15
CNST (clinical negligence)	7	6	3	1
Personal injury (Liability to Third Parties Scheme – LTPS)	4	3	0	1
Total	**11**	**9**	**3**	**2**

A basic overview of the claims for Q2 and Q3 2014/15 is provided below, along with identification of whether or not an incident was recorded and/or an investigation has been completed.

Reference	Claim	Reported as an incident	Comment
Q2 14/15 CNST1	The patient required an orbital floor steroid injection following previous complicated cataract surgery. Unfortunately, the injection led to a penetrating injury causing vitreous haemorrhage and retinal detachment	Yes	This has led to a change in consenting advice and the consent form to advise patients of the very rare risk of serious eye injury and loss of vision in periocular injections
Q2 14/15 CNST2	Claimant alleged that his right eye cataract surgery and post-op care fell below the standards of reasonable care	No	Suggestion that if the patient had not been treated with a prostaglandin inhibitor at the time of his cataract surgery, then the likelihood of his development of cystoid macular oedema would have been significantly reduced
Q2 14/15 CNST3	Patient underwent cataract surgery. Alleged that the eye was left exposed and dry post operatively causing injury	Yes	Private patient
Q3 14/15 CNST1	Poorly performed cataract surgery resulting in deterioration of eyesight in left eye	No	
Q3 14/15	Injury sustained when the patient	Yes	

LTPS1	tripped and fell over trailing cables from equipment, sustaining a broken leg		

Although claims do not necessarily indicate poor practice or negligence, the analysis of claims for learning remains an area in which improvement can be made and a meeting with trust legal team is planned to consider how better to do this. A detailed analysis of clinical negligence claims, as informed by the NHSLA claims scorecard, is included within the Q1 & Q2 aggregate data report.

b. Alerts

Indicators	11/12	12/13	13/14	14/15				YTD
				Q1	Q2	Q3	Q4	
Number of alerts received[2]	112	92	116	30	32	39		101
Number of alerts signed off within specified timescale	111	87	109	29	31	33		93
Number of alerts issued for which action required	4	9	18	2	3	4		9
Number of alerts not signed off (no breach)				0	0	2		2
Number of alerts that have breached deadline				1	1	4		6
On-going breaches (i.e. from a previous quarter) where action is required				2	0	1		3

In the report for the previous 2 quarters it was identified that there had been a number of breaches of compliance with the 'deadline for action' date specified within the alert. The reasons for these breaches were broadly classified as either an administrative oversight, awaiting management response/action or a supply issue (arisen as a result of a medical device alert).

Analysis of the data for Q2 and Q3 demonstrates an improvement in response to the alerts compared with previous years and very few alerts breach. Of the alerts that breached the deadline for compliance, 1 is of particular significance and is detailed below:

[2] *Only alerts for which a response is required have been included (i.e. drug alerts, MHRA Dear Doctor Letters and CMO messaging alerts have been excluded).*

Resources to support the prompt recognition of sepsis and the rapid initiation of treatment. This alert (2nd September 2014) was issued to raise awareness of sepsis and to signpost clinicians across community and secondary care services to a set of resources from the UK Sepsis Trust to support the prompt recognition and initiation of treatments for all patients suspected of having sepsis. The Trust failed to achieve compliance with the original deadline because the need to take into account a number of factors including the specialist nature of our service, the varying nature and staff skill mix of the multiple different settings in which we deliver care which influence our ability to safely deliver sepsis care compared with other acute trusts. A multi-disciplinary team, including representatives from the Resuscitation and Infection Control Committees, Pharmacy and satellites, have been meeting to formulate a risk-based response to the alert overseen by the Clinical Governance Committee. In Q4 2014/15 Islington CCG agreed that the Trust was in a position to be able to sign off the alert but will receive periodic updates regarding action plan implementation at the Clinical Quality Review Group,

c. Infection Control

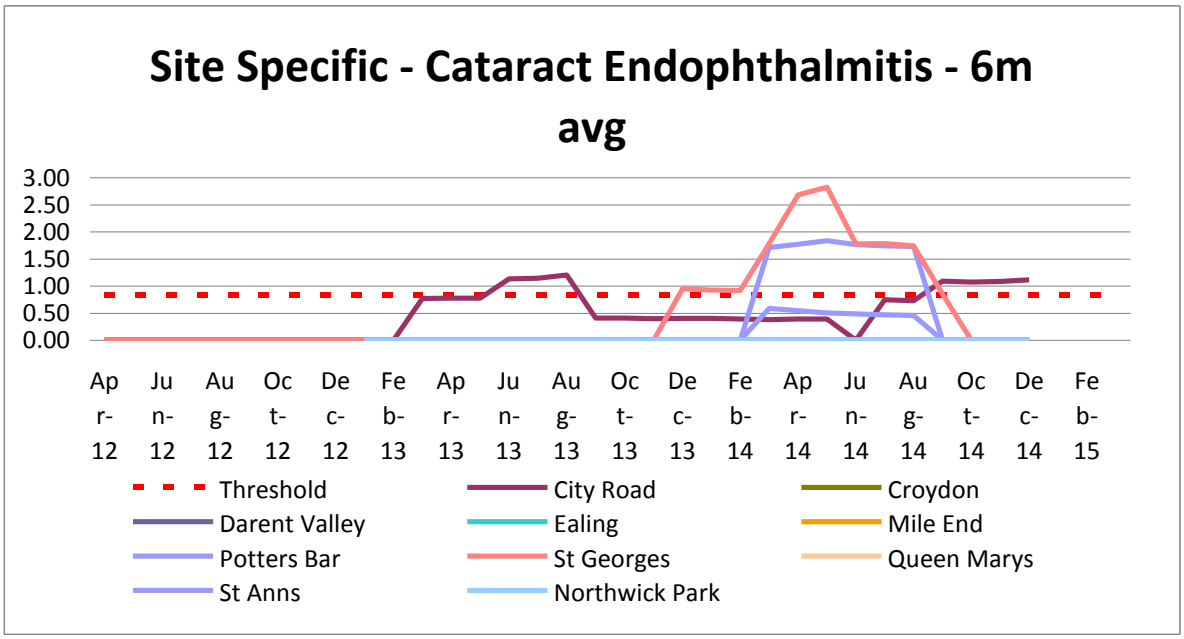
Indicators	2013/14	Target	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2014/15	YTD 2014/15
C.diff infection	0	0	0	0	0	0	0
MRSA bacteraemia	0	0	0	0	0	0	0
E.Coli bacteraemia	0	0	0	0	0	0	0
MSSA bacteraemia	0	0	0	0	0	0	0
MRSA Screening	100%	100%	100%	100%	100%	100%	100%
%Endophthalmitis post cataract[1]	0.04%	0.08%	0.07%	0.02%	0.06%	0.0%	0.03%
%Endophthalmitis post intravitreal Injection[1]	0.03%	0.05%	0.02%	0.01%	0.03%	0.0%	0.01%
Adenovirus possible hospital acquired	0.85%	NA	0.6%	0.6%	0.7%	1.5%	0.9%

[1]Excludes Bedford cases and Ozurdex implant injections

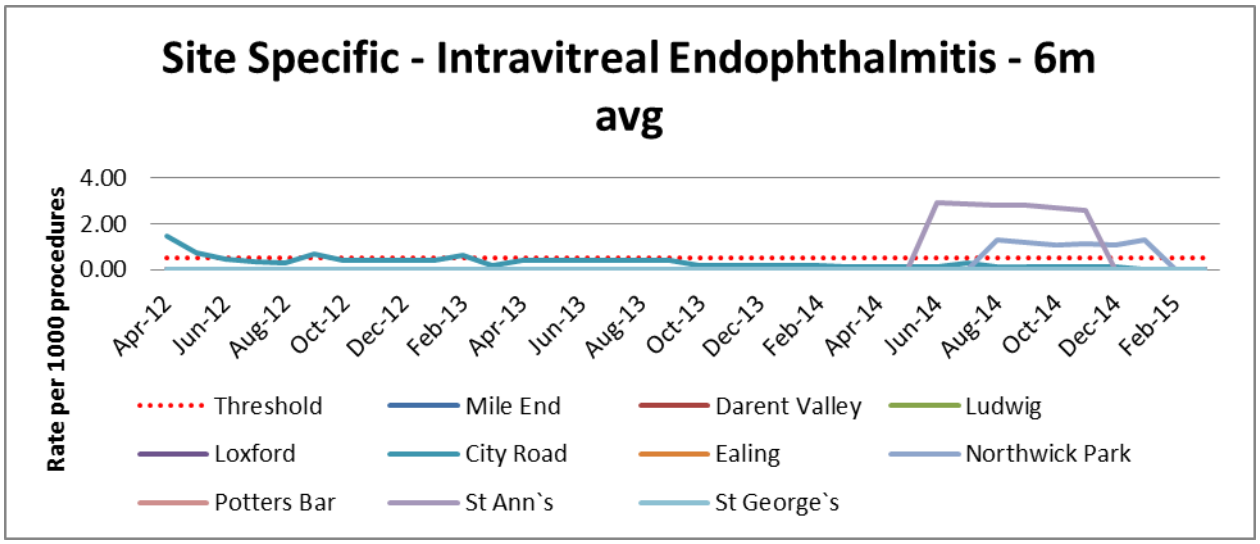
CPE monitoring began in October following ratification of policy. Number to date of suspected cases are 8. All cases have history of admission to hospitals abroad within the last 12 months with no notification of CPE carriage.

Endophthalmitis rate

Benchmarked endophthalmitis	Q2 Q3	Cataract cases x 3 (2 in Theatre 3, one in Theatre 4 at CR) Intravitreal injection x 2 (CR and NWP) No cases
Exception reported cases	Q 2 Q3	No cases No cases
Non-benchmark endophthalmitis	Q2 Q3	1 x Trabeculectomy with injection of provisc at CR No cases (3 cases of bleb related inflammation diagnosed but not meeting trust definition for endophthalmitis)



Both Potters Bar and St George's have returned to within target during Q 2 and 3. City Road is slightly above the target with 3 cases in 2694 procedures but assessment using the trust probability tool indicates that the City Road service is safe to continue for now. Continued monitoring of endophthalmitis cases at City Road theatres, in light of the required work on the ventilation systems, has identified a total of 5 patients for 2014/15 which does not indicate an increase in rate of infection.



St Ann's and NWP rates had temporarily breached but both recovered to below target rates and the trust probability tool indicates that services are safe to continue for now.

Data shows 5 cases of endophthalmitis from 14000 nurse delivered injection, that is a rate of infection of 0.036%, which is well within the trust target of 0.05%.

Decontamination

The Theatre/SSD Lead reported that a new washer-disinfector with a stand-alone ultrasonic washer will be installed in the Sterile Services department. This will enable

automated cleaning of phaco handpieces. External auditors will be informed in preparation for surveillance inspections of the department from April

Compliance

Indicators	2013/14	Target	Q4 2013/14	Q1	Q2	Q3	YTD 2014/15
Hand hygiene compliance	97%	95%	97%	97%	98%	98%	98%
Cleanliness inspections	97%	95%	98%	98%	98%	98%	98%
Slit lamp audit	87.5%	90%	89%		93%		93%
Policy and Practice compliance	91%	90%	89%	91%		95%	93%

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d. Site and service safety: Walkarounds and mGTT

8 mGTT proposals were registered during this time and no reports were received at the Clinical Audit and Assessment Committee (CAAC) but many projects are currently active and we await the completed reports over the next months.

Site/service	Annual Target	July - Dec 2014		Site/service	Target	Reg	Complete
		Reg	Complete				
A&E	2			Bedford	2	1	
Adnexal	2			City Road	2	5	
Anaesthetics		2		Dubai	2		
Cataract	2			Ealing	2		
Corneal / External	2	1		Harlow	1		
General Ophthalmology/primary care	2	1		Loxford	1	1	
Glaucoma	2			Mile End	1		
Medical Retina	2	2		NWP	2		
Neuro, Strabs, Paeds (NSP)	2	2		Potters Bar	1		
Optometry				St Anns	1		
Orthoptics				St Georges	2		
Trustwide (Nursing)				Upney Lane	1	1	
Vitreo Retinal	2						

The safety walkabouts have continued and developed in the 6 month period:

- ***Quality and safety data review:*** *The quality team meet with site/service leads to discuss and take action on quality and safety data.* One data review took place in Q3 14/15 with the Medical Retina service and a data review planned in Q3 with the External Disease Service was postponed due to unavailability of key staff. 15 actions were generated from the meeting with the Medical Retina team, many of which have since been completed including the development and implementation of a Standard Operating Procedure for checking intraocular pressure, the inclusion of uveitis specialist nurses and diabetic specialist nurses in the MR service review,

closer liaison with the clinical audit team and the development of specific actions from a CQC style walkabout

Plans to increase the number of data reviews for each service and site in 2015 have progressed, and the External Disease Service, Theatres and Paediatrics and Strabismus have dates booked for Q4. The quality team plan to increase the frequency to undertake at least one data review per month for 2015-16.

- ***Staff safety walkabouts****. The Head of Clinical Governance, risk team and Patient Experience Manager join the risk assessment visits to provide an accessible and approachable way for local staff to feedback on safety concerns.* In Q2 and 3 staff safety walkabouts were held with the Pre-operative Assessment team at City Road and the Pharmacy team. Staff in the Pre-assessment Department raised a variety of concerns including the locking of security doors, completion of conflict resolution training, inappropriate bookings, patient information, and risk assessments within the phlebotomy room. An unsafe digi-lock has since been removed from one of the doors and a process for better communication between the booking team and pre-assessment team has been developed. Patient information charts and better screen information has also been implemented. The Pharmacy team also raised issues of security following an incident on the street next to the Pharmacy Department, which has now resulted in better lighting installed at the exit. Other concerns raised included better information for patients about waiting, space at satellite sites, delivery issues, and temperature control in and around the Pharmacy area. The temperature flow and control valves were all checked and working correctly. The quality team had also planned to visit Bedford in Q2, but the Bedford visit was utilised instead for a more urgent safety priority, the investigation of Bedford wrong IOLs. The team plan to visit St Ann's in Q4.

- ***CQC style safety visits****. Senior managers, Board members and executive staff will accompany quality staff on unannounced visits to allow two way communication between patients and shop floor staff and those at the most senior levels of the trust and to examine fundamental standards.* Since the last walkabout, the quality team have further refined the process and completed a CQC style visit in Q2 of the Medical Retina and Glaucoma clinics at City Road. Eight very senior staff from different disciplines embarked on a 3-4hr exploration, questioning 40 patient/parent/carers, 14 staff, and conducting 4 environmental reviews that included feedback from the person in charge and a review of medical notes. The visit was again a great success and following extensive analysis and a full report, the Outpatient and Diagnostics Service were able to assist in the development of a comprehensive action plan with input from the involved services which was approved at the directorate meeting and the Clinical Governance Committee, and will be monitored within the directorate. No major issues of concern were identified and all involved, from the visiting team to the staff and patients questioned, appreciated the visit. Completed actions include better signage, the painting of supporting pillars to contrast the background walls, PALS posters, staff reminders, updates and training, and various refurbishment projects with the estates teams.

e. Information governance (IG)

During there were 55 IG related incidents reported, but none reportable to the Information Commissioners Office (ICO). 22 of these incidents involved patient details being inadvertently disclosed to another patient. Other incidents involved notes being left out in clinic areas, password sharing and inappropriate disclosure of staff and patient details.

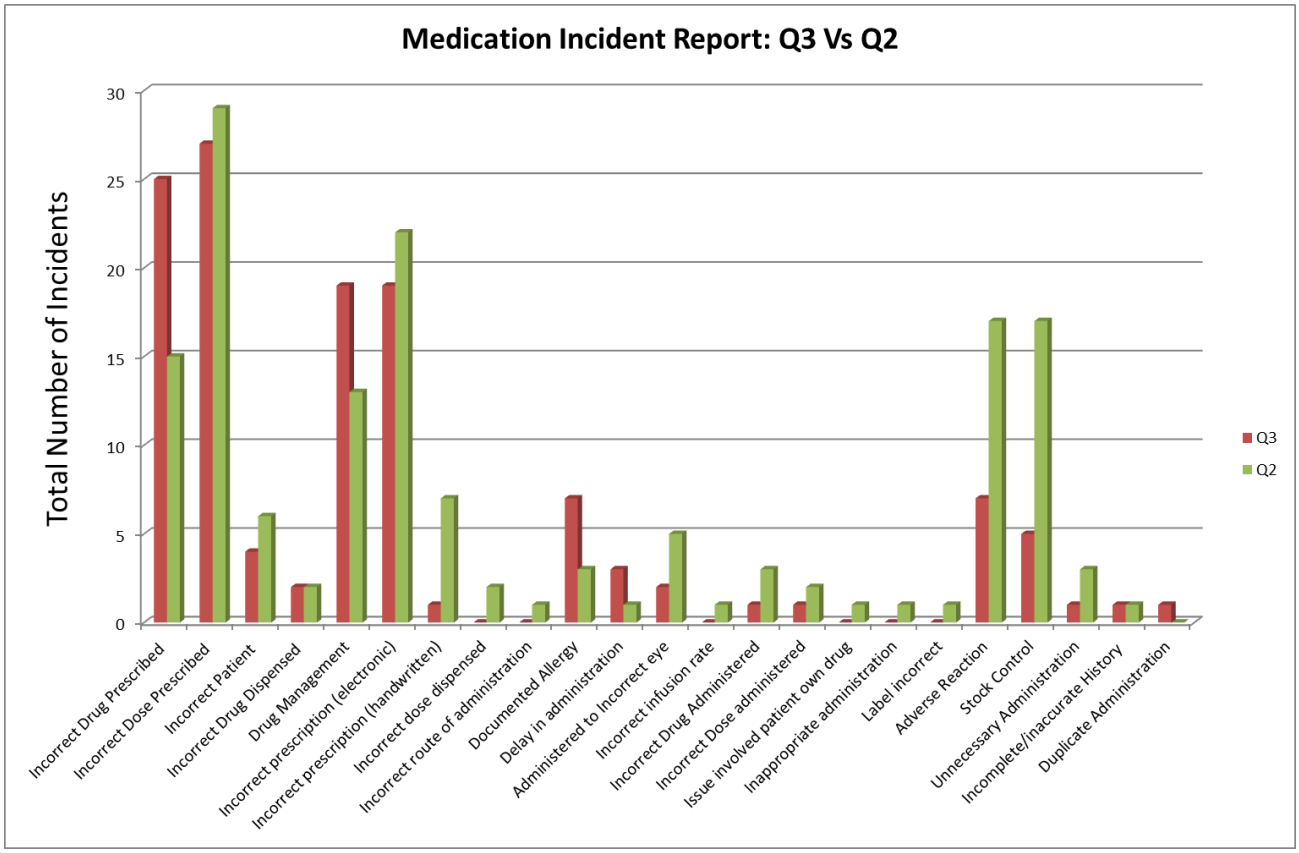
The IG training compliance currently stands as 72.5%, with the aim to meet 95% by March 2015. Compliance is quite low, despite the deployment of the new Learning and Development system in December 2014 which sends reminders to staff, therefore the IG team have started to liaise with directorate leads, to encourage their staff to complete the training. The IG team continues to offer face to face training sessions at all sites and will be attending the CG half day sessions in March.

In January, the Trust introduced Egress Switch, a secure email system. This is an important tool that enables staff to send information securely to external parties such as other NHS organisations, local government, the police and solicitors, including confidential information (patient data, staff records and sensitive corporate records), via Moorfields email accounts.

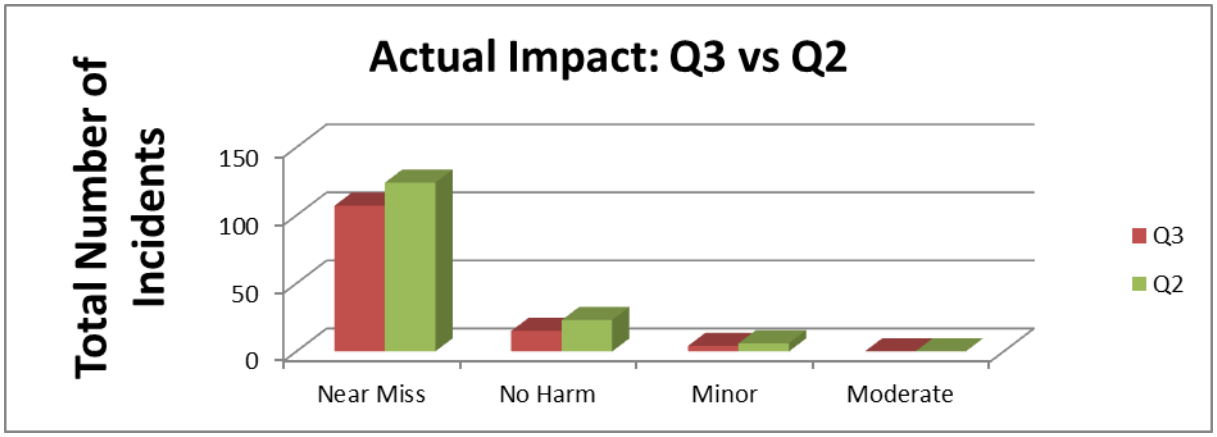
The Information Governance team have now taken over the management of the Freedom of Information requests received by the Trust, and have implemented a robust management system. As required by the Information Governance toolkit, training will be rolled out in February and March 2015 for FOI leads.

f. Medication safety

There were 153 medication related incidents reported in Q2 and 126 in Q3 and the graph shows the causes of which the commonest were: incorrect drug prescribed, incorrect dose prescribed, drug management and incorrect electronic prescription.



The majority of errors were near miss as Pharmacy staff intervened during dispensing, preventing the error reaching the patients. The graph below shows the actual impact on patients for medication incidents was very low with no incidences beyond minor harm.



Those that caused minor harm included: adverse reactions to fluorescein injections, painful eye caused by corneal erosion during phasing and clinical documentation not reaching a GP to change drug therapy. We have a rate of 3.6% minor harm from the incidents recorded in Q2 and Q3 which is well below the national figure of 16% of actual harm from medication incidents.

Medication Safety Group:

The Medication Safety Group, which met in August and December, is a multidisciplinary group supporting the management of operational and risk issues associated with the use of medicines and related policies within the Trust. Two more professionals, a clinical fellow and an operating department assistant, joined in August to broaden the input

across more staff groups, in response to a patient safety directive from NHS England and MHRA on improving reporting and learning from medication incidents.
Some of the work undertaken during this period included:

- review of medication incidents and local follow up actions
- production of the Medication Safety News Bulletins
- production/review of medicines information leaflets
- devising action plan for the medicine security audit
- discussions on NPSA standards (intravenous fluid therapy in adults in hospital and drug allergy: diagnosis and management of drug allergy in adults, children and young people)
- Discussion on response to the sepsis alert
- Ensuring that the drug alerts and recall are addressed in all clinical areas

Medicines alerts
There were 11 drug alerts via the central alerting system over this period, 2 of which involved medicines used at Moorfields. All actions were completed within the time frame.

Medicines security
The report of an audit to assess the safe storage and secure handling of medicines in 65 clinical areas across the trust was presented to the Clinical Governance Committee. The audit was conducted between November 2013 and March 2014 and the data fully verified with section leads and clinical area managers in September 2014.

Fifty Five standards within twelve categories were audited, developed from the East and South East England Specialist Pharmacy Services audit tool and 2012 MEH audit tool, (local policies and the Duthie report March 2005):

1. Access to information, including policies
2. Supplies and ordering of pharmaceuticals
3. Storage and security arrangements of controlled drugs (CDs)
4. Storage and security arrangements where medicines cupboards are located
5. Refrigerators
6. Flammables
7. Keys
8. Waste medicine arrangements
9. Security of FP10 prescription pads
10. Patient's Own Drugs (PODs)
11. Gas cylinders
12. Supply of medicines by nurse

85% or above = **GREEN** = Good compliance
84% to 56% = **AMBER** = Improvement on certain standards required
55% or below = **RED** = Immediate, wide scale action required

The findings are summarized as follows:

In the 2013/14 audit the overall (average) compliance for the Trust was 86% with a **GREEN** RAG rating which was better than the 2012 audit which recorded a compliance of 83%.

Out of the 65 areas within the Trust, **62%** (n=40) of sites all recorded an average compliance of 85% or more compared with 2012 in which, out of the 49 areas within the trust, **73%** (n=36) of sites recorded an average compliance of 85% or more. Although the proportion of areas with compliance scores of 85% or more had reduced from 2012, there were more top scores of ≥90% in 2013/14 and those areas in the amber zone were at the higher end and no clinical area scored in the red zone in 2013/14. Altogether, there was an improvement in compliance scores for the individual clinical areas which increased the overall average compliance in 2013/14 and this is due to the improvements made after the first audit such as delivery of medicines to satellites, storage of FP10s, record keeping of delivery notes and implementation of recommended cabinets for controlled drugs.

Most of the areas of non-compliance highlighted in this latest audit have been addressed e.g. immobilizing trolleys by securing or clipping to the wall in treatment room and segregating internal and external medicines. However there are some actions that are ongoing and challenging due to our infrastructure and clinic set up, such as:

- The availability of locked compartments for all prescription charts in clinics
- Ensuring that when clinics are not in use, all medicines are returned to a locked cupboard
- Ensuring that rooms where medicines are stored are temperature controlled

The Clinical Governance Committee recommended the documentation of these outstanding actions in the trust risk register while work is ongoing to address them.

Controlled drug (CD) management and regulations

Pharmacy conducts quarterly CD checks at all clinical areas which store and administer CDs (Schedule 2 and 3). During our quarterly CD checks at City Road theatres in October 2014, the compliance recorded was 80-85%. Some common errors and themes were identified in the CD register (record books) and the matters have been raised with the relevant leads to address with staff. Useful information on handling CDs and recording in the register was included in our last safety bulletin.

Medication safety initiatives

i. Medication Safety Thermometer. We have been contributing monthly to the data on the NHS medication safety thermometer. This is a national tool with a three step process that measures medication error and harm from error which can identify the level of harm free care we provide in relation to medicines. The first step requires the collection of data on the reconciliation of medicines, allergy status, number of regular medicines,

medication omissions, critical medicine omissions and high risk medicines. The second and third steps require granular information if a patient is receiving any of the listed high risk medicines and if question responses indicate triggers of potential harm. The NHS Safety Thermometer web tool is used to submit and analyse data through a suite of resources. We have now collected data on patients admitted to our in-patient ward for the past 4 months and have recorded 100% compliance for the first step of this process without the need to progress to Step 2.

ii. Utilizing electronic queuing system (QMATIC) in Pharmacy to enhance patient experience. This system consists of informatics display and audible call-out to identify patients and was introduced in Q3. It also allows full management of the patient pathway through the Pharmacy dispensary. It has several advantages that can improve patient experience within Pharmacy:

- Live patient waiting times and information display for patients to inform on prescription progress
- A loud speaker system so patients can hear easily called out numbers especially if visually impaired
- A large informative display screen so patients can see visually how many prescriptions are in the queue
- Can prevent the handing out of prescription to the wrong patient as every patient has a barcoded ticket

g. Safeguarding

Safeguarding children

The trust continues to work towards the guidance outlined in the 'Working Together to Safeguard Children' (2013) statutory guidance and the London Child Protection Procedures (2013). The trust achieved the final two standards in the Section 11 Audit through including a specific safeguarding children and young people section in the Trust Complaints Policy in December 2014 and by submitting the monthly safeguarding children training compliance figures quarterly to the NHS North Central London Commissioning Group (Islington) Designated Child Protection Nurse.

Training remains a priority for the Trust with a target rate of 80% compliance with staff being required to update their training compliance 3 yearly, different levels of training being required for staff with different degrees of involvement with children. A review of training requirements is currently being undertaken by the Named Nurse for Safeguarding who was appointed at the end of 2014.

	Quarter 2			Quarter 3			
Reportable Mandatory Requirement	04/08/14	08/09/14	06/10/14	03/11/14	07/12/14	07/01/15	Target
Child Protection – Level 1	70%	71%	70%	72%	84%	81%	80%
Child Protection - Level 2	84%	86%	86%	86%	83%	80%	80%

Child Protection - Level 3	100%	100%	100%	100%	81%	81%	80%

The Trust is represented on the Islington multi-agency Safeguarding Children's Board by the Executive Lead for Safeguarding who is also the Director of Nursing & Allied Health Professions. The Named Nurse for Child protection continues to represent the trust on the board's training sub-committee. The trust continues to prioritise the core business of the safeguarding board which is focussing on neglect, domestic violence and transition from child to adult services. The Moorfields safeguarding team has supported the board with its preparation in advance of a Care Quality Commission Looked after Children Inspection and has submitted documentation that outlines the quality of our service, for example feedback from children about their hospital visit.

A review of incidents during this reporting period did not identify any worrying trends or omissions of care. The safeguarding teams continue to receive alerts and concern form referrals identifying domestic violence. This aspect of safeguarding remains a priority area for the Trust and work continues to ensure that staff have the appropriate training and resource to manage this issue appropriately.

Safeguarding adults

The Care Bill received Royal Accent on 14th May 2014 and becomes the Care Act from April 2015. The Care Act represents the most significant reform of care and support in more than 60 years and will make safeguarding adults boards statutory and place a duty of candour on providers about failings in hospital and care settings. There will be a requirement for organisations to work more closely to protect people who need help and support. A greater emphasis will be placed on lessons learnt from safeguarding adult's case reviews. As part of the due diligence process, the trust will be reviewing the implications of the Act and any actions we may need to introduce to ensure that we are working within the new legal framework. The Act also includes 3 additional types of abuse:

- Self-neglect
- Domestic Abuse
- Modern Slavery

Islington Safeguarding Adults Partnership Board: The Trust is represented by the Director of Nursing and Allied Health Professions, who is the Trust Executive safeguarding lead. Te Trust presented to the board an overview of Moorfields' progress against the Compassion component of the 'the 'Six Cs' – the nursing strategy for England. The board were briefed on our introduction of the 'Here to Help' initiative, a card given to patients on admission to the hospital, that identifies the nurse who will be caring for them for the duration of their stay. An example of the 'Helping Hand' sticker, a discrete sticker that signifies that a patient requires assistance with their personal care, was also shared with the Board.
The trust is also represented on the Violence against Women & Girls (VAWG) Network, a forum that focuses on the management of disclosures of domestic violence, an area of safeguarding that Moorfields has identified as a particular issue.

Moorfields' Safeguarding Adults at Risk Group. This group continues to be well attended by clinical and managerial staff from across the trust and also by the Head of Safeguarding Adults at Islington Council. The group meets on alternate months and reviews all safeguarding referrals. It monitors progress against the objectives set against the yearly work plan an action of which is to measure our performance against the Safeguarding Adults Assurance Framework (SAAF). The trust's ongoing performance against the assurance framework is positive but a review has identified the need to provide an additional resource to the safeguarding team and a full time adult safeguarding lead joined the trust in January 2015.

Achievements against work plan

- A leaflet has been produced for bank/agency staff explaining how to identify indicators of abuse in adults and children and how to report a concern.
- A staff information sheet has been updated detailing the pathways of care for patients with dementia and learning disabilities.
- Production of a pocket prompt for staff that includes key facts about mental capacity and the consent process.

Examples of Safeguarding Adult at Risk referrals to Safeguarding Teams

- 90 year old lady attended clinic with their carer – concerns raised by staff about patient's appearance and also behaviour of carer who staff felt was controlling and overpowering.
- Gentleman came into the hospital thinking he had an appointment unable to give date of birth or full address, staff recognised the patient and discovered that he did have an appointment but not on that particular day. Clinic staff were unable to track down relatives at the time and the GP was contacted - patient has been recently referred to the memory clinic for further investigations.
- Staff in clinic observed an elderly male patient, who was in a wheelchair, being slapped by the relative/ carer who was with the patient.
- A 58 year old man presented to A&E with a bruised right eye alleged he had been assaulted by partner's 16yrs old child.

Safeguarding Adults Training

	Quarter 1	Quarter 2			Quarter 3		
Safeguarding Adults	02/07/14	04/08/14	08/09/14	06/10/14	03/11/14	07/12/14	*Target*
Safeguarding Adults	81%	81%	81%	81%	82%	65%	80%

With the implementation of the new trust learning management system, several non-clinical staff members had not had safeguarding adult training identified in their training profile and were therefore non-compliant. To address this a leaflet was designed and circulated to increase compliance levels. A review of training requirements is currently

being undertaken by the new safeguarding adult lead with the development of a training strategy.

Dementia initiative. The trust continues to train staff in how to recognise and care for patients with dementia as part of the UCLP/MEH dementia awareness project. As of September 2014, 826 (46%) members of staff have received training incorporating the "Barbara's Story" DVD and training sessions continue. The majority of staff who have received training work in a clinical role but the trust is committed to continuing the training sessions for all staff and the aim is to achieve 80% coverage by the end of 2015. The Dementia Policy has been updated to include information about the application of the "This is Me" booklet. The document is a practical tool used by patients (or carers) with dementia. The tool identifies specific patient needs and assists staff in caring for patients in an individualised way. The document captures specific health information which reduces the risk of incidents / communication errors during clinical consultations.

Learning disabilities. The learning disability policy has been updated following a peer review led by a Clinical Nurse Specialist specialising in learning disabilities. The review, in part, was requested by Moorfields following a concern raised by a patient in May 2014 who had attended the A&E Department and had a poor experience with regard to staff making reasonable adjustments during their visit. The case was reviewed by the A&E senior management team and actions put in place, for example, prioritising the patient at triage and fully utilising the easy-read clinical information booklets available in the trust. The updated policy reinforces the key messages about the importance of making reasonable adjustments for this group of patients. A further piece of work is needed to scope the requirements for patients who attend multiple clinics appointments in different specialties with a view to creating a separate pathway of care.

Deprivation of liberty and mental capacity. The Deprivation of Liberty Safeguards were introduced on 1 April 2009 to safeguard people who lack capacity. These safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. Following a Supreme Court judgement in March 2014, the Court identified that to determine whether a person (without the mental capacity to consent to the arrangements) is being deprived of their liberty, the following 'acid test' should be applied:-
Is the person subject to continuous supervision and control?
Is the person free to leave?
This judgement has increased the number of people who now fall within the scope of what constitutes a deprivation of liberty and where this occurs authorisation is required. The trust has made no requests to the borough for a Deprivation of Liberty Safeguard authorisation during this period.

In September 2014 the trust received a report from the Parliamentary Health Service Ombudsman (PHSO) that partially upheld a complaint raised by a patient's daughter that the trust had failed to adequately document the process of ascertaining the patient's capacity to consent for surgery. The key messages from this report have been shared with clinical staff and the introduction of the pocket prompt highlighting best practice when obtaining consent has been

produced and will be given to all clinicians. The consent policy has also been amended to strengthen the information on the assessment of patients who may lack capacity.

2. Clinical effectiveness

a. Policies, Guidelines, Protocols, Standard Operating Procedures

The following documents were approved in the time period:

Title of Document	Type of document	Status
Botulinum Toxin Policy	Policy	Review
Producing patient information policy	Policy	New
Being Open Policy	Policy	Review
Draft Blood Borne Virus Policy	Policy	New
Management of Creutzfeldt-Jakob Disease (CJD)and variant CJD policy	Policy	New
Sharps Policy	Policy	Review
Viral Haemorrhagic fever (VHF) policy	Policy	New
CPE management Policy	Policy	New
MRSA Screening Policy	Policy	Review
Controlled Drug Policy	Policy	Review
Policy for Nurse Supply of Medicines	Policy	Review
Consent Policy	Policy	Review
Medicine Policy	Policy	Review
Moorfields Direct Line Advice Line Operating Protocol	Protocol	New
Paediatric Accident and Emergency Escalation Protocol	Protocol	New
Guideline for Nursing staff on Measurement of Intraocular Pressure (IOP) on Patients attending the Medical Retinal Service clinics.	Guideline	New
Protocol for the transplantation of ex-vivo cultivated epithelial cells onto the surface of the eye.	Protocol	New
Process for requesting a medicine or indication to include onto Moorfields Eye Hospital NHS Foundation Trust formulary	Formulary information	New
Specialist Paediatric Optometrist Protocol	Protocol	New
Paediatric A&E nurse practitioner practice protocol; diagnosis and treatment of chalazia	Protocol	New
Paediatric A&E advanced nurse practitioner practise protocol; diagnosis and treatment of Corneal Abrasions Practise Protocol	Protocol	New
Cataract Clinic guidelines for Optometrists	Guideline	New

Intra Ocular Lens Measurement Guideline (Adult)	Guideline	Review
Guideline for selection of intraocular lens	Guideline	Review
Collecting a patient specific intraocular lens	Guideline	Review
Technician-led stable Glaucoma Monitoring Service	Guideline	New
Guidelines for the maintenance, decontamination and disinfection of mattresses, couches, trolley covers and pillows.	Guideline	New
Medical Retina service guideline	Guideline	New
Surveillance Policy	Policy	New
Isolation Precautions Policy	Policy	Review
Homecare Service Policy	Policy	New
Policy for the safe use of oral methotrexate and adults and children	Policy	Review
Policy for surgeons joining the refractive service	Policy	New
Non medical prescribing policy	Policy	New
Policies approved but awaiting ratification		
Caring for Patients with Dementia Policy	Policy	Review
Learning Disability Policy	Policy	Review
Paediatric Transition Policy	Policy	Review
Pharmaceutical Representative Policy	Policy	New
Paediatric Fluorescein Angiography Policy	Policy	Review
Interpreting and Translation Policy and procedure	Policy	Review
Thromboprophylaxis Policy	Policy	Review
Clinical Diagnostic Tests and Screening Procedures Policy	Policy	New

b. National Confidential Enquiry (NCE)

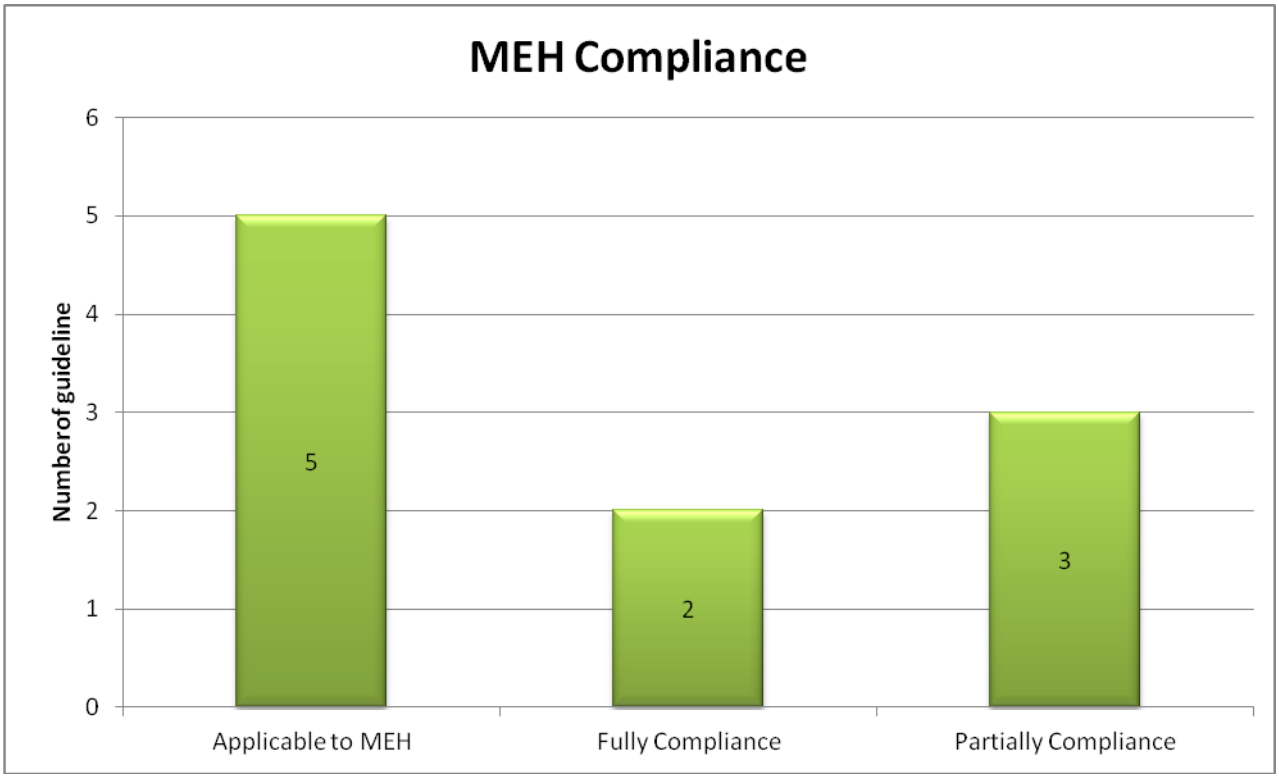
The Trust is 100% compliant with existing NCE (National Confidential Enquiry) guidelines.

c. National Institute for Health and Care Excellence (NICE)

The following NICE guidance had been considered and accepted as relevant to MEH in the period. The table and chart below show the guideline and compliance status.

Type	NO	Title	Service	Status
QS	66	Intravenous fluid therapy in adults hospital	Trustwide	Partially compliant
CG	183	Drug allergy: diagnosis and management of drug allergy in adults, children and young people	Pharmacy	Partially compliant

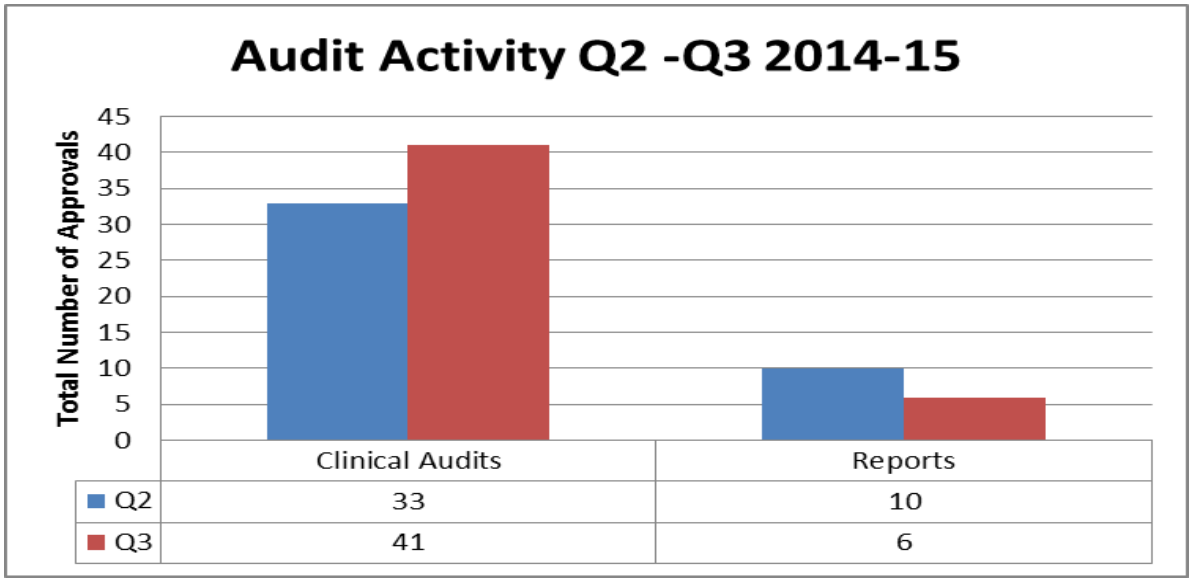
QS	74	Head injury	Accident and Emergency	Fully compliant
CG	189	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults	Nursing	Fully compliant
MTG	20	Parafricta Bootees and Undergarments to reduce skin breakdown in people with or at risk of pressure ulcers	Nursing	Partially compliant

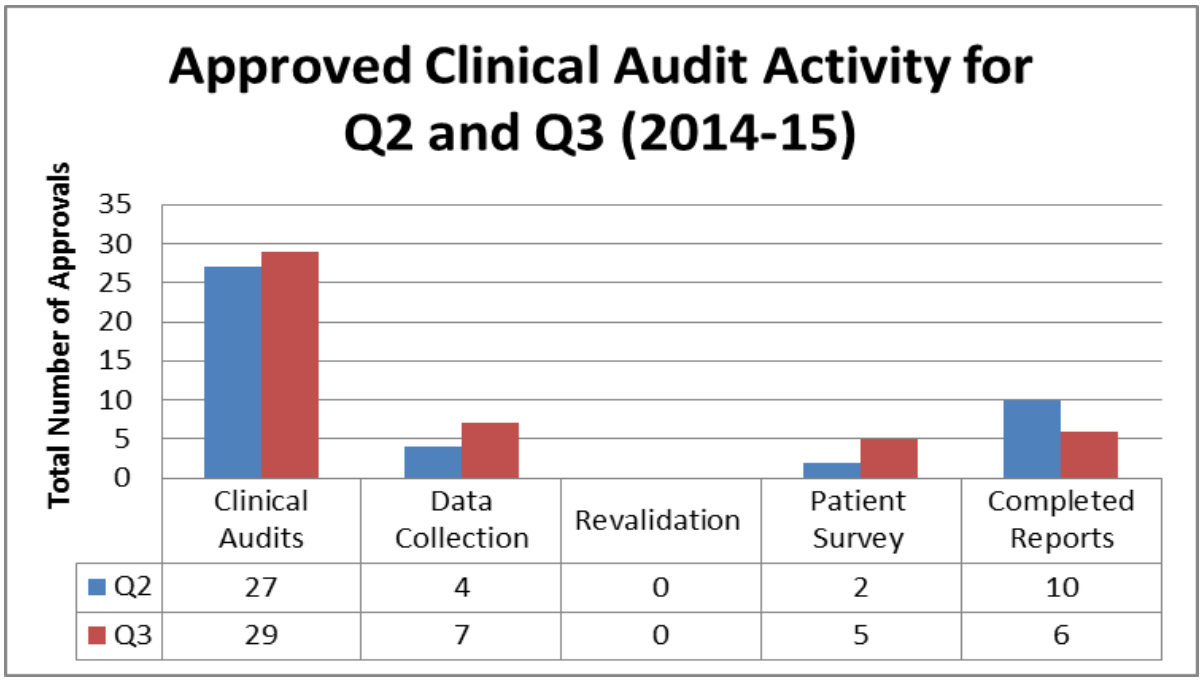


For the 3 partially compliant, this relates to elements of the guidance which do not apply to Moorfields as a specialist trust, not a failure to comply with requirements for our service provision.

d. Clinical audit and outcomes

Clinical audit and related activity (data collection and patient surveys) remains high but there is a drop in completed reports received from previously proposed projects. The reduction in reports may relate to the cancellation of the September CG half day, where which audits are usually presented and overdue audits are chased, due to the requirement for greater activity to address the RTT18 serious incident.





Core outcomes. Many of the annual core outcomes are currently being re-audited as we approach the end of the 2014/5 year. Those which are completed continue to show good results. Of note, the numerous actions put into place for ensuring patients with severe diabetic retinopathy receive suitably urgent clinic appointments, and laser if indicated, are greatly improved and well above the required standard, and the results of refractive procedures for myopia are outstanding.

Whilst we await the results of our repeat core graft outcomes, which will be shared in March in another joint meeting with colleagues from Kings College and Addebnrookes Hospitals, as we did last year, great effort has been made to increase the completion of the national graft audit "yellow forms", with definite improvement particularly in the last couple of months. The intravitreal service business case was approved, which provided funding for a staff member to help analyse injecting outcomes, which should improve our ability to continue to report accurately as numbers of these procedures continues to rise.

Specialty	Metric	Standard	13/14	14/15 YTD

Cataract	Posterior capsular rupture (PCR) in cataract surgery	<1.8%	0.9%	1.06%
Cataract	Endophthalmitis after cataract surgery	<0.08%	0.04%	0.03%
Cataract	Biometry accuracy in cataract surgery	>85%	85%	reauditing
Cataract	Good vision after cataract surgery	>90%	91%	reauditing
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	≤15%	6%	reauditing
Glaucoma	PCR in glaucoma pts	<NOD	1.01%	reauditing
Glaucoma	Glaucoma tube drainage surgery failure	<10%	%	reauditing
MR	Endophthalmitis after injections for macular degeneration	<0.05%	0.03%	0.01%
MR	Visual improvement after injections for macular degeneration	>20%	20.7%	96.2%
MR	Visual stability after injections for macular degeneration	>80%	90.2%	26.9%
MR	Time from referral to assessment of proliferative diabetic retinopathy	80%	51.5%	87%
VR	Success of primary retinal detachment surgery	>75%	88.3%	reauditing
VR	Success of macular hole surgery	>80%	80.6%	reauditing
VR	PCR in cataract surgery in vitrectomised eyes	<NOD	1.6%	reauditing
NSP	Serious complications strabismus surgery	<2.2%	0.3%	0.23%
NSP	Premature baby eye (ROP) screening compliance	95%	100%	100%
NSP	Success of probing for congenital tear duct blockage	> 85%	86%	reauditing
Ext Dis	DSAEK corneal graft failure rate	≤12%	8.9%	reauditing
Ext Dis	PK corneal graft failure rate	UKTS	8.5%	reauditing
Ext Dis	DALK corneal graft failure rate	UKTS	6.7%	reauditing
Refractive	Accuracy LASIK (laser for refractive error) in short sight	>85%	88.7%	93.7%
Refractive	Loss of vision after LASIK	<1%	0	0%
Refractive	Good vision without lenses after LASIK	≥80%	87.9%	96.1%
Adnexal	Ptosis surgery failure	<15%	5%	reauditing
Adnexal	Entropion surgery success	>95%	97.5%	reauditing
Adnexal	Ectropion surgery success	>80%	100%	reauditing
A&E	Unplanned reattendances	<5%	1.5%	0.7%
Serious incidents and never events				
Incident	Wrong pt	0	*0*	0
Incident	Wrong side	0	*0*	0
Incident	Wrong IOL	0	2	5

3. Patient experience

a. Friends and family test.

The main measure of patient satisfaction at Moorfields is the Friends and Family Test (FFT), which is currently run at 42 sites. Patients can rate how likely they are to recommend our service to friends and family and also allows patients to comment on their care. The trust submits the results for A&E and overnight admissions to NHS England for publication on their website. Following a national review, it was decided that the FFT score was difficult to understand and its methodology weak, so from September 14 a simple comparison score has been used of the percentage of those completing the test who would recommend the trust (i.e. Extremely likely and Likely) against the percentage of those who would not (i.e. Unlikely or extremely unlikely). There is no FFT score standard required but there should be a response rate of 15%. Though the majority of responses are still by card, the test is now available on the website and text /SMS options are being explored.

Year to date, approximately 61,800 patients from 42 sites across the trust have completed the FFT and the results and the comments are circulated to the trust management teams on a monthly basis, highlighting those areas where improvements might be made, and a quarterly summary is placed on the intranet and trust website. The results are also discussed in detail at the Patient Experience Committee.

A&E and overnight admissions

FFT response rate and scores for Q2 and Q3 have so far met/exceeded the CQUIN requirement. These results are reportable to NHS England and we compare favourably against the average for all other English A&E and overnight admission wards.

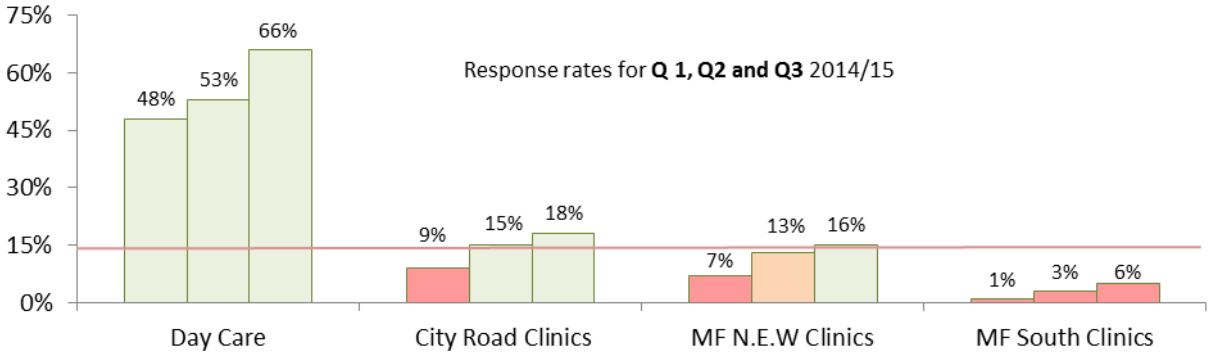
	MEH A&E Pt response	*NHS A&E Average*	MEH A&E FFT Score	*NHS A&E Average*	MEH overnight admission response	*NHS overnight average*	MEH overnight admission FFT Score	*NHS overnight average*
Q2 **2014/15**	**28%**	*20%*	**74**	*54*	**62%**	*37%*	**91**	*73*
Q3 **2014/15**	**27%**	*20%*	**76**	*55*	**71%**	*37%*	**94**	*73*

Using the new measurement criteria for Q3 2014/15 now used by NHS England:

					NHS Eng. Average*	
Overnight Admission wards	% who would recommend MF	**100%**	% who would not recommend MF	**0%**	**95%**	**2%**
Accident and Emergency	% who would recommend MF	**95.1%**	% who would not recommend MF	**1.3%**	**87%**	**6%**

Day Care and Outpatients

The CQUIN requirement is that that day care and outpatients achieve 15% response rate from October 2014 onwards. Most areas achieved this with staff at all levels engaging with the process and encouraging patients to participate. The notable exception is St George's clinic, which has lowered the overall outpatient response rate.



Day Care and Outpatients

Outpatients Q2	% who would recommend MF	**96.1%**	% who would not recommend MF	**1.5%**
Day Care Q2	% who would recommend MF	**98.4%**	% who would not recommend MF	**0.5%**
Outpatients Q3	% who would recommend MF	**96.8%**	% who would not recommend MF	**1.4%**
Day Care Q3	% who would recommend MF	**99.0%**	% who would not recommend MF	**0.3%**

The vast majority of Moorfields patients would be extremely likely or likely to recommend the trust and the reasons remain friendly and kind staff, professional attitude, good organisation and clinical outcome. Approximately an equal number of outpatient and day care patients felt that waiting times were either a problem or commented that they were seen quickly.

- *"New patient in clinic today - very impressed with thorough examination - support and explanation of Glaucoma - thank you for front of house and nurse and doctors professionalism"* Glaucoma clinic 2"
- *"Because each time I have been here the staff from cleaning staff to top consultants everyone treats me with such kindness and respect"* Mackellar Ward
- *"Everyone from reception to consultant were very helpful and caring - everything was explained to me in great detail and the doctors listened to what I had to say without making me feel that I was wasting their time. All round a very pleasant experience"* VR clinic CR
- *"Their kindness attendance was superb. Everything everyone you cannot fault in any way. Thank you all so very much will certainly recommend to everyone, surgery exceptional too."* Potters Bar
- *"Thank you for the extremely high quality of staff you obviously have very experienced and knowledgeable from reception and all the way to operation to the eye surgeon. Please look after your staff - they look after us patients and your reputation depends on them."* Satellite Clinic

The positive feedback from our patients is especially rewarding when staff are individually mentioned and recognized for their contributions to patient care, in

November 2014 for example, 130 staff were named by patients. These personal comments are normally forwarded to the individuals concerned by their management teams.

For those patients who made adverse comments, waiting times. The other reasons given for not recommending Moorfields included: staff attitude (noting rude, abrupt or non-communicative staff); poor experience in clinics or errors made (an example being one patient who had surgery cancelled due to their having a pacemaker that was not recorded); administrative issues, including lost or missing appointments, or appointments being cancelled and them not being informed. Other issues were about the location or environment of the clinic or day care unit they were seen in. Typical comments were:

- *"I have been here for four hours. Only when I asked was I told that my notes were being looked for. Lack of communication. Not impressed. Shocking."* Clinic
- *"I came to the hospital at 12.30pm and time is now 17.05pm - while I was with the doctor at my appointment I was watching the other (exam) rooms and all doctors sitting in their room alone and doing nothing - in the waiting room there was 35 patients waiting for their turn - so is this fair? Staff do not knowing what they are doing."* Clinic
- *"Receptionist was unprofessional, unhelpful and impolite. It was as if we were disturbing her peace, and she was doing us a favour. Customer care training required. No welcome and no smile."* Clinic
- *"Day care ward was perfectly OK - operating theatre was a shambles - not set up to surgeons' liking most of the staff were absent at one point (surgeon -"we need more people") someone argued - wrongly- at some length with the surgeon about a medical issue - the surgeon often had to explain what he wanted to people who did not understand his vocabulary. I would not tell someone to go to Moorfields on the basis of this experience which is why I would not answer question overleaf. But it was not good enough and could have made a patient very anxious."* Theatre
- *"Being a Muslim female I requested only first visit to be seen by a female clinician even though the consultant is female I was seen by all male clinician."* Clinic
- *"I had an appointment on the 14th October but when I came I was told it was cancelled - I received a letter on the 16th October"*

b. Accident and Emergency Survey 2014

The NHS National Accident and Emergency survey 2014 was carried out by the Picker Institute on behalf of Moorfields, capturing the opinions of a random selection of patients who attended the trust between February and March 2014. The survey is part of the series of surveys required by the Care Quality Commission (CQC), the results of which are published, alongside the other 142 trusts taking part in the survey, on their website. This survey was reported in October 2014.

The trust receives two interpretations of this survey. The report received from the Picker Institute reports the findings as a percentage breakdown for each response to any particular question and allows for internal benchmarking of performance against previous surveys. The CQC published results are 'standardised' to enable a better comparison between trusts. The results for each question, given on a scale of between 1 and 10, are calculated to ensure that secondary responses e.g. '...to some extent', form part of the weighted score, as is demographic data such as the age, gender and number

of respondents. The CQC also compares scores achieved by the other 142 trusts taking part in the survey and calculates an 'expected range' within which Moorfields scores should fall. Each question is then scored as to whether Moorfields result is 'better', 'about the same' or 'worse' when compared with most other trusts in the survey. This grading, along with the numerical score, is what appears on the CQC website.

Positive Feedback (Score of 9 or above)

- Patients did not feel threatened by other patients or visitors 9.7
- A member of staff explain the purpose of the medications to the patient 9.4
- Doctors and nurses listened to what the patient had to say? 9.2
- Patients were given enough privacy when being examined or treated 9.2
- A member of staff did not say one thing and another say something different 9.2
- Overall, patients felt they were treated with respect and dignity 9.1
- Enough information about condition or treatment given. 9.1
- Did doctors or nurses talk in front of you as if you weren't there? 9.0

Negative feedback (Score of 6 or below)

- How long did you wait before being examined by a doctor or nurse? 5.3
- Were you told how long you would have to wait to be examined? 5.5
- If you were feeling distressed, did a member of staff help you to reassure you? 5.8
- Did a member of staff tell you about medication side effects to watch for? 4.4
- Did hospital staff take your family or home situation into account when you were leaving the A&E Department? 3.8

The following questions were not necessarily low scoring but Moorfields did achieve the lowest score of the 142 trusts who undertook the survey:

How long did you wait before being examined by a doctor or nurse? 5.3
Do you think the hospital staff did everything they could to help control your pain? 6.3

The A&E survey also gave the opportunity for patients to comment on their care:

- *"Moorfields was a very positive experience. The care I was given was excellent. At all times I felt confident I was being looked after and as a priority. I could not say enough good things about the nurses & doctors who assessed & treated me."*
- *"The experience at Moorfields was very good I cannot say how much I was impressed with all the staff I met. They are very professional, helpful, knowledgeable and friendly. An excellent team."*
- *"I have nothing but praise for the way I was treated and for the patience and caring attitude of all staff at all levels. My problem was a scare but turned out to be something I just have to live with. I was very worried when I arrived but was reassured by my treatment, examination and the explanation I was given. The efficient was so many people were seen to, with dignity and compassion and professionalism was truly wonderful. Many thanks to all involved."*
- *"When you are on your own it would be nice to know where you were in the queue so you could go and get something to eat or drink or even go to the toilet without missing being called."*

- *"It was not made clear regarding the best place to be seated in order to hear your number called for the initial assessment. Otherwise, a positive experience only spoiled by the overall waiting time."*
- *"Medications should be more thoroughly explained. Knowledge level of patient should be checked & not assumed.*

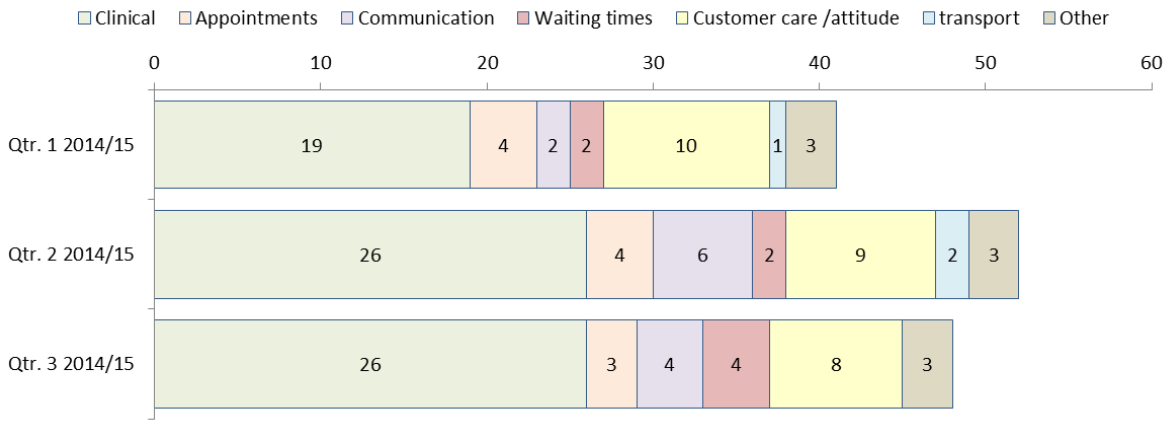
The A&E staff have reviewed the findings of the survey and are developing an action plan to address the issues where there is room for improvement. These improvements will be driven the A&E service meetings and reported to the Patient Experience Committee, and outcomes will be included in future patient experience reports.

c. Complaints

Complaints received by quarter 2013/14 and 2014/15

	Q1 2014/15	Q2 2014/15	Q3 2014/15
	41	52	48
Percentage of patients seen who went on to complain	0.02% (147,198 patients seen)	0.03% (150,171 patients seen)	0.03% (159,583, patients seen)
Complaints per 10,000 patient contacts	2.7	3.4	3.3

Complaints received by type Q1 2014/15 and Q2 2014/15



Clinical complaints.

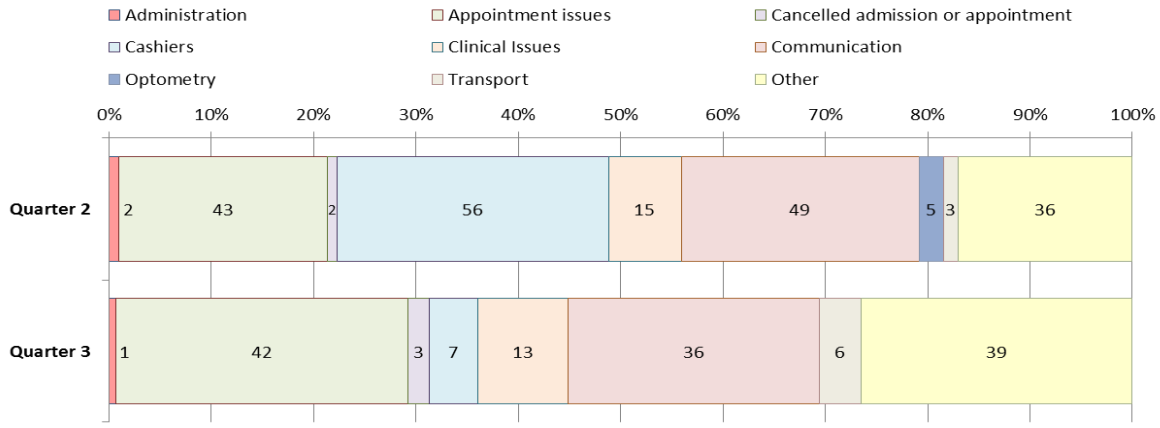
Clinical complaints continue to be the most common cause of complaints. Most focused upon what the patient felt were problems caused by treatment. These included receiving the wrong surgical or medical treatment, not having their concerns taken into account, not being involved in decisions and being given the wrong drops etc. Other clinical complaints concerned the outcome of treatment which might be due to doctor error, delays to surgery, errors made in the past or that the treatment given did not work or the care patients received in clinic.

The number of complaints regarding customer care and staff attitude was almost the same as the previous quarter. Most of these were in regard to what was perceived as unprofessional or offhand behaviour on the part of doctors, drivers, ophthalmic technicians, nurses and receptionists.
Appointment issues that were dealt with as complaints were the result of patients having their appointments cancelled at short notice and one being delayed which caused problems for the patient. Complaints about communication included patients being dissatisfied with the quality of their GP letter, a patient mistakenly being called in for a consultation, a patient having two sets of medical records, and one complaining about the difficulty in getting through on the telephone.
Other complaints were concerned with why a patient was discharged from the cataract service, the condition of a high street optician's premises where Moorfield's patients are referred, perceived lack of hygiene in clinics and excessive waiting time, including one patient who was seen quickly and felt that the warning of a two hour wait was designed to deter people from attending.

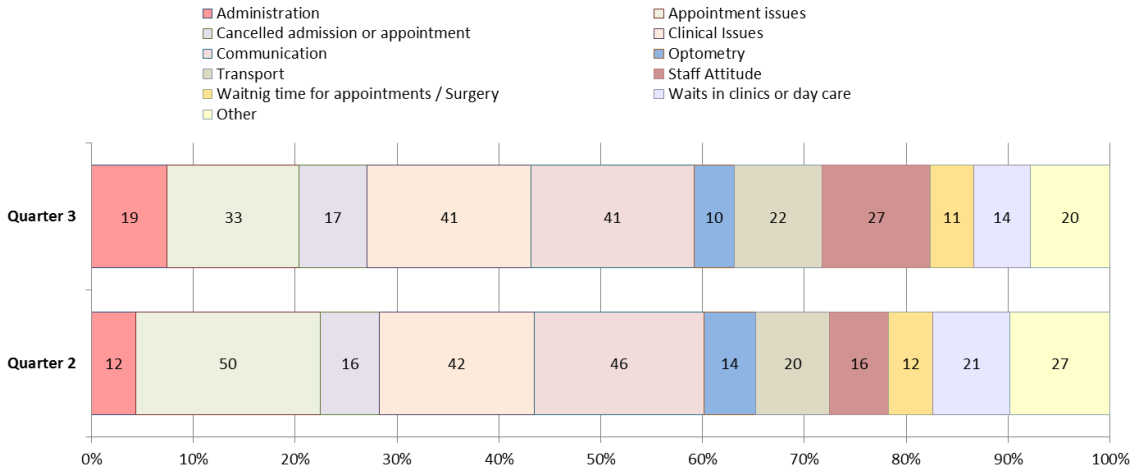
d. PALS enquiries and concerns.
There were a total of 533 PALS enquiries for Q2 compared with 447 for Q3. The drop was partly due to the cashiers enquiries being handled in a different way so that patients no long need to come to the PALS office to confirm their eligibility for transport costs. There was also a notable drop in the number of patients contacting PALS because they could not get through on the telephone, down from 40 in Q2 to 15 in Q3 which we hope is due to the changes from the telecommunications project starting to take effect, as there was also a fall of appointment enquiries to the office regarding appointment issues, down from 93 in Q2 to 77 in Q3.

There were 46 compliments received in Q2 and the 45 compliments received in Q3.

Information and enquiry requests received by PALS Q2 and Q3 2014/15



Concerns and informal complaints Received by PALS Q2 and Q3 2014/15



e. Actions taken in response to patient feedback.

Though many improvements are made in response to feedback gathered from the FFT, patient surveys and complaints at a local level and address local issues (such as ensuring patients are assessed for pain in the A&E, new chairs, strategies for keeping patients informed, more soap dispensers, individual staff behaviour, etc.), many other issues raised by patients are being addressed through trustwide initiatives aimed at addressing some more widespread problems and behavioural issues that give rise to patient frustration. The Moorfields Way project is bringing staff and patients together to identify shared beliefs and values that will inform future staff training, appraisal, recruitment and behaviour management. The Transformation project will address issues such as delays, appointments handling, telephone access, customer service, etc. and, if successful, will address most of the the issues raised in the comments and surveys outlined above. Other areas being addressed are:

- Currently the templates for all letters sent by the trust to patients and GPs (which are copied to patients) are being reviewed to make them simpler to understand (e.g. follow up appointment letters are now just one sheet) and the maps that accompany them have been re-designed to again make them much clearer to follow but also identify the Moorfields clinic area within the host trust site rather than being the standard host trust site map. This is an issue that has repeatedly been requested by patients through the FFT.

- The information that was included in previous letters is now to be contained within the Moorfields Patient Booklet, due to be published in the New Year, which will be sent to all new patients. This includes information on Moorfields services, where to find support and, most importantly, who patients should contact if they have a specific issue.

- To support patients in better understanding their conditions and treatments, the Editorial Committee continues to promote and approve patient information leaflets. There are currently 85 approved leaflets available to staff in the clinical setting with a further 102 under development or awaiting approval. The first of our patient education videos have also been produced and are on the Moorfields 'YouTube' page and will be embedded in the trust website page in the coming months.

- The Transport Committee was re-established in 2014, including a representative from the provider, and meets every two months and reviews all incidents, PALS and complaints and patient feedback in relation to transport issues and identifies ways in which problems can be prevented from recurring. For example, day care patients are now kept on the ward until their transport is ready, so that they are not left uncared for if there are delays. Calling of the patient two days prior to the visit has been formalized and a 'Calling Card' is being introduced, so that if a patient is waiting for transport and does not hear them call, the card will be left asking them to call the transport desk.

- A group has been established to look at how visual impairment awareness training can be best delivered across the trust following comments from several patients that sensibility among staff in this regard is lacking. Patients are currently being asked their opinion and a program of face to face training is being developed for certain staff groups, with a training package, including a video shot at Moorfields for those not in daily contact with patients.

- Dementia awareness training is continuing for all staff with over 850 so far having been trained during 2014 and an online support package currently being developed.

Examples of service change following on as a response to complaints includes:

- Exploring the possibility of having multifocal glasses lenses available to patients through the voucher system (currently not allowable under Department of Health guidelines).
- Expansion of the Moorfields Direct helpline with more staff and improved promotion of the telephone number.
- Increasing provision of onsite dispensing so that medications can be dispensed on patients return from surgery and reduce discharge delays.
- The Medical Director has issued guidelines for how patients should be informed if patients are no longer eligible for Moorfields care (rather than only receiving a copy of the GP letter).
- More effective devices are being issued to drivers to keep them better informed of changes to transport arrangements when they are in the field.
- More leaflets are being made available in braille so the patients do not have to wait for them to be produced should they request one.
- Improved guidelines for the recording of capacity assessments as part of the consent process are to be included in a new Metal Capacity, Deprivation of Liberty and Patient Restraint policy. All clinical staff are to receive a pocket prompt dealing with mental capacity.
- Copies of GP letters are being reviewed to ensure the patient is made aware of the importance, to them, of the contents of the letter.
- Several staff have been advised of their future conduct following complaints about the way they spoke to patients. More generally, administrative and nursing staff at various sites have undertaken customer service training, including telephone etiquette, following specific issues raised by patients.
- Following a complaint, high street optometrist services to which patients will be visited and re-inspected.
- A patient complained they were not given appropriate advice after being discharged from a Moorfields service. As a result, the Moorfields Patient Information booklet will carry advice to visit an optician at least every two years for a check-up.
- The OpenEyes patient record system will be adapted to include patient allergies on prescription forms, following an incident where this was missed.

- The process that ensures patients with a cardiac history who are required to see an anaesthetist prior to surgery is being strengthened following a complaint where a patient was seen in pre-assessment and this did not happen.
- Following several complaints regarding clinic waiting times, especially in the late afternoon, patients now receive a voucher for Costa Coffee should they wish refreshments.
- The complaints policy now specifically encompasses the research department following some confusion as to how complaints received by them should be handled.

4. Compliance with healthcare regulators

The compliance function has the following objectives:

1. Develop and manage a risk, evidence and judgment based approach (the quality and safety assurance model) to:
    a) assess compliance and safety culture for the organisation,
    b) identify areas of concern requiring review and improvement,
    c) undertake and oversee assurance activity for the Quality and Safety Committee (QSC),
    d) develop early warning systems for potential serious failures in quality.
2. Undertake deep dive reviews of key areas of concern as agreed by the Quality and Safety Committee, which require more in-depth analysis.
3. Develop and oversee a compliance program of internal and external compliance for MEH, including CQC inspection readiness.
4. Develop effective relationships with services and directorates to share learning, to drive safety and quality improvement.
5. Act as a learning and improvement hub, coordinating learning from the many and various data sources: incidents, complaints, claims, walkabouts, clinical audit, external inspections and audits, performance, friends and family, In Your Shoes, etc.
6. Facilitate ward to board communication.
7. Horizon scanning, knowledge repository and corporate intelligence, scoping developments and innovations in regulatory compliance.
8. Help to facilitate safely acquiring new sites, and ensuring their compliance.
9. Underpin and support the principles of *The Moorfields Way.*
10. Ad hoc support, knowledge and skills sharing for various trust initiatives/activities.

Current compliance team activity

Quality and Safety Assurance Model: The function continues to support and facilitate the assurance and oversight activity of the QSC, to ensure that targeted remedial and supportive action is taken for non-compliant and / or high risk areas. The assurance model has been used to produce a list of priority concerns for the organisation and, in particular, the top six quality and safety specific concerns have been added to the committee's annual work plan. Work is underway to identify the relevant fora to which the remaining concerns can be allocated for further review and management.

Health records management was agreed to be a priority area for review (as identified previously by the committee and also via the assurance model by the Compliance Team) and was included in the QSC's annual work plan for 2014. The Compliance

Team undertook the first deep dive review, looking at health records management for the organisation in September 2014. The review method (which included a review of available evidence, interviews with staff and an unannounced visit to the health records library), key lines of enquiry and the scope were all agreed by the committee. The QSC has received and reviewed the in-depth analysis report which includes findings, recommendations and suggested improvement actions, and awaits an operational management response to the review, which will be presented to the QSC in April 2015. The completion of this activity has demonstrated the effectiveness of the assurance model, and the QSC is confident that the foundations of the model are robust, and will continue working to this method. The next agreed topic for deep dive review is *satellites and expansion.* The QSC is currently reviewing a draft scope for this review, which will be agreed by April 2015.

***The Worry List**:* The Compliance Team continues to undertake various engagement activities to capture concerns of staff to inform the "Worry List" in relation to risk and compliance. The engagement strategy has been broken down into three phases to ensure that the Compliance Team can engage with staff at all levels. Phase one, engagement with senior management, has come to an end and the interim findings were presented to the October QSC. The second phase, with clinical leads and remaining Heads of Department, commenced in October 2014 and is still underway, and the interim findings were presented in December 2015. The third phase encompassing staff on the ground commenced in January 2015 and is underway.

***CQC Readiness**:* The Quality and Safety team has commenced preparatory work in anticipation of a "new style" CQC inspection during the latter part of 2015. Whilst the CQC has not as yet released a provider handbook for specialist acute trusts, the quality and safety team are working to the existing general acute provider standards, to develop a programme of readiness activities.

Preparation: February – March 2015

- TMB briefing Jan 27th
- Build tools (e.g. handbooks, briefing packs checklists and assurance tools)
- Address resource/staffing requirements, Quality leads within service, gain external advice
- Develop communications plan and soft launch
- Collate existing information, develop organisational map and prioritise individual areas, and begin senior engagement

Education and Communication: from March 13th 2015 onwards

- Major communication launch
- Disseminate handbooks and self-assessment tools with explanations, visit service meetings/CG meetings/dept. and team meetings

Diagnosis and Prioritisation: April – June 2015

- Using data from self-assessment tools, organisational map, existing data and greater frequency walkabouts (data reviews and walkabouts)
- Identify gaps/risks/priority areas and enable assurance to ME, TMB, Board

Action planning and embedding: June 2015 onwards

- Local and central actions plans to be produced and actively managed going forwards
- Continue walkabouts, performance reviews, spot checks, educating/supporting staff to embed quality and ensure ready to speak to CQC

The Compliance Team is working on a programme of communication and materials including talks and presentations to services, as well as developing supporting materials for all staff which will include handbooks (for managers and all staff) and self-assurance tools.

Policies: The trust's policies are currently managed well with regards to accessibility, order and metadata (information about each policy), and a robust repository and register of documents is managed by the team. Issues of effectiveness in relation to approval and ratification, policy formatting and adherence to the corporate standard and naming conventions, have been identified. Improvement works are underway to address these issues, including a revised policy ratification process, additional interim support to format trust policies to fit the corporate standard, and a review of the names of policies is underway to improve accessibility on the intranet. The team is currently working to develop policy summaries (one page accessible and easily understandable summaries of key policies for staff) and is working with an external provider with a view to developing policy infographics for staff, to make policies more engaging and digestible for readers. This will further support CQC readiness preparation.

5. Conclusions

Moorfields has been active in its efforts to ensure quality and safety of care are constantly improved and an enormous amount of work continues to occur. Outcomes for care remain good so far, although many are currently being re-audited, and there are significant projects running to actively improve known issues with our patients' experience, such as communication and waiting times during outpatient clinics and day case surgery. Areas which are of current concern include insertion of the wrong intraocular lens during cataract surgery, paper health records related issues and the continued challenges of ensuring that all our patients receive their follow up appointments in a timely and clinically appropriate manner; for these issues there are many actions being taken. There has been an increase in work around compliance to provide deeper assessments on key issues for assurance and to ensure the trust is well prepared for a CQC inspection and uses that preparation to improve quality and embed quality into behaviours and practice in all staff at all sites.

Appendix: **Clinical Quality and Safety Performance Report MEHD**

Clinical Quality and Safety Performance Report MEHD; Quarter 2 2014/5 (1st July – 30th September 2014)

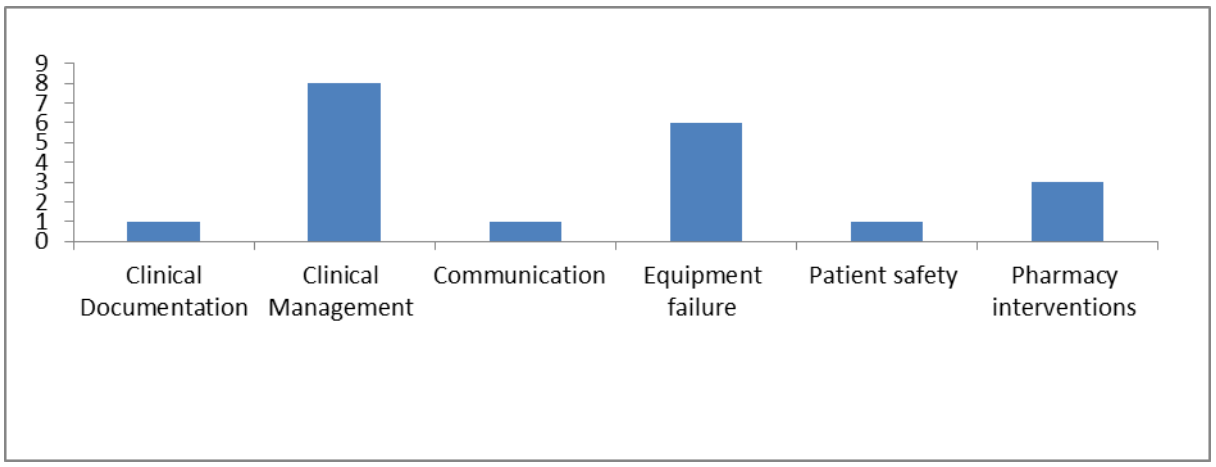
1. PATIENT SAFETY

A) Incident Reporting

Incident reporting at MEHD is a paper-based reporting system. When an incident occurs, each staff member should report it immediately (within 24 hours) to their line manager and together complete an Incident Report form. The line manager will inform the Quality Officer. Once the Incident Report is completed with actions, this should be handed to the Quality Officer for analysis of incidents and to provide an update on progress and challenges faced during the reporting period. The Incident Report forms can be located on the Moorfields Drive, M:\Incident Reporting. Guidance for completing these forms can be obtained from the Incident Reporting Policy (updated September 2014), from any Manager or the Quality Officer. We are currently looking at changing to an online IR platform based on WHO guidelines, similar to that used at MEH. This should be available during Q3.

Summary of Incidents;

Indicators	2014/15				
	Q1	Q2	Q3	Q4	YTD
Patient Safety Incident (PSI)	22	20			
All other incidents					
Total incidents	22	20			
Serious incidents (SIs)	0	1			
Never events (NEs)	0	0			



The SI involved finding a positive result of legionella in a water sample from one of the operating theatres in March 2014. This could have been due to technical issues with the building water supply but the problem has now been resolved.

On 26th January 2014, the Managing Director, Medical Director and Theatre Manager received an email from DHCC to inform of a technical problem with the water. The email stated;
This is to inform all building occupants that due to a technical malfunction at one of the plants at DEWA, the supply of water to DHCC and its neighbourhood has been saline the past 24 hours.
DHCC management is in communication with DEWA to resolve the issue at the earliest considering the risk to clinical operations and equipment. As an interim measure DEWA has agreed to supply potable water through tankers to replace the existing saline water stored in DHCC owned building tanks. Respective investor building management must follow up with DEWA for tanked water supply in the best interest of their occupants.
To further ensure safe operations of our business partners, DHCC facility management will initiate tank cleaning, water sampling and flushing of its piped water distribution system within the building to prevent corrosion and sedimentation inside the pipeline as soon as the problem has been resolved at DEWA.

The water was tested by MEDLAB on 11th March 2014 by taking swabs from all parts of the water system. The results returned back on 25th March 2014 showed positive for Legionella, 98 CFU/ml. This was only located in Theatre 1 tap water. All other theatres had a negative result.
The entire system was cleaned and flushed by DALKIA. The water was rechecked on 29th May 2014 and the results were returned back on 22nd June 2014. The results were still positive for Legionella but much reduced, 29 CFU/ml.
The system was re-cleaned by DALKIA on 26th June 2014. The sample was collected 20th July 2014 and returned 30th July 2014 but had not been checked for Legionella. A new sample was taken 14th August 2014 and returned 4th September 2014 showing less than <1 CFU/ml, a negative result.

During this time the water was not used. Avagard was used in theatres for scrubbing. Literature and policies were provided to staff to ensure safety and compliance. The water is now in use, however the sentinel outlets are being tested monthly. Once we have received at least 3 concurrent negative test results, we will modify the testing to a 3 monthly frequency, demonstrating control of the systems chemical dosing and ensure it is getting to all the outlets. This guidance is from the health and safety executives recommendations regarding Legionella testing from MEH. The Theatre Manager is responsible for ensuring this occurs in a timely manner and reports all results to the Quality Officer on a monthly basis.

In terms of learning, there was some delay during this process due to lack of information and updates from DHCC and a change in Theatre Manager. The confusion with the laboratories was discussed during a meeting between MEDLAB's Pathologist/Medical Manager and Laboratory Manager and MEHD's Theatre Manager and Quality officer.

B) Infection Control

Indicators	Target	Q1 14/15	Q2	Q3	Q4	YTD
C.diff infection	0	N/A	N/A			
MRSA bacteraemia	0	N/A	N/A			
E.Coli bacteraemia	0	N/A	N/A			

MSSA bacteraemia	0	N/A	N/A			
MRSA Screening	100%	*	*			
%Endophthalmitis post cataract	0.08%	0	0			
%Endophthalmitis post AMD/DR	0.05%	0	0			
Adenovirus possible hospital acquired	NA	0	0			

C. Difficile and E. Coli screening is not applicable at MEHD as the patients are out-patients/day case surgeries only.

*MRSA Screening is not currently carried out at MEHD. MRSA screening should have started in Q2. This has not been achieved. It will be started for theatre patients from Q3 under the leadership of Carlo Lopez, Theatre Manager.

C) Compliance

Indicators	Target	Q1	Q2	Q3	Q4	YTD
Hand hygiene compliance	95%	54.5%	93%			
Cleanliness inspections	95%	*	*			
Slit lamp audit	90%	*	*			
Sharps Audit						

The Infection Control team have worked very hard this quarter to highlight the importance of hand hygiene to all staff. This has been done by creating and displaying visual aids, email communication of policy, audits and results. Hand Hygiene compliance has greatly improved.

*Cleanliness Inspections and Slit Lamp Audits should have started in Q2. This has not been achieved. Both audits will now commence in October 2014.

2. CLINICAL EFFECTIVENESS

A) Guidelines and Policies

Title	Standard Operating Procedure, Protocol, Policy, Clinical Guidelines	New/Update
Informed Consent Policy	Policy	Update
Medical Record Policy	Policy	Update
Sharps Management Guideline Policy	Policy	Update
Standard Precautions Guideline Policy	Policy	Update
Risk Management Plan	Plan	Update
Quality Improvement Plan	Plan	Update

All of these documents are stored on the policy drive (B:), to ensure that all staff have access at all times. The Informed Consent, Medical Record, Sharps Management Guideline, Standard Precautions Guideline Policies have been adapted from DHCC policy guidelines.

The Risk Management and Quality Improvement Plan have been modified from earlier in the year.

B) Clinical Audit and Outcomes

Core Outcomes results

Specialty	Metric	Standard	Q2 2014/2015
Cataract	Posterior capsular rupture (PCR) in cataract surgery	<1.8%	0.60% (0% in Q2)
Cataract	Endophthalmitis after cataract surgery	<0.08%	0%
Cataract	Biometry accuracy in cataract surgery	>85%	86.56% (78.12% in Q2)
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	<15%	10%
Glaucoma	PCR in glaucoma patients	<NOD	2.70%
Glaucoma	Glaucoma tube drainage surgery failure	<10%	0%
MR	Endophthalmitis after injections for macular degeneration	<0.05%	0%
MR	Visual improvement after injections for DR	>20%	*
MR	Visual stability after injections for DR	>80%	*
VR	Success of primary RD surgery	>75%	92.86%
VR	Success of macular hole surgery	>80%	N/A
VR	PCR in cataract surgery in vitrectomised eyes	<NOD	0%
NSP	Serious complications strabismus surgery	<2.2%	1.30%
NSP	Success of probing for congenital tear duct blockage	> 85%	83.33%
Ext Dis	DSAEK corneal graft failure rate	≤12%	0%
Ext Dis	PK corneal graft failure rate	UKTS	2.86%
Ext Dis	DALK corneal graft failure rate	UKTS	0%
Refractive	Accuracy LASIK (laser for refractive error) in short sight	>85%	92.86%
Refractive	Loss of vision after LASIK	<1%	0%
Refractive	Good vision without lenses after LASIK	≥80%	100%
Adnexal	Ptosis surgery failure	<15%	0%
Adnexal	Entropion surgery success	>95%	100%
Adnexal	Ectropion surgery success	>80%	75%
Anaesthetic	On the day transfers		0.13% (0 in Q2)

*Limited data. To be discussed with MR department in October 2014 and prepared for Q3.

Serious Incidents and Never Events

Speciality	Metric	Q2 2014/2015
Incident	Wrong patient	0%
Incident	Wrong side	0%
Incident	Wrong IOL	0%
Incident	Unplanned 2nd surgery < 30days	1.22%

Brief summary of unplanned 2nd surgery within 30days; 4 unplanned, 2 planned:

1. 07/07/2014 ROGS (graft not carried out at MEHD) but noted suspicious conjunctiva lesion which was removed and sent for evaluation. Further excision required 04/08/2014
2. 10/07/2014 Removal of IOL from AC. 04/08/2014 emergency corneal wound revision and planned anterior vitrectomy
3. *Planned lucentis/ vitrectomy*
4. *RE PRP 27/07/2014, planned vitrectomy 26/08/2014*
5. RE PRP 27/07/2014, planned vitrectomy 26/08/2014. 28/08/2014 revision of sclerotomies
6. Initial LE vitrectomy 25/08/2013, repeated 31/08/2014 and 17/09/2014

From October 2014, these patients will be identified monthly and reported in a similar format to MEH to ensure clinical quality and learning.

3. PATIENT EXPERIENCE

A) Patient Satisfaction Survey

Patient experience is captured using an ipad survey. There are 3 ipads located in MEHD; OPD, theatre and reception. The results are reviewed weekly at the operations meeting and shared with all staff on a monthly basis.

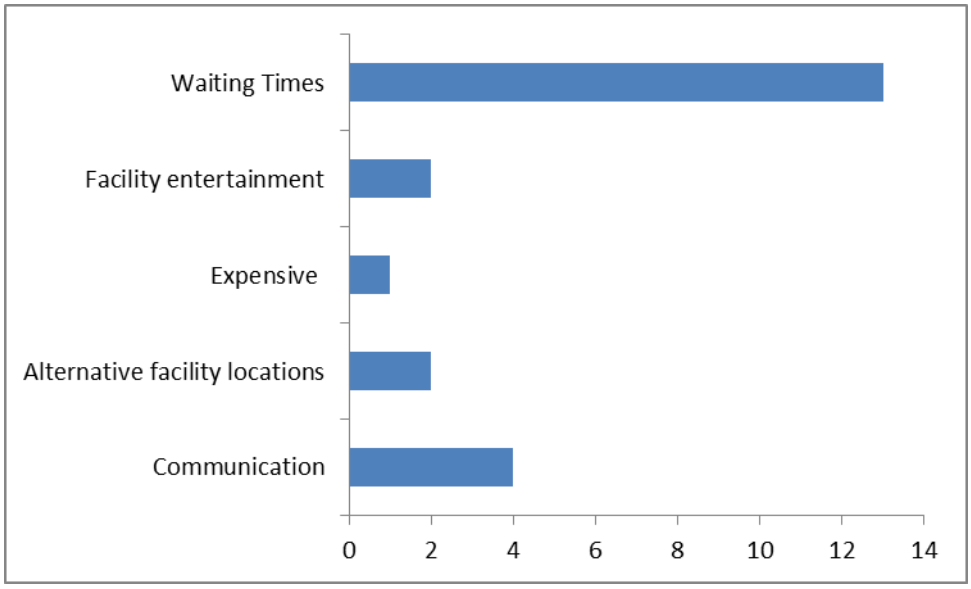
Number of Surveys: 104
Number of OPD patients: 4133 (2.52%)

Very low reporting numbers, aiming for a minimum of 15% response rate as per MEH standards. Technical problems due to the renewal of Opinionmeter contract, minimum data recorded for August. All staff informed of the low figures and advised to encourage patients to complete feedback survey. Operations manager to review alternative methods of collecting patient data.

Question 14: Would you recommend this Hospital to a family member/friend?
Yes 79.11%

Excellent result of 83.67% for the month of September. Met target for MEH Benchmarking/Average of 79% but minimum response rate not met.

Over the period there were 23 complaints recorded on the feedback survey.
Complaints by type;



The main patient complaints are waiting times (13) and communication (4).

The waiting times complaints can be divided into 2 sections, time to see doctor (11) and time to register (2). The Senior Nurse and Quality Officer are starting a project on 11th September 2014 to monitor and improve patient waiting times in OPD. The first stage will be collecting baseline data for 2 weeks before working directly with each Consultant on setting their individual clinic flow requirements. The data shall be recollected after 1 month and reviewed and evaluated for improvement.

One of the communication complaints was regarding communication and information given to patients before surgery. We have changed our process to ensure all patients receive MEHD booklets on the specific surgical procedures and this is now documented in the patient's record by the Nursing staff or Surgical Booking team. We are also looking into ensuring all of our documentation is available in both English and Arabic.

In addition, the Operations Manager is organising a communication course for all staff. The data is currently being collected via mystery shoppers. Once this is complete, the course will commence and will involve a number of sessions divided by departments.

B) Patient Complaints Register

A new IT based complaints register has been set up, with the help of MEH, to ensure we capture and analyse all patient feedback. It will be filled out by managers or leads. This will be started October 2014 and replace the books located In theatre and OPD.

Clinical Quality and Safety Performance Report MEHD. Quarter 3 2014/5 (1st October – 30th December 2014)

1. PATIENT SAFETY

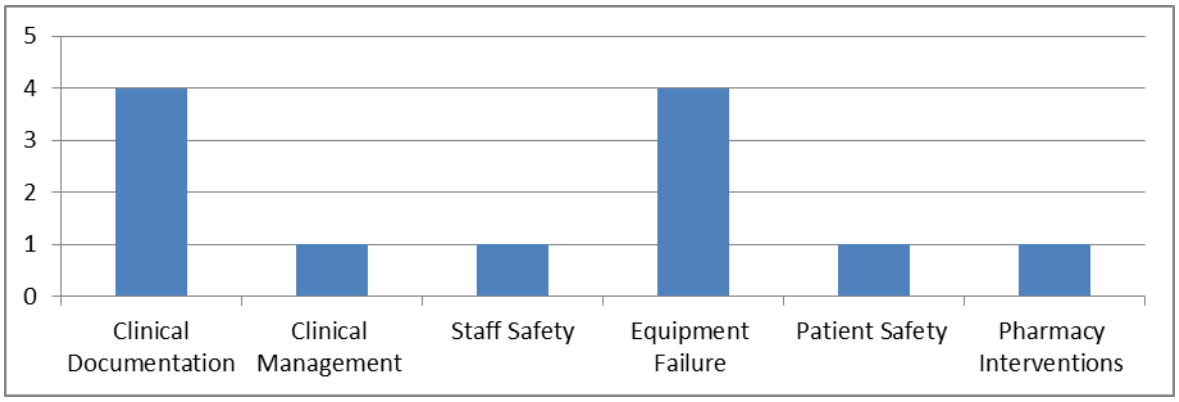
1.1 Incident Reporting

We are currently looking at changing to an online IR platform based on WHO guidelines, similar to that used at MEH. This should be available during Q4.

Summary of Incidents;

Indicators	2014/15				
	Q1	Q2	Q3	Q4	YTD
Patient Safety Incident (PSI)	22	20	12		
All other incidents					
Total incidents	22	20	12		
Serious incidents (SIs)	0	1	0		
Never events (NEs)	0	0	0		

There have been 12 incidents reported this quarter;



Incidents seem to have reduced this month. As the online IR system is not available, all staff have been sent an email reminder (including policy) to complete IR forms when any incident occurs. There have been 4 incidents of clinical documentation errors. One of these incidents involved recording clinical information on the wrong patient record due to confusion with similar sounding patient names. This was quickly noted and rectified at the time. However as this situation is quite likely to reoccur, all patients will be identified using 2 identifiers as per policy. This is be monitored by the Senior Nurse.

There was a minor clinical management incident that involved the incorrect method being carried out. This has been reviewed to ensure all staff are trained correctly and working within their scope of service.

There were 4 incidents of equipment failure this quarter. This is unlikely to be an increase in this type of incident, simply an increased awareness in reporting. The patient safety incident involved a child running into a glass door in the paediatric department. There was no serious injury to the child. To minimise the risk of a similar or more severe incident, a nurse or clinical assistant will always be assigned to the paediatric desk area.

The staff safety incident occurred when a doctor slipped on a wet, recently cleaned floor. Again, no serious injury occurred. The cleaning schedule was reviewed and the area of incident plus other common areas will be cleaned after clinics to minimise risk to both staff and patients.

1.2 Infection Control

Indicators	Target	Q1 14/15	Q2	Q3	Q4	YTD
MRSA Screening	100%	*	*	0		
%Endophthalmitis post cataract	0.08%	0	0	0		
%Endophthalmitis post AMD/DR	0.05%	0	0	0		
Adenovirus possible hospital acquired	NA	0	0	0		

C. Difficile and E. Coli screening is not applicable at MEHD as the patients are out-patients/day case surgeries only.

*MRSA Screening is not currently carried out at MEHD. MRSA screening should have started in Q2. This has not been achieved. It will be started for theatre patients from Q3 under the leadership of Carlo Lopez, Theatre Manager.

Indicators	Target	Q1	Q2	Q3	Q4	YTD
Hand hygiene compliance	95%	54.5%	93%	91.6%		
Cleanliness inspections	95%	*	*	100%		
Slit lamp audit	90%	*	*	75%		
Sharps Audit (March and December)				86%		

The Infection Control team have started Cleanliness Inspections and Slit Lamp Audits this quarter. The results for the cleanliness inspection have been excellent. This is audit has been modified from the MEH model to meet DHCC standards. The results from the Slit Lamp audits are below target. The Infection Control team will be focusing on this during the next few months and will seek advice from MEH during their visit in January 2015. In Q4, this audit will involve all medical equipment with chin rests to ensure hygiene compliance throughout the service.

2. CLINICAL EFFECTIVENESS

2.1 Guidelines and Policies

Title	Department	SOP, Protocol, Policy, Clinical Guidelines	New/ Update

All Pharmacy Policies	Pharmacy	Policy	Update
Look Alike Sound Alike (LASA) Policy	Pharmacy	Policy	New
Clinical Privilege Policy	General (MEHD)	Policy	New
All General MEHD Policies	General (MEHD)	Policy	Update
All Theatre Policies	Theatre	Policy	Update
All Clinical OPD Policies	OPD	Policy	Update
Employee Handbook	HR	Handbook	New
Recruitment Policy	HR	Policy	Update
Retention Policy	HR	Policy	New
Crash Cart Management	OPD	Policy	Update

All of the policies have been reviewed during Q3 as part of the two year review. All policies will be reviewed every 2 years unless there are any process or staff changes. All of these documents are stored on the policy drive (B:), to ensure that all staff have access at all times. A policy register has been created to track changes and monitor review dates.

2.2 Clinical Audit and Outcomes

Core Outcomes results

Specialty	Metric	Standard	Q3 2014/2015
Cataract	Posterior capsular rupture (PCR) in cataract surgery	<1.8%	0.64%
Cataract	Endophthalmitis after cataract surgery	<0.08%	0%
Cataract	Biometry accuracy in cataract surgery	>85%	86.86%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	<15%	8.33%
Glaucoma	PCR in glaucoma patients	<NOD	2.08%
Glaucoma	Glaucoma tube drainage surgery failure	<10%	0%
MR	Endophthalmitis after injections for macular degeneration	<0.05%	0%
VR	Success of primary RD surgery	>75%	100%
VR	Success of macular hole surgery	>80%	N/A
VR	PCR in cataract surgery in vitrectomised eyes	<NOD	0.32%
NSP	Serious complications strabismus surgery	<2.2%	2.35%
NSP	Success of probing for congenital tear duct blockage	> 85%	88.89%
Ext Dis	DSAEK corneal graft failure rate	≤12%	0%

Ext Dis	PK corneal graft failure rate	UKTS	3.33%
Ext Dis	DALK corneal graft failure rate	UKTS	0%
Refractive	Accuracy LASIK (laser for refractive error) in short sight	>85%	94.44%
Refractive	Loss of vision after LASIK	<1%	0%
Refractive	Good vision without lenses after LASIK	≥80%	100%
Adnexal	Ptosis surgery failure	<15%	0%
Adnexal	Entropion surgery success	>95%	100%
Adnexal	Ectropion surgery success	>80%	75%
Anaesthetic	On the day transfers		0.07% (0 in Q3)

Serious Incidents and Never Events

Speciality	**Metric**	**Q3 2014/2015**
Incident	Wrong patient	0%
Incident	Wrong side	0%
Incident	Wrong IOL	0%
Incident	Unplanned 2nd surgery < 30days	1.45%

Brief summary of unplanned 2nd surgery within 30days; 4 procedures:

1. 1026677 – Complicated glaucoma patient.
   08/10/2014 - Needling surgery on LE (LE enhanced trab 18/06/2013).
   14/10/2014 - 2nd procedure to suture conjunctiva LE.
   20/10/2014 - Revision of wound RE (RE trab 23/04/2013)
   28/10/2014 - Revision of wound RE

2. 1030729 – Eylea, 3.5 weeks in-between injection.

3. 1032801 - Complicated glaucoma patient.
   11/11/2014 – Aqueous shunt (24/02/2014 RE cyclodiode)
   17/11/2014 – Tube flushing

4. 1039356 - Complicated glaucoma patient.
   11/11/2014 – Aqueous shunt LE.
   15/12/2014 – Aqueous shunt adjustment.

These patients are identified monthly and reported in a similar format to MEH to ensure clinical quality and learning.

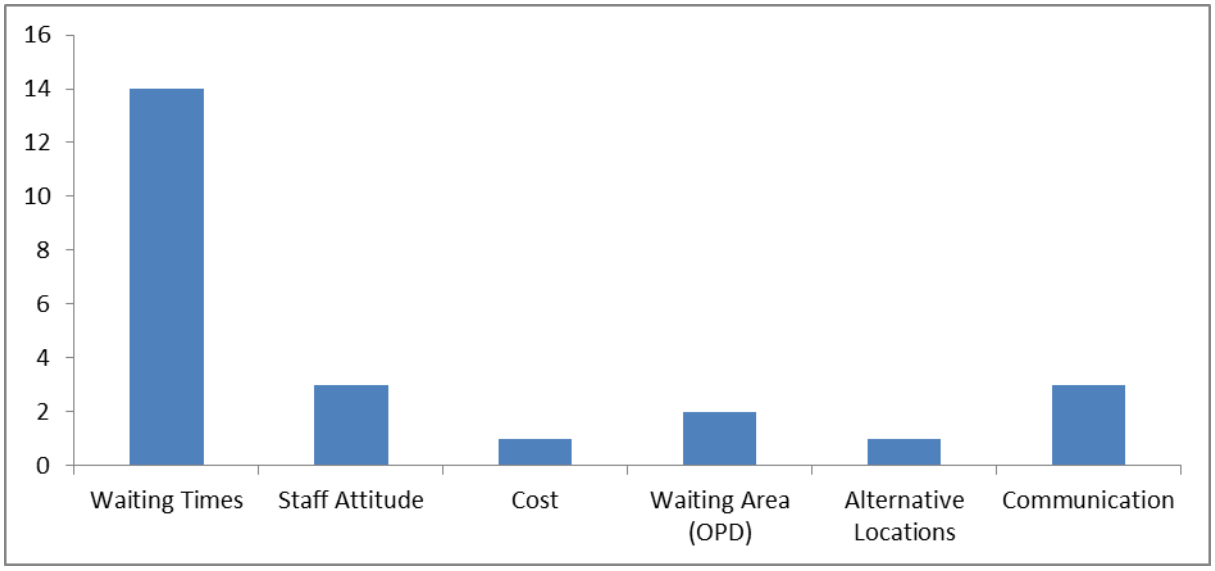
3. PATIENT EXPERIENCE

3.1 Patiens Satisfaction Survey

Number of Surveys in Q3: 119
Number of OPD patients in Q3: 4656 (2.55%)
Very low reporting numbers again this quarter, aiming for a minimum of 15% response rate as per MEH standards. All staff informed of the low figures and advised to encourage patients to complete feedback survey in monthly email.
Limitations with current system as not able to send text message with online link to survey. Email option is available but due to previous IT issues not a viable option. The Performance Improvement Committee is further reviewing additional and/or alternative methods of collecting patient data.

Question 14: Would you recommend this Hospital to a family member/friend?
Yes 79.37%
Excellent result of 89.36% for the month of December, highest this year. Met target for MEH Benchmarking/Average of 79% but minimum response rate not met.

Over the period there were 24 complaints recorded on the feedback survey. Complaints by type;



The main patient complaints are waiting times (14), communication (3) and staff attitude (3).
The project to monitor and improve patient waiting times in OPD was started in September 2014. The targets are for a patient to see the first healthcare professional within 30 minutes of arrival and to see the doctor within 30 minutes of completing all investigations (including dilation). Two doctors clinics were reviewed and both met the waiting times targets.

The complaint of patient waiting times covers a range of issues. The new OPD manager (appointed January 2015) will be working on gaining clarification on waiting time complaints to better evaluate the service. In order to support the service and improve communication, two clinical assistants have been recruited. They will be allocated to the most demanding and busy clinics; cornea/oculoplastics and paediatrics. These roles will be managed by the Senior Nurse and OPD Manager, with support from the Operations Manager when required.

In response to both waiting time and communication concerns, the reminder text message (sent to patients before their appointment) has been modified to include the statement;

"Appointment time may be over 2 hours if dilation is required". Furthermore, when patients arrive they will receive information leaflets on eye drops, informing them of the length of time of drops and reason for instilling. The information is drop specific and available in both English and Arabic. The final draft of leaflet has been approved and this should be available from February 2015.

In addition, the Operations Manager is organising a communication course for all staff. The data is currently being collected via mystery shoppers. Once this is complete, the course will commence (expected March 2015) and will involve a number of sessions divided by departments.

3.2 Patient's Complaints Register

This quarter a complaints register was introduced to replace the complaints/error books in OPD and Theatre. This also provides a record for the administrative department to use. This allows patient complaints to be recorded, monitored and analysed.

40 patient complaints have been reported over the last 3 months; 33 on waiting times in OPD, 4 regarding understanding the explanation of their eye condition, 2 poor communication between staff, 1 unhappy with surgical outcome and 1 about staff attitude.