Quality Account 2021/22

(includes quality priorities for 2022/23)

Our commitment to quality excellence

FINAL v1.0

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Part 1: Statement on quality

1.1   Statement on quality from the Chief Executive

I joined Moorfields halfway through 2021/22 during a further wave of the Covid-19 pandemic. Covid-19 has had huge impact on the NHS, and I have been impressed how Moorfields Eye Hospital NHS Foundation Trust (the trust) has continued to rise to this challenge clearly putting the patient at the heart of all that it does. We were able to continue to operate our services and remained focused on prioritising care for those most at risk of sight loss or serious disease. We have also continued to innovate the way our patients are treated and assessed, using technology to support patients through their clinical journey. This technology, with the support of our hard-working staff, has enabled us to recover from the impact of Covid-19 and provide access to our services for a greater number of patients. Due to the success of these pathways, many remain in use, and we will continue to develop them to ensure we combine accessible, fast and smooth treatment with excellent outcomes and a high-quality experience.

As is often the case through incredibly challenging circumstances, the pandemic has made us think differently on how we benefit patients. This was exemplified through our cataract drives, which commenced in 2020/21 and continued in 2021/22. These drives were a fantastic effort involving multi-disciplinary teams coming together to work efficiently to ensure patients received high quality care in a Covid-19 safe environment. Some initial data on patients' experience was impressive, with 70% of patients giving us top marks for their experience, and no scores were lower than 7 out of 10. We are also immensely proud of the way we are helping and supporting other trusts, through mutual aid, as they also recover from the ongoing impact of Covid-19.

Despite the ongoing impact of the pandemic, we have once again achieved excellent clinical outcomes in 2021/22. Also, the integrity of our quality governance has remained central to our processes which provides the organisation with robust assurance over our three key quality areas of patient safety, clinical effectiveness, and patient experience.

Our quality account reflects our quality performance in 2021/22. Overall, we have made good progress with many of our indicators. Others have performed less well, and we will restore performance to those areas as we continue to recover from the pandemic.

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

I recognise the impact that the last two years have had on our extremely dedicated and committed staff, who have worked so hard to meet the challenges that have been put in front of them. Staff well-being remains a top priority at Moorfields, and it is only through caring for our staff that we can continue to provide such excellent ophthalmic care for our patients.

In 2022 we are launching our new trust strategy, which builds on the achievements of the previous 5-year strategy and has a clear focus on excellence, equity, and kindness - we look forward to implementing our strategy as we continue to improve the quality of our services in the year ahead.

Martin Kuper
Chief Executive

Our values

We are **caring** – so everyone feels listened to and valued.

We are **organised** – so we don't waste anyone's time.

We are **excellent** – so we always deliver a first class, professional service.

We are **inclusive** – so everyone feels informed, involved and part of a team.

1.2 Introduction to the Quality Account 2021/22

Quality Accounts are a way for NHS trusts to report on the quality of care they provide and show improvements in the services they deliver. The Quality Account is a key mechanism to provide demonstrable evidence of improving the quality of trusts' services by looking at patient safety, the effectiveness of treatment that patients receive, and patient feedback about the care provided. The Quality Account is an opportunity to assure our service users and stakeholders that we provide high quality clinical care to our patients. It also shows where we could do better and our commitment to quality improvement.

Quality Accounts incorporate the requirements of the quality accounts regulations, as well as those of NHS Improvement's (NHSi) additional reporting requirements. The purpose of the account is to:

• promote quality improvement across the NHS

• increase public accountability

• enable the trust to review its services

• demonstrate what improvements are planned

• respond and involve external stakeholders to gain their feedback, which includes patients and the public

Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2021/22.

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

1.3   Moorfields Eye Hospital's approach to improving quality

At Moorfields our core belief is 'people's sight matters', and our purpose is 'working together to discover, develop and deliver the best eye care'. We define quality as 'providing safe care, outstanding outcomes, and positive experiences and involvement for all our patients'.

Quality is our core philosophy, and the central thread of every decision we make. At a time of rapid technological advances and focus on restoring services affected by the pandemic, Moorfields remains in a unique position to lead the way in supporting the delivery of high-quality eye care. We want to continue to build our skills and enthusiasm for learning and sharing our experiences to deliver excellent clinical care and world-leading research. This will ensure we continue to deliver the outstanding quality our patients deserve, and to truly live up to our reputation as a world-leading organisation.

Our priorities are consistent with the objectives set out in our quality strategy and form an important part of its implementation. The priorities are ambitious and aspirational by design. Throughout this document, we set out our priorities under the three well established domains of patient safety, patient experience and clinical effectiveness.

2021/22 has been dominated by the recovery from the Covid-19 pandemic. It has been focused on embedding improved processes, such as clinical risk stratification, and ensuring services paused or altered during the height of the pandemic were fully reinstated.

In 2022/23, we are implementing a trust-wide transformation programme, supporting delivery of our refreshed strategy, which will bring together initiatives from across the trust, ensuring that work streams are coordinated and delivered effectively with robust governance arrangements.

The Quality and Safety Committee, on behalf of the board, takes responsibility for the overview and scrutiny of the development and delivery of the Quality Account and quality priorities.

For information, or to provide feedback on this quality account, please email Ian Tombleson, Director of quality and safety at i.tombleson@nhs.net.

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Progress with 2021/22 priorities

Throughout the year, we have focused on six key quality priorities identified in last year's quality account. We developed these collaboratively with patients, staff, governors, commissioners, and relevant charities. The rationale behind the priorities was based on the progress made with the 2020/21 priorities, as well as staff and patient feedback regarding how we could further improve their experience at Moorfields. During the year, progress to achieve our quality priorities has been monitored by the trust's Clinical Governance Committee (CGC).

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

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

Summary of the 2021/22 quality priorities:

Domain	No	Description	Priority continued from 2020/2021
Patient safety	1	Implement the NHS patient safety strategy: (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)	New
	2	Maintain patient safety during COVID-19 recovery; minimising levels of harm caused to patients during the pandemic	New
Patient experience	3	Improve our customer service within our telephone booking centre	New
	4	Improve patient appointment experience through standardisation of content and format for new and follow up patient letters	New
Clinical effectiveness	5	Improve patient outcomes and achieve a high-quality patient experience through the implementation of diagnostic hubs across the network	New
	6	In creating the best patient outcomes environment for patients, Moorfields will support and improve the health and well-being of staff, focusing on the additional support needed during recovery from the pandemic	New

Improvement achievements against priorities in 2021/22

This section of the quality account highlights achievements against the priorities set for 2021/22.

Patient safety

Quality Domain: Safety	
Priority 1: Implement the NHS patient safety strategy	
Our priority for 2021/22 is to: Implement the NHS patient safety strategy: *(https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)*	**Rationale:** The new national patient safety strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. The strategy is being introduced in a phased way. Moorfields will implement the objectives in line with national requirements. **What success will look like by the end of March 2022:** We will have implemented the requirements for the new NHS patient safety strategy by March 2022. **What we will measure and when:** • Central team will connect local systems to the new patient safety incident management system by end of Q4 2021/22 (subject to local software compatibility). • Central team to work with divisions to implement quality governance arrangements for implementation of the patient safety incident response framework by Q4 2021/22. • Working with the central team, divisions will include patient safety partners in their divisional governance arrangements by Q4 2021/22.

Background

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

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

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

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

What have we achieved to date?

There have been delays in the dissemination of guidance from NHS England and NHS Improvement relating to the implementation of the NHS strategy's key objectives. For example, the framework for involving patients in patient safety was originally expected during April 2021; however, NHS England and NHS Improvement have announced that trusts are not required to commence recruitment until September 2022.

Therefore, the focus for this priority has been to review and ensure assimilation of available information so when we are required to commence implementation of the strategy in June 2022, we will be ready to do so as outlined:

- An update to the strategy was published in February 2021. Whilst the principles and high-level objectives of the strategy remained the same, there has been a shift in scope, considering learning and experience associated with the COVID-19 pandemic. A new objective was introduced in relation to the reduction of health and patient safety inequalities. Several timelines have been revised to reflect the disruption and uncertainty arising from the pandemic.
- The patient safety specialist (PSS) network continued to develop over the year, providing access to, and oversight of several tools to support the role. This included information and expectation sharing in relation to strategy implementation. National and regional events are scheduled on MS Teams and networking and information sharing has taken place.
- Organisational readiness has commenced:
  - The provision of briefings to staff via the Risk & Safety Committee, Clinical Governance Committee, and divisional quality forums.
  - Confirmation from Ulysses 2000 Ltd, the provider of Safeguard our local risk management incident reporting system, that the system has passed Learn from Patient Safety Events (LFPSE) compliance testing. The trust will now make the transition from reporting to the National Reporting and Learning System (NRLS) to LFPSE, when advised to do so.
  - Enabling work by the central team.
  - Scoping the most effective ways to engage with patients and other stakeholders regarding patient safety priorities.
  - A business case has been approved to support the introduction of a minimum of two patient safety partners (PSPs) in accordance with the requirements identified in the Framework for Involving Patients in Patient Safety.

What are the gaps in delivery if any?

There have been no gaps in delivery because of the publication and implementation delays arising from the pandemic. A robust delivery plan is being developed for 2022/23. It has been recognised that the patient safety strategy should also form part of the quality priorities for 2022/23, as it will have a significant positive impact on the organisation.

What will we do in 2022/23 to continue with progress?

- We will commence the development of a trust patient safety strategy focused on organisational safety culture, to align with the new trust strategy and the national strategy. The engagement undertaken during development will inform the Patient Safety Incident Response Plan (PSIRP) that is to be devised to implement PSIRF.
- We will implement levels 1 and 2 of the patient safety syllabus, delivery of which will provide staff with standardised and enhanced patient safety training. Consideration of the supporting organisation readiness tool has commenced, as has attainment of a baseline assessment of safety culture, using a recognised methodology.

Quality Domain: Safety	
Priority 2: Maintain patient safety during COVID-19 recovery	
Our priority for 2021/22 is to:	**Objective and Rationale**: Maintain patient safety during COVID-19 recovery, minimising levels of harm caused to patients during the pandemic.
Maintain patient safety during COVID-19 recovery; minimising	**What success will look like by the end of March 2022:** All divisions, services, and teams aim to maximise patient safety and minimise patient harm. During COVID-19 recovery, we need to be especially vigilant of

levels of harm caused to patients during the pandemic.	any additional consequences of the pandemic on our patients to prevent harm. Services continue to lead on and develop methods of patient risk stratification. This priority focuses on mechanisms to help minimise harm. **What we will measure and when:** • Divisions to describe all safety risks and mitigations in risk register by end of Q1. • Divisions to accurately record and report their safety incidents throughout the year. • Divisions will assess data/trends quarterly at divisional quality forums. Learning will be shared through all local and central routes including the LIFEhub. • Specific quarterly reviews of all triangulated data will take place at the SI panel with all divisions in attendance. • Divisions will ensure learning is clearly identified and communicated at quality forums and beyond to frontline teams. • Learning will be collated and shared quarterly at the central quality forum.

Background

Throughout the pandemic, the trust strived to ensure that patient safety was a priority at all times. In March 2020, in advance of the first lockdown, the trust established an emergency Clinical Advisory Group to set out a clinical action plan in response to Covid-19. It was agreed early on that the trust would provide emergency sight or life-threatening care only. To this end, all patients were risk stratified in March/April 2020, as high, medium, or low risk, and this stratification was used to determine how and when individuals would be reviewed during the pandemic. Care was taken during this process to ensure that patients were not lost from the system, and this has not materialised as an area of concern. During this time, the trust also introduced new ways of working, including *AttendAnywhere*, a video consultation platform, as well as increased use of diagnostic hubs to shorten appointment and waiting times for patients.

What we have achieved to date

Throughout the year, the patient safety control measures that had been established during 2020/21 (via bronze command and control, infection control and workforce groups) were sustained. The command-and-control groups continued to review the requirements and implications of national and local North Central London (NCL) guidance and support implementation by operational teams. The frequency of meetings was adjusted dependent on need and local/regional prevalence of Covid-19. Examples of the extensive work undertaken include:

- Provision of a Covid-secure environment, for example, adherence to social distancing requirements, the requirement to wear a face mask, utilisation of hand sanitiser, adequate ventilation.
- A vaccination programme, which provided two vaccines and a booster injection to Moorfields and NCL staff and several patients attending an appointment at City Road.
- A testing programme, including the development of surgical pathways, pre-operative PCR testing of surgical patients and lateral flow and PCR testing requirements for staff.
- A fit testing programme.
- Workforce arrangements for staff, which have helped to protect both staff and patients.

The year has seen a period of intense operational recovery. The incident reporting system has been a mechanism by which sources of potential or actual harm have been recorded during the recovery period and this has afforded operational teams the opportunity to:

a) Review and investigate where harm may have occurred during the pandemic. Clinicians within each ophthalmic sub-specialty are well versed regarding the risk stratification process that was implemented and have been able to report harm (e.g., a patient's condition has developed beyond that which would have been expected and the delay in review has caused harm).

b) Identify learning, including the need to proactively review patients meeting specific criteria.

c) Share local learning via existing governance processes, including at divisional quality forums and performance meetings and service business meetings.

d) Share trust wide learning.

The Serious Incident Reporting and Management Group (SI panel) has continued to meet weekly throughout the pandemic, undertaking reviews of incidents, complaints, and claims in accordance with its terms of reference. At meetings, there has been representation from divisional management teams, including quality partners, the central quality team, patient safety specialists, and relevant sub-specialties. Other groups, such as the safeguarding and infection control teams, attend on a case-by-case basis.

During Q1, a thematic review of all Covid-19 associated incidents which occurred during 2020/21, was undertaken. The findings were reported to the clinical governance committee in May 2021, facilitating review at subsequent divisional quality forum meetings. The Q1 quarterly and safety report presented the Q1 data and compared this with 2020/21 to identify emerging themes or trends. This was repeated for Q2, Q3 and Q4 reports. The comparison undertaken to date acknowledges that there are limitations associated with the reviews that have been completed. The limitations include, but are not limited to:

- Some incidents may have been excluded because neither the reporter nor the investigating manager have made an explicit association with the pandemic, and it is not obvious from reading the available text.
- Incidents continue to be reported in relation to outpatient clinic capacity. These have not been included in the analysis unless there is a specific reference to Covid-19 within the incident or outcome description. It is likely there is an association between the reported incidents that have been excluded from the analysis because of the need to increase activity yet maintain social distancing.

The numbers of incidents reported during each quarter have been consistent, with 70 associated incidents having been recorded during Q1, 90 during Q2, 91 during Q3 and 73 during Q4. During all quarters, incidents have been reported across a range of cause groups and from several different sites.

No harm incidents account for 77% (Q1), 78% (Q2), 76% (Q3) and 88% (Q4) of the reported incidents that have a Covid-19 association. There have been no Serious Incidents declared to date as a direct result of the impact of Covid-19, for example due to delayed appointments. SI panel will continue to review, as a minimum, those incidents that have an actual impact of moderate or above harm assigned.

The nature of the risk stratification that was applied for operational recovery, means that it may be some time before any harm arising from the pandemic can be quantified.

What are the gaps in delivery if any?
No gaps in delivery have been identified.

What will we do in 2022-23 to continue with progress?
We will continue to track and monitor incidents to identify any Covid-19 related themes or patient harm.

Patient experience

Quality Domain: Patient experience **Priority 3: To improve our customer service and responsiveness within our telephone booking centre**	
Our priority for 2021/22 is to: Improve our customer service within our telephone booking centre	**Rationale:** We are not achieving the levels of service we wish to achieve for answering calls for our patients. Patients continue to have difficulties reaching Moorfields via telephone and this is a recurrent theme captured through complaints and PALs enquiries. Improving the responsiveness of our service and the information we give to patients remains a key priority at Moorfields and this has been carried forward from 2020/21. **What success will look like by the end of March 2022:** • Patients are directed to the right place at the right time and are answered within an acceptable waiting time. • Messaging regarding appointments is consistent and responsive. Fewer patients will have to contact the hospital for details regarding their appointments. **What we will measure** • Patients will by exception wait longer than 2 minutes to speak with a Moorfields staff member. • Fewer patients will have to call the hospital as they will have clear information via a patient portal system and improved correspondence via letters and text messages. • Improved coverage and monitoring of calls across the trust through increased system coverage. • Reduction in complaints and PALs enquiries about appointments.
Lead update	

Background

Appointments and difficulties reaching Moorfields network sites via telephone is a recurrent theme captured through complaints and PALS enquiries. This is also a theme amongst the call agents, who struggle to pass calls through to the correct service or site, as telephones are either not answered or directed incorrectly. Improving the responsiveness of our service and the information we give to patients remains a key priority to improve the quality of our services. It is imperative that staff are providing the same information to patients when asked questions about appointments and know what sites or services to forward the queries to.

What we have achieved to date

Improvements are still required in this area. Call response times, despite challenges regarding staffing, are dependent on call volumes, and improvement has been further limited during Quarter 4 2021/22, due to long-term and intermittent sickness, some related to the pandemic. Despite remedial actions, patients continue to have difficulties reaching us via telephone and waiting times are inconsistent and can sometimes be long. This theme was also captured through complaints and PALS enquiries.

We did not meet our target of 90% of calls answered as outlined in our SLA (service level agreement). Good progress was made in Q1 and Q2, however, this improvement was not maintained due to the impact of sickness and the number of inbound calls increased as expressed in the data below.

Number of inbound calls
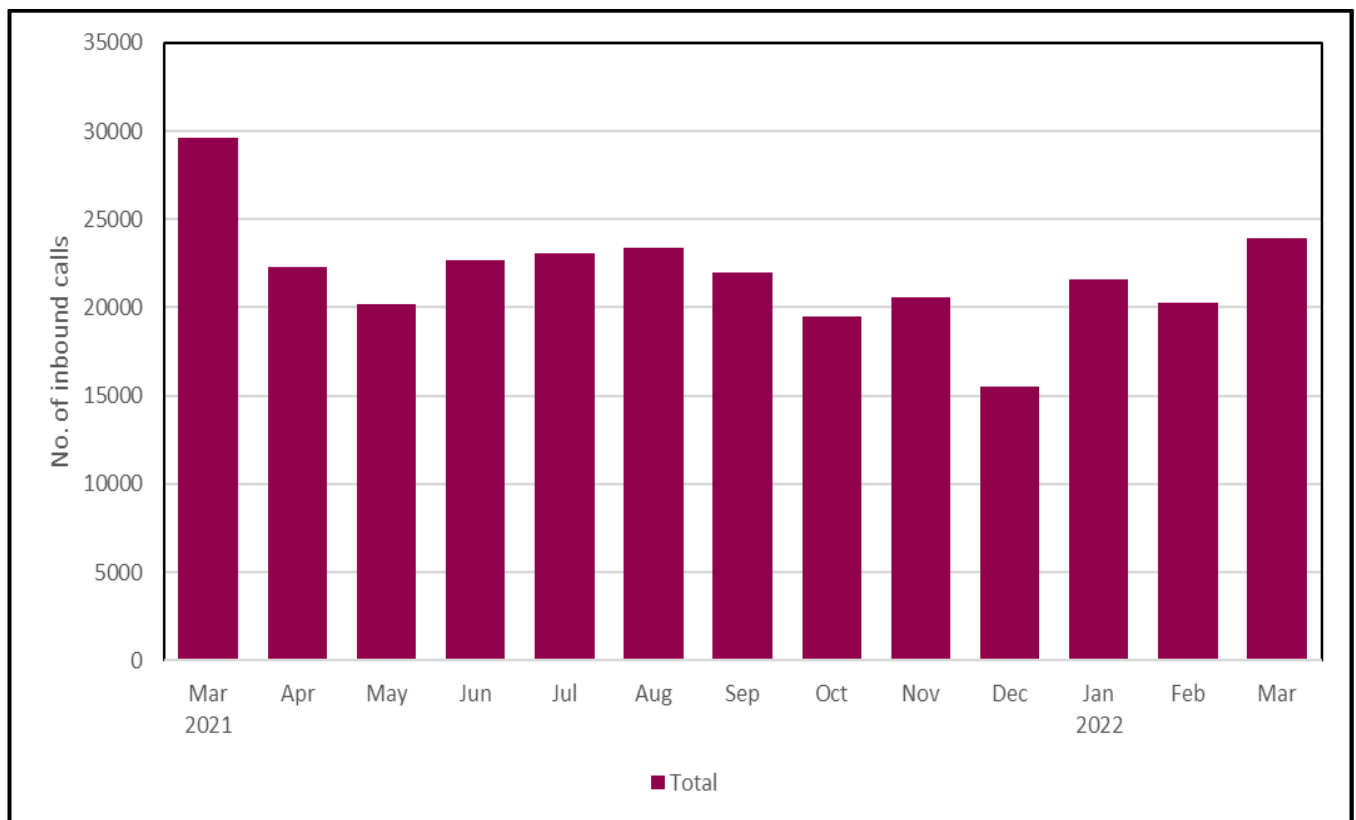
Calls answered
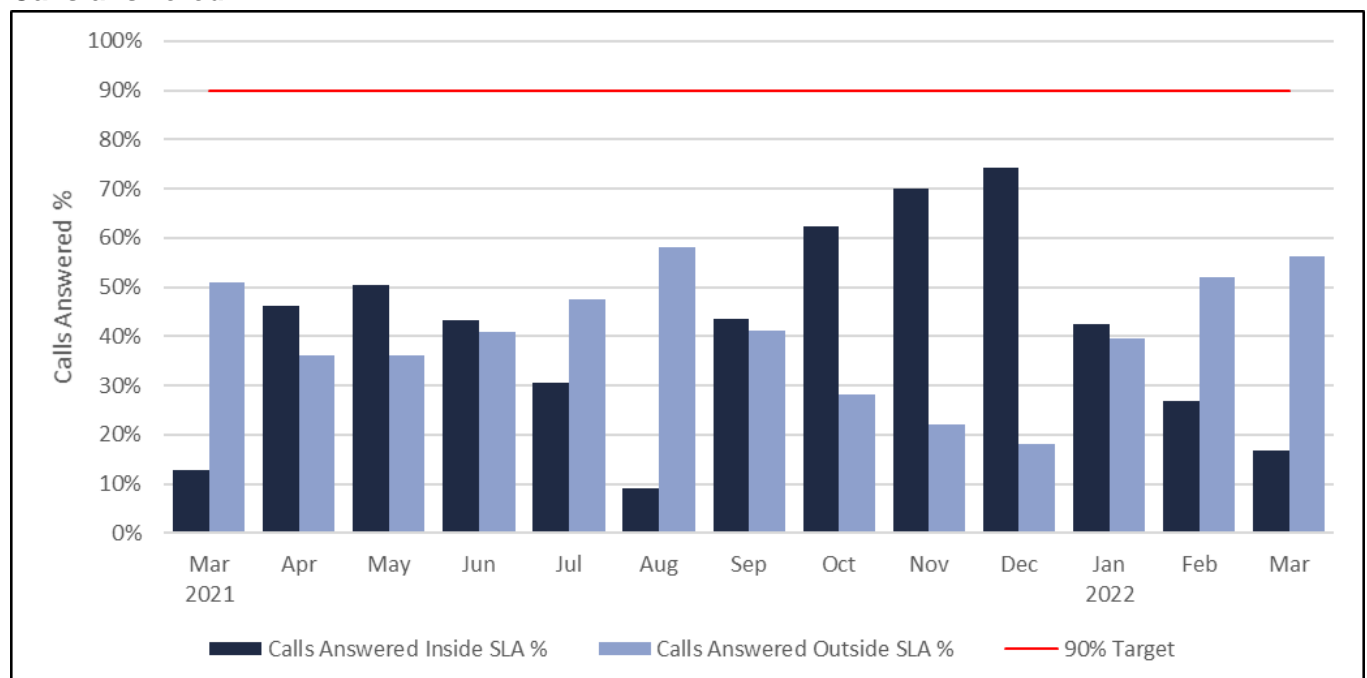
Calls abandoned
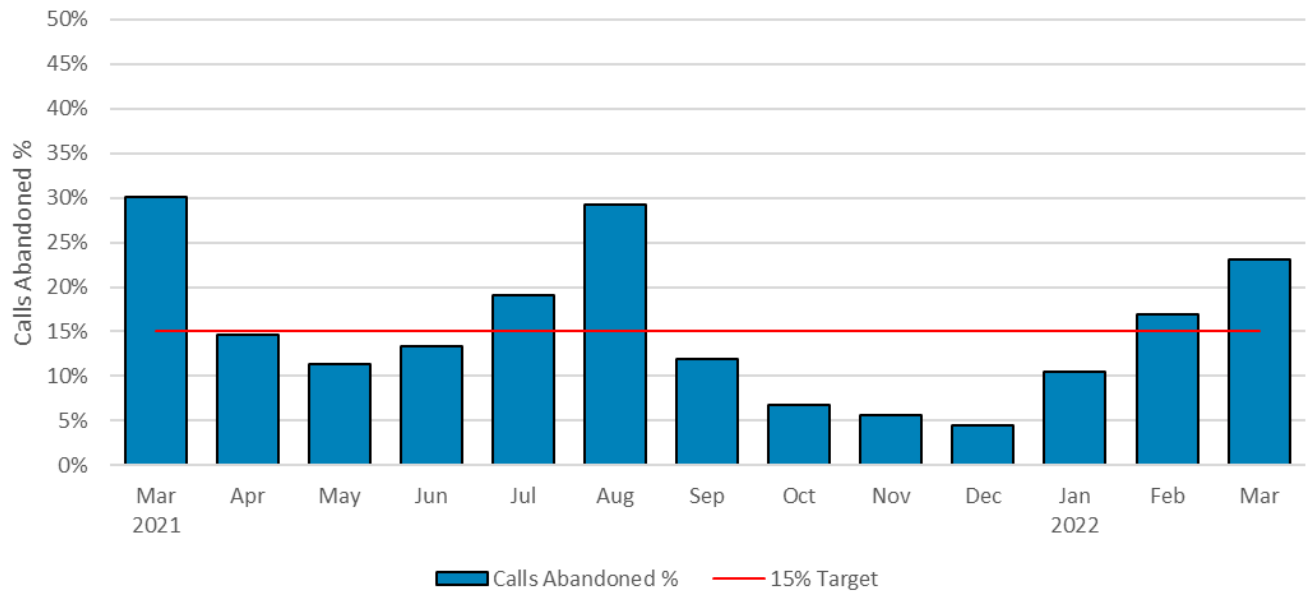
Average waiting time
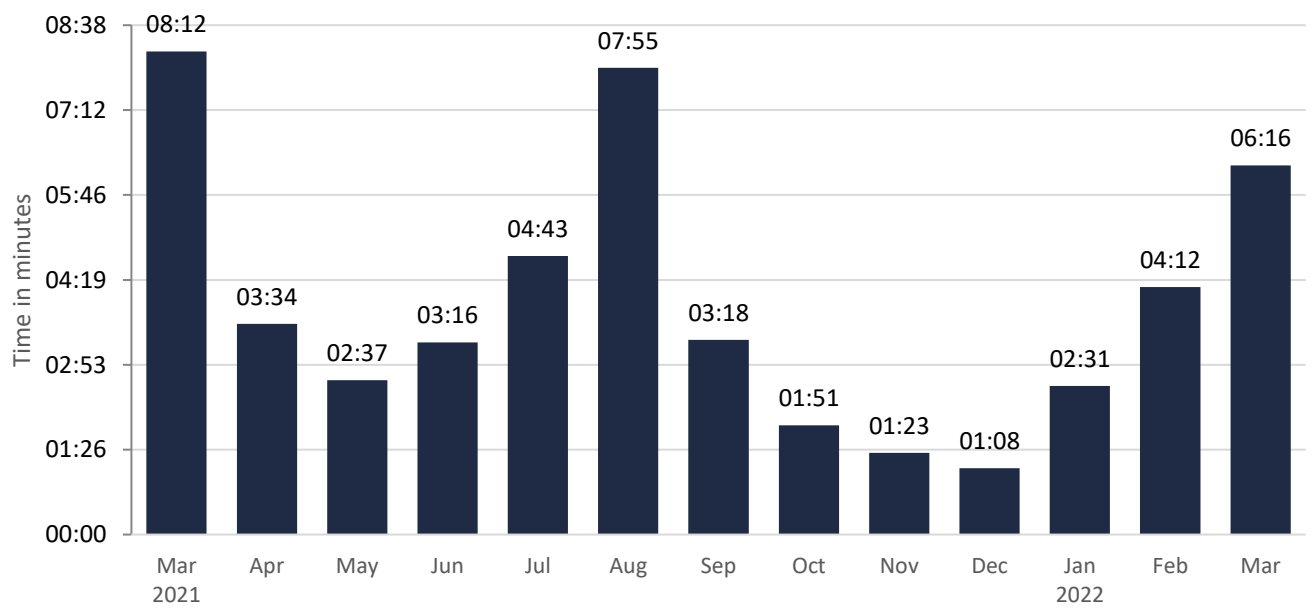
Calls queued outside SLA
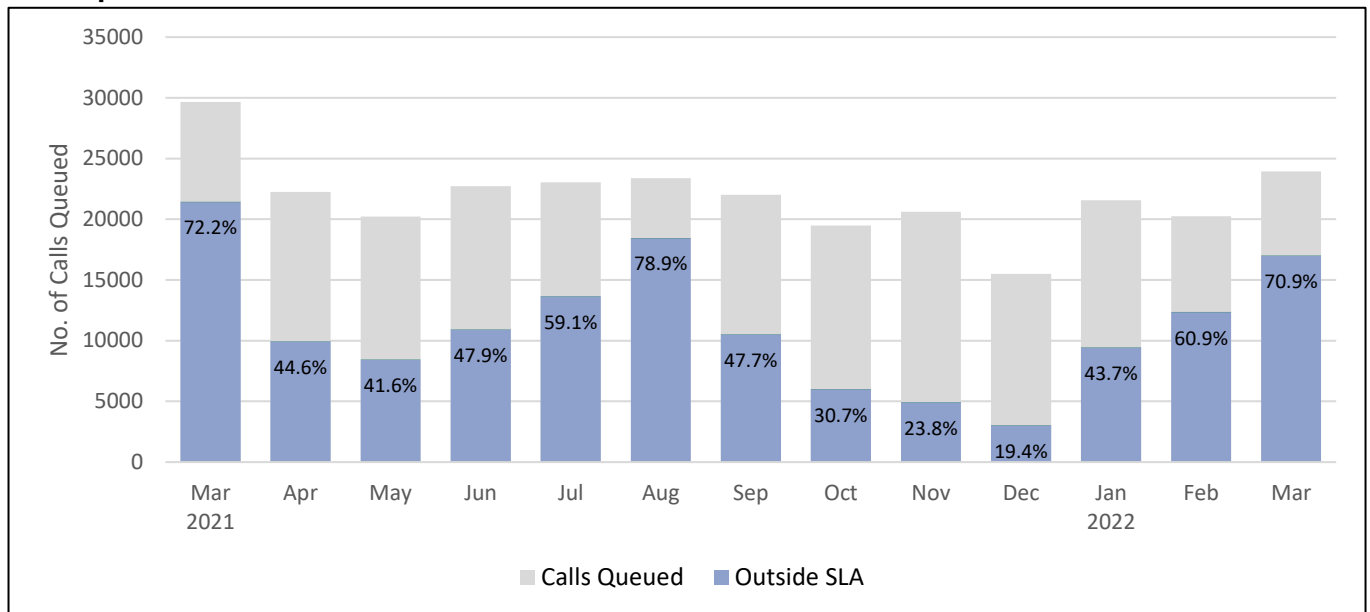
Rollout of patient portal

Our aim to roll out the *DrDoctor* patient portal system was achieved, and the system has gone live across all diagnostic hub sites and appointment reminders will soon be completed for all sites. This enables patient appointment reminders to be sent out by the platform as follows:

Notification of receipt of referral via ERS – when appointment not booked.	Appointment confirmation sent – following appointment booking.	Reminder message sent to patient 7 days prior to appointment.	Reminder message sent to patient 3 days prior to appointment.

Each of these messages has an option for a patient to contact us and leave a message.

This replaces the need for the patient to call us regarding their appointment and enables our team to act upon these requests – with a typical aim to respond within 72 hours to any request. This will also lead to further improvement in call answering times, as there will be fewer in bound calls received.

Increased Telephone Coverage

In terms of broader telephone coverage on the *Netcall* system, the divisions are working closely with the facilities team to ensure that there is a call monitoring system on all main administrative sites, so that patient call times and compliance are being monitored. This allows both local and central monitoring to ensure there is appropriate scrutiny of call waiting times.

An example of the dashboard can be found below:

0 CONTACT CENTRE NEW	**2** ACTIVE CALLS	**0s** LONGEST WAIT	**175** CALLS ANSWERED	**1m 18s** AVERAGE ABANDONMENT TIME	**1m 46s** AVERAGE WAIT
0 CONTACT CENTRE FOLLOW- UP	**0** ACTIVE CALLS	**0s** LONGEST WAIT	**114** CALLS ANSWERED	**1m 42s** AVERAGE ABANDONMENT TIME	**1m 46s** AVERAGE WAIT
0 CONTACT CENTRE ONCOLOGY	**0** ACTIVE CALLS	**0s** LONGEST WAIT	**12** CALLS ANSWERED	**44s** AVERAGE ABANDONMENT TIME	**1m 29s** AVERAGE WAIT
0 ST ANNS ADMISSIONS	**0** ACTIVE CALLS	**0s** LONGEST WAIT	**5** CALLS ANSWERED	**49s** AVERAGE ABANDONMENT TIME	**6m 32s** AVERAGE WAIT
0 ST ANNS OUTPATIENTS	**0** ACTIVE CALLS	**0s** LONGEST WAIT	**27** CALLS COMPLETED	**1m 41s** AVERAGE ABANDONMENT TIME	**2m 5s** AVERAGE WAIT

Call queues have been set up at St Ann's, Potters Bar, and St George's and are in place at Croydon, Ealing and Northwick Park. The divisions will then be monitored against their performance levels for each site through divisional performance review meetings with the executive team.

Booking Centre PALS appointment queries received (excluding enquires and compliments) by quarter.

Q1 21/22		Q2 21/22		Q3 21/22		Q4 21/22	
Appointment queries	Calls not answered	Appointment queries	Calls not answered	Appointment queries	Calls not answered	Appointment queries	Calls not answered
62	5	72	3	67	2	86	1

The types of appointment queries received were:

- Request for NHS appointment
- Queries about bookings
- Manner and attitude (Administration)
- Access to treatment or care
- Appointment/operation/admit time/list
- Calls not answered/followed-up
- Appointment/operation /admit-delay
- Administration/clerical error
- Information regarding hospital and service

(Based on queries received Between 5 October – 13 November 2021)

What are the gaps in delivery if any?

• Booking and Contact Centre performance remains a risk, due to staffing levels, until call volumes can be reduced sufficiently. It is anticipated that this will be achieved with the further roll out of the *DrDoctor* system.

• Mailbox and *DrDoctor* can only be addressed by allocating overtime, which has not made a significant difference in reducing the numbers of emails waiting to be addressed. A longer term and sustainable means to manage the inbox needs to be put in place.

- While telephone systems across the trust are now rolled out and reportable, ongoing focus remains on call times.
- Quality of calls is still under review, via appraisal objectives/1:1 meetings and listening of calls.

What will we do in 2022-23 to continue with progress?

- The roll out of *DrDoctor* and *Netcall* will continue until all sites are covered by the systems.
- At least 2-3 additional agents will be employed to address the outpatient mailbox and *DrDoctor* patient portal, or redirect elsewhere, to facilitate the ability for call agents to prioritise answering calls. This will reduce number of patients calling in when they do not receive a timely response to their emails or *DrDoctor* requests.

Quality Domain: Patient experience
Priority 4: Improve patient appointment experience through standardisation of content and format for new and follow up patient letters

Our priority for 2021/22 is to: Improve patient appointment experience through standardisation of content and format for new and follow up patient letters	**Rationale:** It is essential that our patient appointment letters are clear, easy to read and inform patients about what they need to know. **What success will look like by the end of March 2022:** • The trust will have a clear and consistent approach to how letters will be sent out to patients. • All agreed changes will be implemented and live in the system. **What we will measure and when:** • A working group has been established by the access division. Other divisions will provide representation. Measures and monitoring will be put in place. • Scope completed by the end of Q1 (Divisions to feed in requirements). • Templates to be agreed by the end Q2. Content to be tested. • Pilot implementation in Q3. • Fully implement changes in Q4.

Background
Moorfields is committed to improving the experience of our patients by providing clear, easy to read appointments letters. The pandemic highlighted the number of letter templates varying in consistency, relevance and accuracy on our Patent Administration System (PAS), and an overhaul to standardise this method of communication was necessary.

What have we achieved to date?
Good progress has been made with this priority with letter templates agreed and pilot testing phases almost complete. We are on track to achieve full implementation.
A patient communication survey was undertaken on a two-monthly basis. The survey for July-August 2021 identified that complaints about appointment letters (save for the letters allegedly not arriving) are low. How the letters are written has not been raised as an area of concern in patient responses.

What are the gaps in delivery if any?
No gaps in delivery have been identified.

Clinical effectiveness and patient outcomes

Quality Domain: Effective
Priority 5: Improve patient outcomes and achieve a high-quality patient experience through the implementation of diagnostic hubs across the network

| Our priority for 2021/22 is to:

Improve patient outcomes and achieve a high-quality patient experience through the implementation of diagnostic hubs across the network | **Rationale:**
Diagnostic hubs are new facilities across our network, performing rapid access diagnostics in new patient pathways. We are evaluating the benefits and improvements for our patient outcomes and patient experiences because of these hubs.

What success will look like by the end of March 2022:
• Clinical support services will produce a diagnostic hubs patient outcomes and experience performance baseline, including supporting measures and key performance indicators (KPIs). This forms part of a wider performance review of diagnostic hubs performance.
• Each division will compare the performance of their diagnostic hubs against this baseline.
• The information obtained will be used for further improvements.

What we will measure and when:
• During Q1 we will develop a suite of performance indicators for our Hoxton Hub.
• In Q2 we will begin to measure these in Hoxton and establish a performance baseline.
• In Q3 and Q4 we will ensure that all divisions have their own suite of indicators, and we will have introduced measurements for all diagnostic hubs to compare against the baseline. |
| **Lead update** |

Background

With the development of diagnostic hubs across the trust, it was recognised that we need to measure the impact of these hubs to ensure there were no unexpected or adverse outcomes on our patients. We also wanted to ensure that excellence was captured and monitored to facilitate the roll out of other diagnostic hubs.

What have we achieved to date?

We have developed a dashboard, which will apply to all diagnostic hubs. The agreed dashboard, provided below, has been signed off by the divisions:

	MEASURE	KEY PERFORMANCE INDICATORS	RAG	DATA SOURCE	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
SAFETY	*Clinical review time from images to review by clinician	For MR and Glaucoma this is within 1 week from attendance	<50%, 51-75%, >75%	QlikSense data	68.6%	87.0%	94.6%	85.3%	59.1%	79.6%	57.5%	51.4%	56.8%	78.0%	91.0%	65.9%
	*Patients visible for virtual review in Open Eyes	% of patients correctly sent to the Open Eyes Virtual Clinic module	<80%, 81-95%, >96%	QlikSense data	93.3%	97.8%	99.1%	98.8%	99.3%	98.5%	97.8%	99.6%	98.7%	98.7%	99.5%	98.7%
	*Timeliness of intended follow-ups	% of patients booked a follow-up appointment within 25% of their intended interval	<80%, 81-90%, >91%	QlikSense data	76.2%	75.4%	82.1%	85.1%	81.3%	85.4%	85.3%	83.5%	87.4%	88.4%	91.2%	89.3%
	*Accuracy of intended follow-ups	% of follow-up appointment entered by admin into Open Eyes VC module that matches next booked appt in PAS	<80%, 81-90%, >91%	QlikSense data	78.0%	73.4%	76.5%	75.7%	74.2%	74.4%	75.0%	78.1%	85.1%	86.4%	90.0%	94.8%
	Patients where harm has been reported	% harm caused / Tot. No. of incidents reported	N/A	Ulysses	0	0	0	0	0	0	1	1	0	3	0	1
PATIENT EXPERIENCE	Median patient journey time (mins)	Median journey time for Glaucoma patients in minutes	>60, 59-46, <45	QlikSense data	45	42	39	39	37	40	39	32	26	35	34	34
	*How long for the results to be relayed to the patient	% of referral tickets in Open Eyes VC module actioned by admin within 1 week of clinical review	<80%, 81-90%, >91%	QlikSense data	56.28%	33.81%	7.91%	20.62%	51.51%	81.68%	61.61%	91.31%	98.34%	86.37%	98.09%	99.13%
	FFT	Response rate	> 15% response rate	Nautilus	45.56%	43.85%	40.67%	44.18%	43.33%	40.56%	41.54%	38.20%	41.88%	43.80%	42.10%	41.80%
	FFT	Positive response rate	> 95% positive response rate	Nautilus	95.53%	93.62%	97.02%	95.98%	94.00%	93.99%	94.27%	95.05%	94.25%	96.19%	94.74%	94.74%
	Formal complaints	Number of complaints	N/A	Divisional complaint database	0	0	0	0	0	0	0	0	1	0	0	1
CLINICAL EFFECTIVENESS	*Patients discharged	% of patients discharged at virtual review	N/A	Ad-hoc report / Qlik Sense data	6.84%	5.29%	5.48%	6.86%	4.24%	4.74%	2.53%	2.52%	4.57%	5.77%	5.72%	5.09%
	*Patients returning to F2F	% of patients given outcome of follow-up in F2F clinic	N/A	Ad-hoc report / Qlik Sense data	32.72%	34.12%	33.26%	34.58%	37.25%	33.80%	29.96%	29.56%	23.92%	28.83%	29.39%	30.24%
	Number of patients who have emergency appointment booked (Same day or following day)	Patients with a standard F2F attendance on the same or following day as diagnostic hub (in the same service)	N/A	Ad-hoc report	4	3	5	3	4	5	6	11	4	1	5	6

This will now form part of our divisional reviews throughout the year.

Further work was undertaken regarding divisional testing of KPIs in the proposed dashboard and setting of these KPIs into a diagnostic quality scorecard on *Qlik sense*. This was reported on in Q3 and then handed over as business as usual in Q4. The City Road and South divisions will start using the dashboard from Q1 2022/23.

What are the gaps in delivery if any?
None identified.

What will we do in 2022-23 to continue with progress?
The divisions continue to participate in assessing patient outcomes and experience against the baseline of the KPIs and other measures, participating in the wider review of the diagnostic hubs. The diagnostic hub quality priority scorecard has been developed with divisional leads and will be used to ensure that the quality, safety, and outcomes measured against baseline will also be reported at monthly divisional performance meetings.

Quality Domain: Effective
Priority 6: Support and improve the health and well-being of staff

| Our priority for 2021/22 is:
 In creating the best patient outcomes environment for patients, Moorfields will support and improve the health and well-being of staff, focusing on the additional support needed during recovery from the pandemic. | **Objective and rationale:** In creating the best patient outcomes environment for patients, Moorfields will support and improve the health and well-being of staff, focusing on the additional support needed during recovery from the pandemic.

 What success will look like by the end of March 2021:
 • Staff feel supported to raise health and wellbeing issues if they arise.
 • Managers feel prepared to support staff with health and wellbeing issues
 • Other teams, particularly workforce and organisational development, support the resolution of health and well-being issues by providing a range of awareness and education tools.
 • Other supporting structures work in combination to support staff with health and well-being issues, for example, our counselling service and the Freedom to Speak up Guardians.

 What we will measure and when:
 • Each division will identify two or three health and well-being priorities and develop indicators to measure their success. A plan for delivery during the year should be put in place in Q1. |

What have we achieved to date?

We have:

- Secured funding from NHS Charities Together to fund a health and well-being role on a 12-month fixed term contract

- Defined an action plan to deliver against the agreed strategy, which was signed off at the health and well-being group in December 2021. Implementation has been impacted by the resource gap outlined below.

Training for line managers on well-being conversations will be offered as part of our recently launched Leading with Compassion package.

Funding to deliver Active Bystander training has been secured – we will deliver 20 sessions, for up to 40 colleagues at a time during 2022/23. This training will equip colleagues with the skills and confidence to intervene if they witness inappropriate behaviour and will contribute to the emotional well-being pillar of our action plan.

Freedom to Speak up Guardians continue to raise awareness across the trust and have completed a series of site visits in the last six months.

Support routes, tools, and national offers are promoted weekly via the staff newsletter and *eyeQ* stories. Each division has identified areas for health and well-being that were incorporated into their workforce plans for 2021/22. These continue to be reported on as part of performance meetings with the executive team.

What are the gaps in delivery if any?

The health and well-being officer role was vacant between November 2021 and March 2022, which impacted on our progress.

2.2 Core clinical outcomes

Progress in 2021/22

Our performance against the core outcome standards has demonstrated excellent clinical care, with most standards being met and many being far exceeded. The complete core outcome data is tabulated below. Of note is that most outcomes are for all relevant patients across the trust over a full year. This increases the robustness of the data when compared to sample audits.

From September 2020, it became mandatory for all services to collect electronic patient record (EPR) data. Some of the 2021 outcomes are based on 1or 2-year follow-up data, where a combination of data collection from notes and EPR was required. In future years, data collection should be electronic throughout, allowing a larger proportion of the complete dataset to be captured.

Our cornea service previously circumvented delay in receiving corneal graft success rates from the NHS blood and transplant services (NHSBT) by collecting this data internally. This was possible through the establishment of a specific post-graft follow-up clinic with collaborative working to set up a database for measuring outcomes on these patients. Since 2020, NHSBT has provided 2-year outcome data on corneal grafts for specific conditions. Accordingly, from 2020, we restarted reporting from the NHSBT service data. In terms of Descemet's Membrane Endothelial Keratoplasty (DMEK) for pseudophakic bullous keratopathy (PBK), the rates of survival are nationally: 69.2%

(95% CI: 57.0% - 78.6%) and at Moorfields: 55.6% (95% CI: 28.5% - 75.9%). The difference is not statistically significant as there are wide confidence intervals (CI) due to small numbers of grafts in this category, but the CIs still overlap between both groups. We will monitor this group carefully in the next report to see if there is a trend.

The NHSBT report of DMEK for PBK for all grafts over the last 5 years showed an overall higher survival at Moorfields (74%) compared to 68% nationally. The latest 2-year survival report did not show a lower survival rate at Moorfields for the DMEK group for Fuchs endothelial dystrophy again suggesting that our DMEK outcomes are comparable to other national centres. It may be that, as we become more confident with DMEK, we tend to do DMEK in complex PBK cases where previously we would have done a Descemet's stripping with endothelial keratoplasty (DSEK).

Glaucoma tube surgery success this year has only, at this stage, been analysed in terms of final intraocular pressure (IOP) value instead of against multiple metrics. Whilst 82% is higher than the gold standard when looking at IOP alone (80%), further analysis is needed, for those cases where vision loss occurred with hypotony. We audit all tube operations, whereas the gold standard is based on randomised controlled trials which exclude certain high-risk cases where vision loss may be due to co-pathology.

Trust core clinical outcomes 2021-2022

Specialty	Metric	Standard	2019/20	2020/21	2021/22
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	0.77%	1.04%	0.81%
Cataract	Endophthalmitis after cataract surgery*	<0.04%	0.025%	0%	0%
Cataract	Biometry accuracy in cataract surgery*	>85%	92%	92%	93%
Cataract	Good vision after cataract surgery*	>90%	92%	89%	90%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	100%	97%	86%
Glaucoma	Tube (glaucoma drainage surgery) success	>90%	89%	92.%	82%
Glaucoma	PCR in glaucoma patients*	<1.95%	0.98%	0.91%	1.2%
Medical Retina (MR)	Endophthalmitis after intravitreal anti-VEGF injections*	<0.03%	0.01%	0.014%	0.006%
MR	Visual improvement after injections for macular degeneration*	>20%	21.1%	24.3%	23.9%
MR	Visual stability after injections for macular degeneration*	>80%	92.1%	93.4%	92.8%
MR	PCR in medical retina patients*	<4%	2.0%	1.2%	2.4%
MR	Time from screening to assessment of proliferative diabetic retinopathy*	80%	89%	80%	87%
Vitreo-retinal (VR)	Success of primary retinal detachment surgery	>75%	80%	84%	85%
VR	Success of macular hole surgery*	>80%	87%	89%	90%

Specialty	Metric	Standard	2019/20	2020/21	2021/22
VR	PCR in vitrectomised eyes*	N/A	2.6%	3.3%	2.6%
Neurotheology, Strabismus and Paediatrics (NSP)	Significant complications of strabismus surgery*	<0.43%	0.70%	0%	0%
NSP	Premature baby eye (ROP) screening compliance	99%	98%	99.1%	99.6%
Accident and Emergency (A&E)	Patients seen within 4 hours*	>95%	98.6%	100%	99.9%
External Disease	PK for keratoconus (2-year survival from NHSBT report) *	See table below	97%	97%	96%
External Disease	DALK for keratoconus (2-year survival from NHSBT report) *	See table below	93%	94.0%	98%
External Disease	DMEK for Fuchs' endothelial dystrophy (2-year survival from NHSBT report) *	See table below	84%	87%	87%
External Disease	DMEK for pseudophakic bullous keratopathy (2-year survival from NHSBT report) *	See table below	71.9%	74.3%	56%
Adnexal	Ptosis surgery success	>85%	98%	93%	100%
Adnexal	Entropion surgery success	>95%	99%	97%	95%
Adnexal	Ectropion surgery success	>80%	98%	98%	100%

*Indicators marked with an asterisk are based on a whole year's data for all relevant cases across the trust. All other indicators are based on a sample of cases collected over at least a 3-month period during 2021/22

Detailed report of the survival of corneal grafts including confidence intervals:

	2018/19 grafts 2-year follow-up data to end of 2021
Penetrating Keratoplasty (PK) for Keratoconus (KC)	• Nationally: **93.6%** (95% CI: 89.1% - 96.3%). • At Moorfields: **96.0%** (95% CI: 84.7% - 99.0%). • No statistically significant difference
Deep anterior lamellar keratoplasty (DALK) for KC	• Nationally: **95.2%** (95% CI: 90.6% - 97.6%). • At Moorfields: **97.8%** (95% CI: 91.6% - 99.5%). • No statistically significant difference
DMEK for FED	• Nationally: **83.8%** (95% CI: 80.0% - 86.9%). • At Moorfields: **86.7%** (95% CI: 78.9% - 91.8%). • No statistically significant difference
DMEK for PBK	• Nationally: **69.2%** (95% CI: 57.0% - 78.6%). • At Moorfields: **55.6%** (95% CI: 28.5% - 75.9%). • No statistically significant difference

2.3 Performance against key local indicators for 2021/22

This financial year has been focused on responding to the Covid-19 pandemic recovery and returning to business-as-usual levels of activity and beyond, where achievable. Whilst the tables on the following pages reflect a comparison with previous years, that comparison must be viewed with caution given the operational pressures for 2021/22 (and 2020/21) have been unequivocally different to previous years.

2021/22 key indicators

INDICATOR	SOURCE	2018/19 RESULT	2019/20 RESULT	2020/21 RESULT	2021/22 Target	2021/22 RESULT
PATIENT EXPERIENCE						
Reduce patient journey times in glaucoma and medical retina	Internal (QSIS) programme	New patients =94 mins. Follow-up = 90 mins.	New patients =94 mins. Follow-up = 101 mins.	New patients =102 mins. Follow-up = 85 mins.	New patients =91 mins. Follow-up =100 mins.	New patients =81 mins. Follow-up = 83 mins.
Improve patient experience through digital patient check-in kiosks	Internal (QSIS) programme	Indicator not in use	26.7%	2.7%[1]	60%	3.6%[2]
Data completeness for clinic journey time (Total)	Internal (QSIS) programme	46.6%	61.4%	46.6%	80%	53.6%
Data completeness for clinic journey time (Glaucoma)	Internal (QSIS) programme	59.9%	75.5%	65.7%	80%	70.9%
Data completeness for clinic journey time (MR)	Internal (QSIS) programme	55.2%	64.6%	53.7%	80%	55.8%
Reduce the % of patients that do not attend (DNA) their first appointment	Internal performance monitoring	11.6%	11.8%	13.4%	≤10%	13.3%
Reduce the % of patients that do not attend (DNA)	Internal performance monitoring	10.4%	10.5%	14.4%	≤10%	13.2%

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[1] Reflects reduced outpatient appointments and impact of pandemic
[2] Reflects reduced outpatient appointments and impact of pandemic

INDICATOR	SOURCE	2018/19 RESULT	2019/20 RESULT	2020/21 RESULT	2021/22 Target	2021/22 RESULT
their follow up appointment						
% of patients whose journey time through the A&E department was three hours or less	Internal performance monitoring	76.6%	75.5%	95.1%	≥80%	90.3%
Theatre sessions starting late*	Internal performance monitoring	33.8%	32.0%	53.0%	≤32.4%	44.1%
Theatre cancellation rate (overall)	Internal performance monitoring	7.1%	6.8%	6.5%	≤7.0%	7.3%
Theatre cancellation rate (non- medical cancellations)	Internal performance monitoring	0.8%	0.76%	0.49%	≤0.8%	0.70%
Number of outpatient appointments subject to hospital initiated cancellations (medical and non-medical)	Internal performance monitoring	3.52	4.58%	28.5%	≤3%	4.0%
SAFETY						
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	99.5%	99.6%	99.6%	95%	98.9%
% overall compliance with hand hygiene standards	Internal performance monitoring	99%	99.0%	99.5%	≥95%	99.1%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0	0
Number of reportable clostridium difficile cases	Number of reportable clostridium difficile cases	0	0	0	0	0

INDICATOR	SOURCE	2018/19 RESULT	2019/20 RESULT	2020/21 RESULT	2021/22 Target	2021/22 RESULT
Incidence of presumed endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.35	0.12	0.09	≤0.4	0.09
Incidence of presumed endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	0.17	0.08	0.14	≤0.3	0.08
Incidence of presumed endophthalmitis per 1,000 Glaucoma cases	Internal performance monitoring	N/A	0.37	0	≤1	1.14
Number of serious Incidents (SIs) open after 60 days	Internal performance monitoring	N/A	0	2	0	0
CLINICAL EFFECTIVENESS						
% implementation of NICE guidance	Internal performance monitoring	95.7%	100%	97%	95%	100%
Posterior capsule rupture rate for cataract surgery (cataract service)	Internal performance monitoring	1.13%	0.85%	0.98%	≤1.95%	1.03%
Number of registered and ongoing clinical audits past their target deadline date	Internal performance monitoring	N/A	1.65%	15.8%	≤10%	20.7%
Number of breached policies	Internal performance monitoring	N/A	6%	3%	≤10%	7%

* A late start is a session that started more than 15 minutes later than the planned start time.

2.4 Performance against 2021/22 national performance and core indicators

Moorfields reports compliance against NHS Improvement's requirements, the NHS constitution and NHS outcomes framework to the trust board, both as part of monthly Integrated Performance Reports (IPR) and as specific, issue-focused papers.

We consider this data is as described in the sections and tables below, because of our internal and external data checking and validation processes, including audits, but it is subject to the caveats raised in the statement of directors' responsibilities. An integral part of the IPR process is to identify not just performance against a numerical target but also to add value to the reporting process by articulating, using remedial action plans, any corrective actions the trust is taking to address areas of underperformance.

National performance data

All NHS foundation trusts are required to report performance against a set of core indicators using data made available to the trust by NHS Digital. Where the required data is made available by NHS Digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS Digital website and may not reflect the trust's current position (please note the data period refers to the full financial year unless indicated).

National performance measures

The trust uses comparative data to benchmark performance. The date ranges covered vary for each measure, but the latest available data has been used in the table below:

Description of target	Performance 2020/21	Target 2021/22	Performance 2021/22	Average for applicable trusts (latest)	Best performing trust (latest)	Worst performing trust (latest)
Infection control						
MRSA (rate per 100,000 bed days)[4]	0	0	0	0.7	0	6.07
Clostridium difficile year on year reduction	0	0	0	n/a	n/a	n/a
Risk assessment of hospital-related venous thromboembolism (VTE)[1]	98.5%	95%	98.6%	n/a	n/a	n/a
Waiting Times						
Two-week wait from urgent GP	97.8%	93%	98.7%	82.4%	100%	47.9%

Description of target	Performance 2020/21	Target 2021/22	Performance 2021/22	Average for applicable trusts (latest)	Best performing trust (latest)	Worst performing trust (latest)
referral for suspected cancer to first outpatient appointment[2]						
Cancer 31-day waits –diagnosis to first treatment[2]	100.0%	96%	99.1%	93.5%	100%	73.0%
All 62 days from urgent GP referral to first definitive treatment[2]	100.0%	85%	100%	69.6%	100%	25.5%
Four-hour maximum wait in A&E from arrival admission, transfer or discharge[3]	99.98%	95%	99.9%	97.6%	100%	85.5%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks[5]	59.7%	92%	78.1%	63.7%	99.8%	35.9%
Maximum 6 week wait for diagnostic procedures[2]	64.4%	99.0%	99.0%	74.3%	100%	18.1%
Other						
28-day Emergency readmission rate (over 16 years old) – excluding retinal detachment	1.74%	2.64%	1.15%	n/a	n/a	n/a
28-day Emergency readmission rate (over 16 years old) –retinal detachment only*	5.33%	n/a	4.21%	n/a	n/a	n/a

Description of target	Performance 2020/21	Target 2021/22	Performance 2021/22	Average for applicable trusts (latest)	Best performing trust (latest)	Worst performing trust (latest)
28-day readmission rate (0-15 years old)	0.0%	n/a	0%	n/a	n/a	n/a

[1] – National data collection suspended

[2] – Comparison data from NHS Statistical Work Areas – April 2021 – Jan 2022

[3] – Comparison data from NHS Statistical Work Areas – April 2021– Dec 2022

[4] – Comparison data from Model Health System. Metric is rate per 1000,000 bed days

[5] –Comparison data from NHS Statistical Work Areas – April 2021 – Jan 2022

Referral to treatment (RTT 18 weeks) performance

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

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

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

Measure	Target	Q1	Q2	Q3	Q4	Year end 2021/22
18-weeks RTT incomplete	92%	75.3%	80.7%	78.6%	77.6%	78.1%
18-weeks RTT incomplete with decision to admit (DTA)	N/A	68.9%	74.5%	72.8%	69.0%	71.2%
18-weeks RTT admitted	≥ 90%	61.7%	69.0%	78.2%	64.1%	73.4%
18-weeks RTT non-admitted	≥ 95%	65.8%	72.3%	70.7%	71.3%	70.0%
New RTT periods (clock starts) all patients	N/A	30,225	30,898	30,062	32,769	123,954

Performance of the measure of the RTT18 incomplete pathway (the key RTT18 performance indicator) across all pathways has increased throughout the year, despite the ongoing effects of the Covid-19 pandemic. This has been achieved through rigorous monitoring of patients as well as excellent work and initiatives within the services. We continue to be on course for recovery of our RTT position. There were also a considerable number of checks and balances introduced that provided assurance that patients from these challenging events were not overlooked or missed, in addition to our already rigorous patient safety measures.

The largest negative impact seen to our overall RTT performance has been due to the significant mutual aid we have provided to other trusts, to the tune of 700 long waiting patients. These patients

have been managed effectively, becoming our responsibility well into their pathways, and have been seen promptly, while maintaining our overall performance.

Establishment of diagnostic hubs at Brent Cross and Hoxton has also shown improvement in patients overall waiting times and the expansion of these hubs will only improve our position in the coming year.

Onward referrals from other trusts

As a tertiary provider receiving onward referrals from other trusts, a key challenge for us is reporting pathways for patients who were initially referred to other providers. This is because we are required to report performance against the 18-week target for patients under our care, including those referred from other providers.

Depending on the nature of the referral, and whether the patient has received their first treatment, we can either 'start the clock' on a new 18-week treatment pathway, or represent a continuation of the patient's waiting time, which began when their general practitioner (GP) made the initial referral. Therefore, to report waiting times accurately, we need other providers to share information on when each patient's treatment pathway began.

Although providing this information is required under the national RTT rules, and there is a defined inter-provider administrative data transfer minimum data set to facilitate sharing the required information, we do not always receive this information from referring providers despite extensive chasing. This means that, for some patients, we do not know definitively when their treatment pathway began. The national guidance assumes that the clock start can be identified for each patient pathway and does not provide guidance on how to treat patients with unknown clock starts in the incomplete pathway metric.

While internal and external audits have shown instances of this to be markedly reducing, it is still an issue for Moorfields as a tertiary centre. Our approach for reporting the indicators where the clock stop cannot be identified is as follows:

- **Incomplete:** we include these patients in the calculation with some form of assumption about the start date.[3]
- **Admitted:** we exclude these patients from the calculation and report as unknown clock starts in national data submission.
- **Non-admitted:** we exclude these patients from the calculation and report as unknown clock starts in national data submissions.

Performance indicator data quality

A vital pre-requisite to robust governance and effective service delivery is the availability of high-quality data across all areas of the organisation. The organisation requires quality data to support

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[3] For incomplete pathways, the trust makes the performance calculation on the assumption the pathway has started on the date the referral is received by the trust. These referrals are then investigated to see whether an earlier 'clock start' date is required to measure the whole pathway. If we cannot ascertain an accurate clock start, the pathways are counted as unknown.

several business objectives, including safe and effective delivery of care, and the ability to accurately demonstrate the achievement of Key Performance Indicators (KPIs). Our data quality policy sets out the specific roles and responsibilities of staff and management in ensuring that data is effectively managed from the point of collection, through its lifecycle, until disposal.

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

Data quality continued to be given a high profile in 2021/22, with the inclusion of a larger range of directly related KPIs published within the Integrated Performance Report (IPR), which was presented to the board each month. These KPIs now include:

- Data Quality - Ethnicity recording (Outpatient and Inpatient)
- Data Quality - NHS Number recording (Outpatient and Inpatient)
- Data Quality - GP recording (Outpatient and Inpatient)
- Data Quality - Ethnicity recording (A&E)
- Data Quality - NHS Number recording (A&E)
- Data Quality - GP recording (A&E)

Due to the Covid-19 pandemic, the data quality audit team also designed and implemented a new digital audit process for some of the audit portfolio. This ensured that data quality auditing could still commence and was viable in an agile working environment. The team are planning to move more audit areas into a digital/virtual based platform and hope to use the *Tendable* app (previously Perfect Ward) to support this. This will provide continued assurance to the organisation that all audit areas, including data submissions to bodies such as NHS Improvement, NHS England, and NHS Digital, are of a continued high standard. The performance team has worked closely with the operational teams to develop processes that support the trust-wide implementation of standard operating procedures (SOPs) and will continue undertaking a series of compliance audits. This ensures that information capture processes are standardised and are adhering to guidance, thereby ensuring accuracy and completeness. We have also established the audit of *paperlite* documents/CITO scanning to provide the assurance that we provide a high-quality electronic patient record which is usable across the organisation, these audits are conducted using the BSI1008 standard as a guidance.

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

The data quality team are leading a task and finish group which is supporting data improvement for areas such as Next of Kin (NOK) data and are now working with teams across the trust to support improvements in collection and recording of this vital information. A data quality risk register has also been implemented to support ongoing data quality improvement work and can be used to highlight areas of concern across the trust.

28-day emergency readmission rate

The information below is gathered on our internal dataset. The trust is unable to provide national comparative data for this measure due to data not being available on the NHS Digital website. The trust considers this data is as described, as we have a robust clinical coding and data quality assurance process, and readmission data is monitored through the trust management committee monthly.

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

We have taken the following actions to improve these indicators and in turn the quality of services by:

• improving electronic data capture using our improved electronic systems.

• continuing to audit data capture and use the results to improve data recording accuracy through monthly monitoring.

• further improving standard operating procedures and maintaining staff training programmes.

• using the data assurance framework to strengthen data capture across several defined criteria.

Our dedicated information management and data quality group, which supports improvement, meet monthly and monitor readmission rates.

Patient participation

The patient participation strategy's aim is to embed patient participation activities across the trust and ensure our service users, carers and communities are central to everything we do. We engage both patients and staff to work together to identify and address issues, and to create excellent patient experience and outcomes.

Face to face patient groups have been substantially reduced during the Covid-19 pandemic and recruiting patients to online fora has been difficult. The focus has been on other patient feedback gathering activities and implementing change.

National Cancer Patient Experience Survey 2020 (published November 2021) is an annual survey which monitors national progress on cancer care to drive local quality improvements, assist commissioners and providers of cancer care, and inform the work of the various charities and stakeholder groups supporting cancer patients. The survey asked adult patients from the Moorfields oncology service a range of questions about their treatment pathway and the support they received.

39 questions were relevant to Moorfields and of these, 12 received a positive score of 80% or above, and there were no significant changes on previous surveys.

Areas where we did particularly well included where patients said they were given the name of a Clinical nurse specialist (CNS) who would support them through their treatment, and where patients found it very or quite easy to contact their CNS.

Patients felt they were not excluded in conversations about their care and treatment, and that enough privacy was provided when these discussions took place. In addition, patients felt that the time waiting for their tests and the information given to them regarding their tests was about right.

If patients had undergone surgery, they felt they were given the information they needed prior to their operation and the advice needed following discharge. A further, inhouse, survey is being conducted to look at this in more detail. Actions taken in response to the survey include the re-formation of the Moorfields Cancer Board to oversee how the service may be improved. Suggestions for change include developing a guide for patients, providing audio-recordings of consultations to patients, obtaining real-time feedback about patients' experiences, and allowing easier patient access to their personal health records.

The Young Person and Children's survey and A&E survey were also reported this year. Parents and children reported that we did particularly well with both parents and children feeling looked after by staff and care plans being agreed with parents for their child's care. An area of improvement was regarding cancellation of admission dates.

The Sight Loss Awareness Committee brings together patient and representative stakeholder groups, including Guide Dogs, Royal National Institute of Blind People (RNIB) and London Vision, who meet regularly to discuss how we can better improve the experience of those with sight loss and other vulnerabilities when visiting Moorfields. The group has initiated a communications plan to promote sight loss awareness among staff and these activities will continue through 2022/23. The group also provides a patient perspective to Accessible Information Standard (AIS) implementation.

A significant event this year was the introduction of sight loss awareness training, which is mandatory for all staff every two years. Feedback from an initial patient survey was very positive, suggesting improvements following the introduction of the training. However, it also identified some inconsistency, which it is anticipated will be improved once more staff are trained.

Future events for the patient experience team include the promotion of the Eye Care Liaison (ECLO) service and the launch of *animmersive*, virtual reality training tool, focusing on holding conversations with empathy (breaking bad news) and the experience of a clinic visit for someone with sight loss.

A stakeholder group, to which patients, CCGs, and Healthwatch were invited, discussed what quality priorities the trust should aim to achieve during 2022/23. The topics discussed included AIS, the Patient Safety Strategy, and the *Tendable* audit tool.

Transport

A virtual patient user forum with patient and carer representation was held regularly to discuss the transport service, providing an opportunity to raise issues with the transport provider (DHL/Royal Free hospital). The data for 2021/22 shows that transport provision has been variable, especially for collecting patients in the evening. Regular representation is made to DHL/Royal Free Hospital (RFH) to address these issues. Following patient feedback and incidents, a health care assistant has been engaged to care for patients waiting for transport, especially those facing delays for transport. We will continue to monitor and drive improvement through 2022/23.

Accessible Information Standard

The project group formed to look at how we meet the AIS, continued to meet in 2021/22 and has developed two work streams focusing on immediate implementation of AIS improvements, and adapting digital systems (PAS, *OpenEyes*) to automate the AIS process. The quality and improvement team have identified a project manager to support the implementation. The working group has collected data to support improvement and progress in this area, and AIS has been identified as a quality priority for 2022/23.

Digital exclusion

We understand, as we move to the use of digital systems to communicate and monitor our patients, there is a need to ensure our patients are not digitally excluded from access to our care. A multi-disciplinary Digital Exclusion forum (led by this year's Darzi fellow) was held and discussed ways that patients can be helped to overcome barriers preventing them from engaging with the technology used by Moorfields, such as online consultations or digital consenting (the feasibility of which another group is currently looking at). There was also a session where patients could use technology and identifying potential training needs. Going forward, we are piloting 'digital pods' where patients can attend and receive support for their online consultation.

The customer service excellence programme continues in Moorfields Booking Centre, focusing on improving customer service with the aim of a wider trust roll out, as described in the quality priorities for 2021/22.

The 2021/22 Complaints and PALS report showed an increase in complaints and PALS enquires this year. The main themes of complaints remain clinical concerns, staff attitude, communication, and transport. PALS enquiries still focus on appointments management and communication. The patient experience committee continues to meet to discuss patient feedback and what changes can be made as a result.

NHS England Friends and Family Test results (FFT)

During 2021/22, 221,597 (35%) of patients who attended face to face appointments, or had telemedicine or telephone consultations, responded to a FFT text with around 80% leaving a comment (positive, negative or suggestions for improvement).

As well as the FTT question…*how would you rate your experience today?* a supplementary question was also asked *Please tell us about anything that would have improved your visit* ('consultation' for telemedicine and calls).

FFT Results

FFT Trust results for 2021/22

Responses: (total- 221,597) to the question *how would you rate your experience?*

All consultations

	Response rate	Very good or good	Poor or Very Poor
A&E (n- 61,879)	40.1%	92.8%	3.2%
Inpatients (n- 33,280)	42.6%	95.3%	1.2%
Outpatients (n- 538,708)	33.9%	93.4%	2.2%
Trust total (n- 633,867)	35.0%	93.4%	2.3%

FFT themed analysis of comments

Face to face consultations

It was not possible to theme all FFT comments from a trust wide perspective, although they are accessed and read locally. Most comments are positive, commenting on the kindness, friendliness, and service delivery of staff. However, the responses for those patients seen face to face, who scored their experience as **very poor, poor, or neither good nor poor** does allow for themed analysis. Below are themed comments from these categories for **Q3 2021/22** as an example for the year.

Fig. 1 Themed comments for **Q3 2021/22**
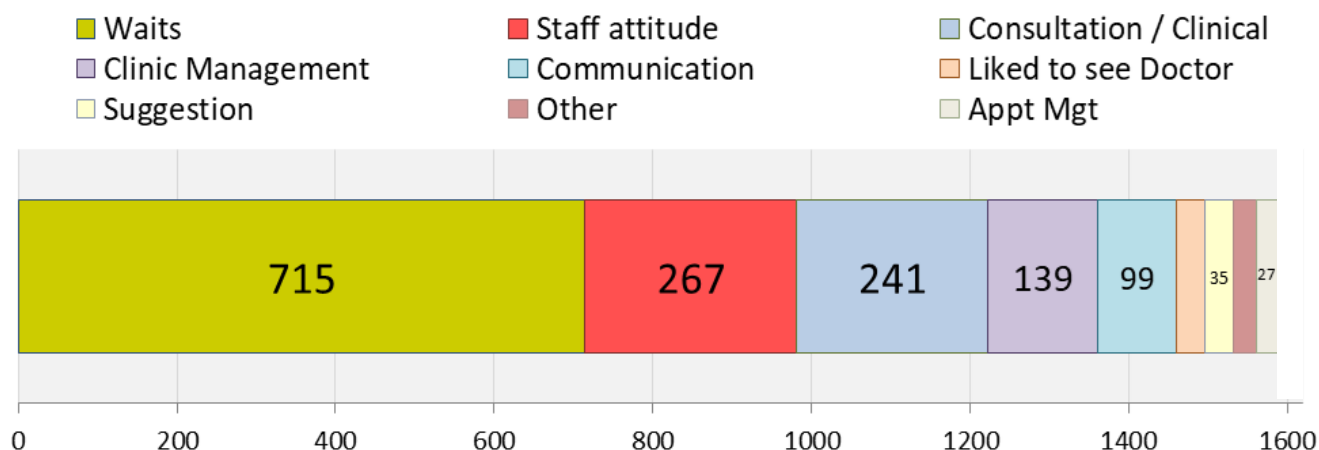
Waiting and not being informed of delays remain the main issues raised by patients.

The second largest number of concerns in this group was related to staff attitude and poor customer service. When the scores of **very good and good** were included in the analysis, there were 439 comments received regarding perceived poor attitude for Q3. These came from 31 different network sites and City Road services and involved all staff groups. 60 mentioned nurses, 61 doctors, 118 receptionists, and 24 security, volunteers, or staff at entrances. Though the situation related to the pandemic has caused difficulties, and perhaps some confusion, the word 'rude' was cited 98 times and (poor) attitude 49 times. Most of the comments related to the normal clinical setting.

Where patients reported issues regarding their clinical outcome, this was due to various reasons including not seeing a doctor (e.g., patient being seen in virtual A&E or diagnostic hubs), feeling rushed, clinical expectations not being met and other, more specific, concerns. Clinic management issues centered around the organisation of clinic appointments on the day and included medical records management, perceived disorganisation and pathway management. The data tells us that communication is at the core of many of the concerns raised, both between staff and patients as well as between teams.

Complaints and PALS concerns
Complaints and PALS concerns are a valuable source of patient feedback about services, outcomes, and individual performance. They provide scope for learning and service improvement. The trust received a total of 298 complaints in 2021/22, compared to the 230 received the previous year.

Complaints
Clinical concerns continue to be the cause of most complaints. Concerns focus on treatment outcomes, misdiagnosis, questioning treatment, or lack of information relating to care. All complaints responses relating to clinical care are reviewed by the medical director and shared with the risk and safety, and safeguarding teams. Where appropriate, complaints are also discussed at the trust's serious incident panel. There were 3 complaints related to Covid-19 arrangements (down from 13),

mainly in relation to patients not being allowed to be accompanied by companions (to ensure social distancing), mask wearing, and Covid-19 sampling.

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

PALS Concerns

PALS received 5,637 enquiries in 2021/22 (5,204 in the previous year). Of these, 153 were compliments, 2,899 were requesting information and 2,585 were concerns. Of the concerns, the largest number related to appointments management, followed by communication issues (including telephone responses) and questions about clinical care or treatment.

Compliments

The number of compliments received by PALS is relatively low, with more being received locally by individual teams and on trust social media channels. Most patients prefer to compliment staff through the FFT, the overwhelming majority of which are complimentary as noted above.

Fig. 2 Complaints by broad category - 2018/19 to 2021/22
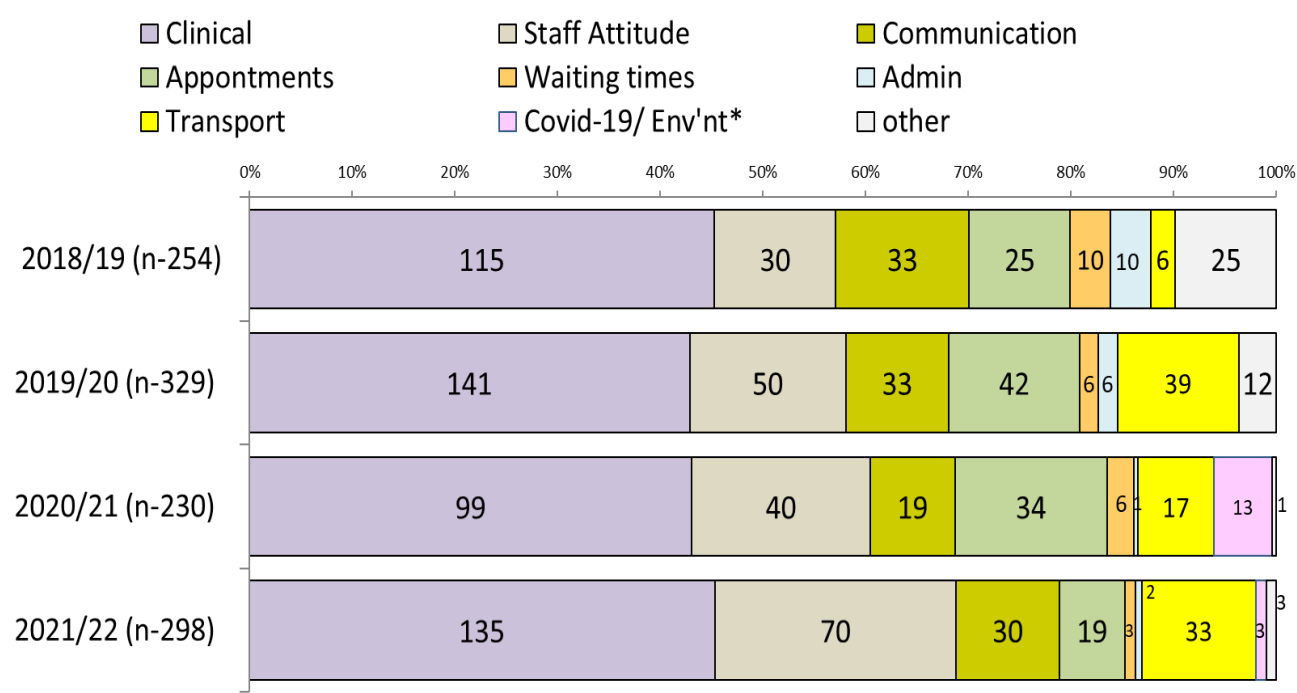
Fig.3 Complaint's performance: Key performance indicators for 2021/22:

KPI		Target	2018/19	2019/20	2020/21	2021/22
Response <25 days		80%	82%	59%	88%	71%
Acknowledgment <3 days		80%	96%	85%	99%	95%
Re-opened cases		n/a	11% (28)	14% (33)	14% (33)	13% (38)

Re-opened cases: During 2021/22, there were 38 re-opened cases from those who initially complained during the period. These were from complainants who had further concerns or who challenged the findings. The majority were satisfied following a second response.

Ombudsman referrals: During 2021/22, there were eight referrals to the Parliamentary and Health Service Ombudsman (PHSO). None have been upheld and two continue to be under investigation.

Response time: All but one complaint was acknowledged within the three-day KPI. In cases where the final response breached the 25-day KPI, this was often due to it requiring a complex investigation with multiple aspects and issues. There is a continuous focus on improving the patient experience of complaints handling and the central teams and divisions continue to work to develop this.

The organisation did not meet their target this year for complaint responses. This was mainly due to the impact of the pandemic, and the complexity of the complaints received. However, we acknowledged 95% of complaints within three days and where a complaint response was delayed, patients were kept informed. We will continue to improve our patient focus when responding to complaints and PALS enquiries and our responsiveness.

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

We value the feedback that we get from our staff; we use this to improve our staff experience by shaping our strategies and informing our plans. Previously, our staff FFT was conducted quarterly with the survey sent to all staff, and the FFT questions also included in the annual national staff survey. However, during 2020/21 there was no data submission or publication due to the pandemic, this followed the advice from NHS England and NHS Improvement.

Monitoring staff engagement and maintaining staff satisfaction is a key part of our strategy to attract, retain and develop great people. The staff survey asks staff to tell us whether they would recommend Moorfields as a place to receive treatment and whether they would recommend it as a place to work. Moorfields considers that the data in the table below is as described because we regularly review and share the results with our staff.

Moorfields intends to improve this indicator by implementing the workforce strategy linked to the NHS people plan, particularly the 'best place to work' work-stream.

The results from the national questions show that most of our staff are proud to recommend Moorfields as a place for treatment, and likewise as a place to work, keeping us in a good position compared to all NHS organisations. We recognise the impact of internal change and the pandemic on our staff and their perceptions of the working environment. Therefore, we are allocating some time and resources, including creating safe spaces, to have meaningful conversations with staff groups through listening exercises, line management, and leadership support. The outputs from these conversations and our workforce plans will help us create measurable action targeted at improving the overall staff experience within the trust.

	2019/20				2020/21	2021/22
	Q1	Q2	Q3	Q4*	Year*	Year*
% staff recommending Moorfields as a place for treatment	(92.95) 93	(94.8) 95	89	N/A	88	86.7
% staff recommending Moorfields as a place to work	(57.96) 58	(54.7) 55	69	N/A	70	63.2
Response rate/ (completions)	156	115	56% (1204)	N/A	54% (1184)	54.0% (1232)

*Following advice from NHS England and NHS Improvement and due to the pandemic, there was no data submission or publication since Q4 2019/20. Therefore, we are submitting the data taken from the staff survey results.

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

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

- All patients admitted for day surgery or as overnight inpatients have their nursing assessments using our Integrated Care Pathway document. 'VTE Risk Assessment and Treatment Plan' forms part of the risk assessments for all patients admitted.

- Most ophthalmic treatment or ophthalmic surgery poses low risk for hospital acquired VTE. So far, there has not been any recorded incidents of hospital acquired VTE via our incident reporting systems and the incident reviewing system, including Serious Incident Panel.

Moorfields continues to take actions to continue to improve this indicator and so the quality of our services as below:

- For those paediatric patients who are between the age of 16 and 18 and are being operated on and admitted onto the paediatric day care ward rather than admitted via adult wards, we have been carrying out VTE assessment using the VTE Risk Assessment and Treatment Plan to risk assess. This had been an improvement from the year before and we are continuing this practice in our children's hospital.

Patient safety incidents (PSIs)

The incident reporting system continued to be effective throughout the year and was available for use by all staff at all locations. During this period there has been an increase in clinical activity, in comparison with 2020/21 where there was a considerable reduction as a direct consequence of the pandemic. The increase in activity and associated increase in patient footfall at the sites, as patients have been welcomed back for face-to-face appointments, is reflected in the number of reported incidents. However, the trust is yet to achieve pre-pandemic reporting levels and further work to assess the extent to which this should be expected, given the new ways of working that have been introduced, is required. This work will inform the development of the trust PSIRP and implementation of PSIRF, in accordance with the requirements of the national patient safety strategy.

The number of incidents reported has been monitored throughout the year, on a weekly basis, and the clinical divisions are able to challenge local incident reporting rates based on the information that is shared. Throughout the year, the risk and safety team has continued to adjust and make improvements to the system to ensure continued ease of use. The reporting functionality has continued to improve, and divisions continue to monitor their own progress locally. The changes have been made in conjunction with service users which, in turn, should encourage reporting.

The timely management of incidents, including their reporting, investigation, and closure, means that the opportunities to learn and take appropriate action to minimise future reoccurrence are maximised. There has been sustained trust-wide focus on the timely closure of incidents and reports have been consistently generated throughout the year, both by the central quality team and locally by divisions, providing an overview of performance and which indicate areas in which improvement is required. Bi-weekly quality and safety summary escalation reports have been provided to the executive quality and operational directors throughout the year. Performance has been variable throughout the year, and this year has continued to be affected by events such as higher levels of sick leave and the sustained focus on increasing clinical activity. Further improvement is needed; however, this is achievable and will be driven by the central team and quality partners. This will remain a focus over the next year, informed and supported by the work that will be undertaken to better understand and improve the trust safety culture.

In 2021/22, we declared six serious incidents (SI), one of which was classified as never event (wholly preventable untoward events, which have the potential to cause serious patient harm or death, which are deemed to be serious enough that they should never occur – for example, surgery on the wrong eye muscle, implantation of the incorrect intraocular lens). Of the six SIs reported during 2021/22, no deadline breaches were recorded, and the trust worked collaboratively with the commissioning support unit (CSU) and clinical commissioning group (CCG) to ensure that extensions were applied appropriately. At the time of writing, one SI investigation remains on-going. Robust investigations,

supported by clinical harm reviews where required, were undertaken in all 3 cases, and learning from each incident has been shared across the organisation.

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

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

- The trust uses an electronic reporting system, which undergoes continual improvement in order to satisfy the needs of reporters and internal subject matter experts (SMEs). The incident reporting system includes a complex range of notification rules to ensure that the correct managers are notified when an incident is reported. In addition to these notification rules, the risk & safety team notifies additional managers and SMEs, as required, and local teams can do the same.
- The trust has a weekly SI panel, chaired by a consultant ophthalmologist, which considers in detail those incidents that fall within the scope of the terms of reference (for example, incidents, excluding complications, graded as moderate or above harm, potential never events). The terms of reference for this group were revised and approved in April 2021, having been updated to reflect the new ways of working that were established during the pandemic and which proved to be highly effective because of the enhanced inclusivity that a virtual meeting offers. Increased focus on shared learning and improvement has been sustained throughout 2021/22.

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

- Continued monitoring of the numbers of reported incidents, and identification of barriers to reporting.
- Seeking feedback from users regarding the barriers to reporting and identifying improvement opportunities.
- Development of the PSIRP and implementation of PSIRF.
- Connection to the learn from patient safety events (LFPSE) service, as the replacement for the national reporting and learning service (NRLS), when advised to do so. LFPSE will create a single national NHS system for recording patient safety events. It will introduce improved capabilities for the analysis of patient safety events occurring across healthcare, and will enable better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.
- Enhanced monitoring of reporting specifically during the period of PSIMS implementation, which is expected over the next 12 months.

Summary of Serious Incidents (SIs)

Never Event title	Brief details

Incorrect site (correct eye) brachytherapy	One case of a patient having a radioactive plaque applied to the incorrect site (posterior suspicious naevus, which required monitoring, instead of the planned ciliary body melanoma)

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

Serious Incident title	Brief details
Two cases where the incorrect intraocular lens (IOL) was inserted	Two different patients had the incorrect IOL inserted. In both cases the lens inserted was that which had been described on the IOL selection sheet. Both involved transcription errors.
Referral management	The trust received a report from the referral system third party supplier detailing that, in the period between 8 July 2020 and 21 October 2021, 10,809 referrals had a workflow status suggesting that the referral had not been transmitted to the trust's booking centre or for onward clinician scrutiny. Every affected referral has been reviewed by a clinician to determine whether clinical harm had occurred. The clinical harm review remains on-going for a small number of patients.
Delay in the provision of a post-operative appointment	A patient was reviewed at 5 weeks post-operatively instead of approximately 1 week, as requested by the surgeon.
Death of an outpatient	A patient who had attended an outpatient appointment passed away shortly after leaving the building. This investigation remains on-going.

All completed SI investigations have associated action plans, which are formally approved by an executive director as part of the report sign-off process. Implementation of the action plan is monitored by the central risk & safety team and the SI panel. Learning is shared via various mechanisms, including at divisional quality forums, service (sub-specialty) meetings, via divisional and quality team newsletters and learning and improvement following events (LIFE) bulletins (LIFEline).

Total number of reported PSIs

The table below shows the total number of reported PSIs during the period April 2019 to March 2022, where data has been made available. The NHS Digital files are not updated when new data is released, and this accounts for the discrepancy between the Moorfields local record data and that which has been published by NHS Digital for the same period. Trust data, for all 3 years, has been refreshed since the previous report. The number of PSIs reported at Moorfields has increased during the financial year 2021/22, in comparison with the data from the previous year during which there was a reduction in patient activity during the pandemic. It has not yet returned to pre-pandemic levels and the possible reasons for this will be examined in more detail. Reporting activity, in particular the level of reporting by clinical divisions, has been monitored on a weekly basis throughout the year.

	Reporting period		
	2019/20	2020/21	2021/22
Moorfields (trust local record)	6449	2622	4274

Moorfields (NHS Digital)	5861	2539	Data not available
National average*	3015	2566	Data not available
Lowest performing trust**	753	466	***466
Highest performing trust**	5861	5411	***5411

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

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21 as no new data was available

Rate of PSIs reported

The table below presents a summary incident reporting rate for the trust, during the period April 2019 to March 2022. Because Moorfields primarily provides ambulatory care, the organisation calculates a reporting rate based on incidents per 1,000 events. The reporting rates shown have been extracted from the Moorfields' quality and safety dashboard. These rates are not comparable against the reporting rates published by NHS Digital, which are calculated per 1,000 bed days.

	Reporting period		
	2019/20	**2020/21**	**2021/22**
Moorfields (trust local record)	8.9	7.5	7.4

Number of PSIs resulting in severe harm or death

The table below presents a summary of the total number of PSIs which resulted in severe harm or death that were reported from April 2019 to March 2022. The trust has a dynamic incident reporting process and records are continually reviewed and updated.

	Reporting period		
	2019/20	**2020/21**	**2021/22**
Moorfields (trust local record)	10	9	9
Moorfields (NHS Digital)	13	10	Data not available
National average*	3.7	6.4	Data not available
Lowest performing trust**	17	27	***27
Highest performing trust**	0	0	***0

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

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21 as no current data available.

Percentage of PSIs resulting in severe harm or death

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

	Reporting Period		
	2019/20	**2020/21**	**2021/22**
Moorfields (trust local record)	0.17%	0.34%	0.21%
Moorfields (NHS Digital)	0.22%	0.39%	Data not available
National average*	0.12%	0.25%	Data not available
Lowest performing trust**	0.78%	1.95%	***1.95%%
Highest performing trust**	0%	0%	***0%

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

**figures available on NHS Digital

*** Benchmarking data refers to 2020/21 as no current data available at the time of this report.

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

We have continued to strengthen and promote systems to support an open and transparent culture when things go wrong and show a willingness to report and learn from incidents. Adherence with the individual elements of the process continues to be captured within the electronic incident reporting system, and the risk and safety team and divisional quality partners monitor compliance on an on-going basis. Compliance data is routinely provided to SI panel, clinical governance committee and quality & safety committee (a sub-committee of the trust board). Where potential non-compliance with requirements is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. Actions are assigned by SI panel where a need for DoC is identified during the review of an incident. Individual incidents are not closed by the central team until assurance is received from clinical divisions that the DoC has been appropriately applied. This continues to have a positive impact, although the timeliness with which action is taken could be improved further.

In Quarter 1 2022/23 the trust undertook a re-audit of DoC compliance and compared the results with the previous audit completed during 2020/21. The audit results suggest that the application of DoC would benefit from a period of enhanced scrutiny, as there are some practices that require attention. For example, DoC letters continue to be addressed to the GP, and copied to the patient, and documentation of DoC in the health record when a complication of surgery has occurred needs to be improved. The trust will take the findings of the audit, and some learning from a Serious Incident (which did not form part of the audit), and use them to inform the review of the DoC Policy, supporting material for staff and the e-learning package. All materials will be formally re-launched later in the year.

The content of the existing e-learning package, for which compliance was noted to be 89 % in early-May 2022, will be reviewed to ensure that the improvement opportunities are adequately addressed.

Learning from deaths

The death of patients in our care is an extremely rare event. The scope of our learning from deaths policy is deliberately broad to make the best provision for potential learning opportunities; the scope includes not only mandatory inclusion requirements (for example, an inpatient death, the death of

an individual with a learning disability or mental health needs, the death of an infant or child) but also, for example, deaths within 48 hours of surgery, deaths of patients who are transferred from a Moorfields site and who die following admission to another hospital, and deaths about which the trust becomes aware of following notification, and a request for information, by HM Coroner.

During 2021/22 the trust was required to attend an inquest into the death of a patient who died in 2020 following elective surgery. A prevention of future deaths report was issued by HM Coroner in April 2021, and a response was provided in advance of the stipulated deadline.

The following statements meet the requirement set by NHS Improvement.

27.1   During the period 1 April 2021 to 31 March 2022, 1 of Moorfields Eye Hospital NHS Foundation Trust patients died (of which 0 were neonatal death, 0 were still births, 0 were people with learning disabilities and 0 had a severe mental illness). This comprised the following number of deaths, which occurred in each quarter of that reporting period:
- 0 in the first quarter.
- 0 in the second quarter.
- 0 in the third quarter.
- 1 in the fourth quarter.

27.2   By 31 March 2022, 0 case record reviews and 1 investigation has been carried out in relation to the 1 death included in section 27.1. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

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

27.3   0 deaths, representing 0% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

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

The one death that has occurred this year has been investigated as a serious incident, therefore these numbers have not required estimation using a modified version of the Royal College of Physicians Structured Judgement Review methodology, which is a retrospective case record review of the quality of clinical care provided.

27.4   The investigation into the one patient death that occurred in Q4 2021/22 highlighted the importance of a multi-disciplinary team approach in the event of a medical emergency. Administrative staff can provide valuable support to the clinical team by promptly alerting the necessary local staff, and host trust medical emergency team, and by ensuring that resuscitation equipment is brought to the location of the emergency. For input to be effective administrative teams should receive a local induction that includes orientation of emergency call bells, telephones and resuscitation equipment and they should complete basic life support (BLS) training. A national early warning score (NEWS) chart should be completed immediately for all patients who attend in poor health or who are recognised as starting to deteriorate. If a NEWS score does not trigger the need for medical emergency team support, staff should act independently of the score and refer patients for review by a doctor if they are concerned.

27.5   The investigation into the patient death that occurred in Q4 2021/22 was completed in Q1 2022/23 and the actions are in the process of being implemented, therefore the impact of the actions cannot yet be assessed.

27.6   There were zero case record reviews and one investigation completed after 31 March 2021, which related to a death which took place before the start of the reporting period.

27.7   One death, representing 100% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the internal SI investigation process.

2.5 Statements of assurance from the Board

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

Review of trust services

During 2021/22, Moorfields provided ophthalmic NHS services covering a range of ophthalmic sub-specialties (A&E, adnexal, anaesthetics, cataract, cornea and external disease, glaucoma, medical retina, neuro- ophthalmology, optometry, orthoptics, paediatrics, strabismus and vitreo-retinal).

Moorfields has reviewed all the data available on the quality of care in all the ophthalmic services that we provide. At Moorfields, we regularly review all healthcare services that we provide. During 2022/23, we will continue with our programme of reviewing the quality of care and delivery of services through our quality and service improvement and sustainability programme (QSIS).

The income generated by the NHS services under review in 2021/22 represents the total income generated from the provision of NHS services.

Freedom to Speak up

All NHS trusts are required to have Freedom to Speak Up (FTSU) guardians and a policy setting out FTSU arrangements. For 2021/22 there were four FTSU guardians in place:

- Dr Ali Abbas, locum consultant, City Road, St George's and Croydon
- Derek Scott, Health records team leader
- Amita Sharma, Infection Control Lead Nurse
- Julia Smythe, ECLO (Eye clinic liaison officer) Croydon
- Ian Tombleson, director of quality and safety (lead guardian)

If individuals are not happy to raise concerns via these guardians, or their concern is about the guardians themselves, or is at trust board level, these can be raised with Adrian Morris the appointed non-executive director of the trust board responsible for FTSU. Moorfields has a FTSU policy which sets out the scope of our arrangements. FTSU has a much broader definition than the previous term 'whistleblowing', which was often only used in the most extreme of circumstances and was viewed negatively. FTSU is viewed as way to provide additional support to staff. Examples of potential FTSU concerns in the policy include, but are by no means restricted to:

- Unsafe patient care
- Unsafe working conditions.
- Inadequate induction or training for staff
- Lack of, or poor, response to a reported patient safety incident
- Suspicion of fraud

- A bullying culture (usually across a team)
- A criminal offence has been committed, is being committed or is likely to be committed
- Concerns about staff well-being
- That the environment has been, is being, or is likely to be damaged

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

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

Provision of seven days services

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

- Clinical standard 2 – the trust is 100% compliant with this standard, with all patients seeing a consultant level subspecialist within 14 hours of submission.
- Clinical standard 5 – relates to access to diagnostic services. Services are available for microbiology, CT and ultrasound. MRI is only available on weekends via formal arrangement off-site.
- Clinical standard 6 – the only element that applies is access to emergency surgery which is available on weekdays and weekends.
- Clinical standard 8 – as a single specialty ophthalmology hospital we do not admit patients with high dependency needs so CS8 does not apply.

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

Guardian of safe working

As per Schedule 6, paragraph 11b of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in training (England) 2016, the board receives quarterly reports from the guardian of safe working and an annual report that provides assurance that doctors are safely rostered, and their working hours are compliant with the 2016 TCS. As at the end of quarter 3 in 2021/22, there have been no identified gaps in the rota. Exception reporting has been low, and this reflects trainees' well-being and satisfaction in working conditions.

Participation in clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that Moorfields was eligible to participate in during 2021-22 are as follows:

National Audits
- National Audit of Corneal Graft Outcomes

- National Ophthalmology Database (NOD) Cataract Audit

National Confidential Enquiries
- No studies were undertaken that were relevant for Moorfields to participate in 2021-22.

The national clinical audits and national confidential enquiries that Moorfields participated in, and for which data collection was completed during 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Numbers of cases submitted & relevant
National Audit of Corneal Graft Outcomes	1188/1436 (82.7%) (data from 01/04/2021-31/03/2022)
National Ophthalmology Database (NOD) Cataract Audit	7760/9261 (83.8%) *(data from 01/04/2020-31/03/2021)

*Due to a lack of HQIP funding and plans to align with the financial year, no new NOD reports have been circulated since their previous report covering period September 2018 – August 2019. A new report focusing on the financial year 2020-21 (with appendices results for the previous 4 years is hoped to be published by May 2022.

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

There were no National Confidential Enquiries (NCE) in 2021-22 whereby the trust was required to take part or submit data. Any relevant NCE studies are discussed at the bi-monthly Clinical Audit and Effectiveness Committee.

Although we did not qualify for submission for any of the studies in 2021-22, an organisational questionnaire detailing the trust structures in place for patient transition from child to adult services was submitted. This will contribute to a dataset that will lead to the development of a report and recommendations in March 2023.

Of the 1,436 ocular transplant forms received from the NHS Blood and Transplant team from 1 April 2021 – 31 March 2022, the trust completed and returned 1,188 (82.7%.) However, some of the forms received were for planned appointments yet to take place. The corneal graft clinic described above (Clinic 10) also proactively submits details to the NHS Blood and Transplant team without waiting for receipt of a form. Since 1 April 2021, the trust has also submitted several forms received during the previous year. In total during 2021-22, the trust submitted details of 1,612 patients to the NHS Blood and Transplant team.

Unfortunately, no reports have been received from the NHS Blood and Transplant service during this last year.

The NOD produced a report in May 2021 entitled *feasibility study of post-cataract posterior capsule opacification;* however, no annual reports from NOD have been published since the 2020 report assessing detail from September 2018 – August 2019.

National Audit Report	Discussed	Actions
NOD: No recent reports have been published, with plans to circulate a report of 2020-21 data by May 2022 (with appendices results for the previous 4 years)	Cataract Service	Once published, the report will be shared with the Medical director and Cataract service. Findings will be shared and discussed at Clinical Audit and Effectiveness Committee (CAEC) in 2022.
NHSBT: No reports have been published in 2021-22.	Corneal service	Progress with NHS Blood and Transplant audit data is discussed at CAEC throughout the year. The trust maintains internal processes to monitor data submission to the NHS Blood and Transplant team as no external reports have been forthcoming.

During the period 1 April 2021 to 31 March 2022, we proposed and approved 77 audits assessing national clinical standards/guidelines* (many of which have been completed or were re-audits).

*National audits are those registered by all trusts where benchmarking and comparisons can be made between organisations. Due to the single specialty nature of Moorfields, many national audits are not relevant. Moorfields therefore also audits against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists, National Institute for Health and Care Excellence (NICE), and national service frameworks. These are referred to as 'nationally derived' audits whereby all trusts undertake them but there is no benchmarking as these are done individually by trusts.

The 77 clinical audits derived from national standards and guidelines that Moorfields participated in from 1 April 2021 to 31 March 2022 can be summarised as:

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

(5 proposals have since been archived)

There were 51 nationally derived audit 'reports' completed and submitted during this time, summarised as:

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

Participation in clinical research

In 2021/2022 the number of patients recruited to studies increased to 9,058, the highest annual patient recruitment to Moorfields studies on record, while the number of studies active in the year increased to 179. Recruitment procedures were improved to make it easier for patients to participate in studies. These included obtaining consent by telephone and having recruitment coordinators based in the diagnostic hubs. These measures contributed to the increase in recruitment numbers.

Our highest recruiting studies for 2021/22 were
- **Addressing the Impact of the COVID-19 pandemic on the Mental Well-Being of Patients with Chronic Eye Disease in the United Kingdom**: 1,760 patient participants
- **Healthcare Exemplar for Recovery from COVID-19 by Use of Linear Examination Systems (Project HERCULES):** 3,473 patient participants
- **Study to ascertain the impact of deferring intra-vitreal injections for diabetic macular oedema under the COVID-19 pandemic at Moorfields Eye Hospital NHS Foundation Trust:** 508 patient participants

These three studies are particularly important as they address the NIHR and NHS priorities of increasing "out of hospital care" while minimising the effect of Covid induced restrictions on outcomes for patients, as well as on their mental health and equality of access to care.

- **Optical Flow Analysis in Robotic, Endoscopic, Micro and Ophthalmic Surgery Developing Feedback Algorithms for Enhanced Outcomes:** 610 patient participants

This surgical study conducted at four Moorfields sites uses digital information on surgical performance to optimise training, which is an NHS priority to address the pandemic induced backlog in surgical training.

We have continued to be a national and international leader in the field of high-quality ophthalmic research. This was recognised by the renewal of our quinquennial £6.48 million grant from the National Institute of Health Research to continue to support the work of the Moorfields Clinical

Research Facility and receiving over £713,000 for 2022/2023 from the North Thames Clinical Research Network to aid recruitment to our wide range of portfolio adopted studies.

Quality, Safety and Research Governance

The Research and Development (R&D) Quality Management System [QMS] documents the departments research delivery practices to ensure regulatory compliance, and meet the requirements and expectations of study participants, research clinicians, as well as our research partners. The QMS has been developed to meet the requirements of ISO 9001: 2015, and covers the provision of all R&D. Internal audits are regularly conducted to provide assurance that studies are conducted to the required regulatory standards and in accordance with our internal policies and procedures.

Findings from internal audits, audits conducted by external sponsors and regulatory inspections are reviewed by the R&D Quality Review Group to help ensure appropriate corrective and preventative actions are implemented on a study specific and portfolio wide basis.

This year there has been a particular emphasis on information sharing with study participants to ensure that they are able to give fully informed consent prior to entering studies. This will continue with formal training programmes for all staff involved in consenting processes.

Major research initiatives include:

1. Optimising delivery of ophthalmic healthcare: Project HERCULES

The pandemic has brought into stark focus the need for novel approaches to deliver NHS care efficiently. Project HERCULES (Healthcare Exemplar for Recovery from COVID-19 by Use of Linear Examination Systems), established at Brent Cross Shopping Centre in September 2021 with £3.2million funding, forms part of our network of innovative high volume diagnostic centres providing, safe, accessible services to patients This 15,000ft^2 experimental digital facility is transforming ophthalmology care from conventional face-to-face to digital patient pathways. Such pathways combined with remote reporting are much more convenient for patients while making optimum use of the multidisciplinary care team.

The Brent Cross diagnostic centre can assess up to 1,000 patients per month. Over 3,000 patients have now been recruited to determine the optimal diagnostic hub pathways and compare them to traditional pathways. Project HERCULES will serve as a blueprint for the other high-volume specialties across the NHS developing new methods of providing accessible, effective, diagnostic services for patients particularly to those with chronic conditions requiring long term care.

2. Patient Navigation Maze

The Patient Navigation Maze was established in August 2021, with £800k investment from an industry partner, to support our clinical trials for novel therapies like gene therapy and innovative devices. It is one of only two such facilities in the UK putting Moorfields in a strong position to attract more ophthalmic clinical trials and strengthen our research pipeline. Based at the Moorfields Hoxton clinical site, the Patient Navigation Maze is used to measure a patient's ability to navigate through a maze including obstacles, under different lighting conditions, mimicking real life situations. This

provides FDA approved mobility data for our clinical trials to assess the impact of novel therapies on patient vision and quality of life. Several hundred study participants have now completed assessments in the Maze.

3. ROAM - Research Opportunities at Moorfields

To drive research forward, maintain our reputation as a global research leader and improve patient care, it is vital that patients and healthy volunteers participate in our research studies. To facilitate this, Dr Roxanne Crosby-Nwaobi developed "Research Opportunities At Moorfields (ROAM)". In October 2021, ROAM won the Nursing Times Award for Clinical Research Nursing.

ROAM is an easy-to-use web application where people can express an interest in contributing to research at Moorfields. We use this information to identify people who are suitable to take part in the wide range of studies at Moorfields. Participants also can contribute to the development of research questions and studies as part of our patient and public involvement and engagement programme.

To date over 1,000 people have signed up to ROAM to participate in eye research. 36% of the volunteers are non-Moorfields' patients encouraging patients throughout the UK to contribute to and participate in eye research in Moorfields.

4. Sight saving bionic chip clinical trial

In January 2022, a patient from Moorfields Eye Hospital was the first in the UK to receive a revolutionary new implant to potentially improve central vision in people with geographic atrophy (GA), a form of dry age-related macular degeneration (AMD). The *Prima* System device used in this operation was developed by Pixium Vision.

The procedure involves inserting a 2mm wide microchip under the patient's retina, who then uses special glasses, containing a video camera for vision. Four to six weeks later the patient was able to detect signals in her blind eye. A rehabilitation programme will enable the patient to learn to use the improved visual awareness. The success of this operation, and the evidence gathered through this clinical study, will provide the evidence to determine the true potential of this treatment.

5. 3D-printed prosthetic eye fitted at Moorfields Eye Hospital

In November 2021, the world's first 3D-printed prosthetic eye was provided to a Moorfields Eye Hospital patient. This was the culmination of a four-year programme funded by a collaboration between a charitable donor and a commercial partner facilitated by Moorfields Eye Charity. The 3D-printed prosthetic eye replaces conventional painted acrylic prostheses, halves production time whilst avoiding uncomfortable fitting procedures. The printed eye is a biomimic and is more realistic, with clearer definition and real depth to the pupil that light can interact giving a more natural appearance. This is the first significant change in ocular prosthetic technology in over 50 years and will benefit patients worldwide.

A clinical trial has commenced which will provide robust evidence of the value of this new technology, and of the quality-of-life improvements that it offers patients.

Commissioning for quality and innovation (CQUIN) framework

Due to the pandemic the funding arrangements for 2021/22 have meant that CQUIN schemes were suspended for this financial year. The block funding from commissioners was based on historical levels of activity and CQUIN achievement and therefore this has ensured that the trust can meet its financial obligations.

Note: For 2022/23 CQUINs funding is part of the national tariff and not separately financed. Providers will still need to undertake CQUIN schemes and commissioners have proposed a number from the national list which are currently being worked through for appropriateness.

Registration with the Care Quality Commission (CQC)

The trust is required to be registered with the CQC and is currently registered without conditions. The CQC has not taken any enforcement action against the trust in 2020/21, nor at any time previously.

The trust's most recent CQC inspection occurred in November 2018 and was unannounced. This was followed by a well-led assessment in December 2018. The report was published on 12 March 2019, covering:

- The trust overall;
- Bedford (Outpatients and Surgery)
- City Road (Outpatients and Surgery)
- St George's (Outpatients only)

The trust was given an overall rating of 'Good', with all the services being rated as 'Good' or 'Outstanding'. Effectiveness was rated as 'Outstanding'. In addition to the ratings, the CQC found several areas of outstanding practice.

As was the case with previous recommendations, the 2019 recommendations were turned into an action plan. Progress with the actions has been excellent and the embedding of the resulting enhancements is part of the trust's journey of continuous improvement, with the CQC's conclusions being used as an improvement tool to think about how patient care can be further improved.

In addition, we continue to engage with the CQC relationship manager, and in September 2021, the CQC appointed a new person to this post. A good relationship has been established with them, and we are looking forward to continuing to work collaboratively with the CQC in the coming years.

Information governance

Information governance (IG) at Moorfields is overseen by the Information Governance Committee which reports to the Quality and Safety Committee (a Board sub-committee). The Information Governance Committee is chaired by the Senior information risk owner (SIRO) who is the Director of quality and safety. Membership includes the Caldicott guardian, Deputy Caldicott guardian, Chief information officer and Head of information governance who is also the trust's Data protection officer.

The information governance agenda is driven by key standards set down in the NHS Operating Framework and measured by compliance with the Data Security and Protection Toolkit (DSPT).

The trust is required to process information (personal and corporate) in line with the standards set out in statute, regulation, and guidance. Information governance at Moorfields includes strategy, policy and procedures that enable staff to handle information in line with these requirements. Annual data security awareness training is mandatory for all staff. Further specialist IG training has been provided to key staff on Redaction and Scrutiny, NCSC Stay Safe Online, Sharing Confidential Information and International Transfers, Requests for Information & IG Related Incidents, Freedom of Information Requests, and Subject Access Requests. The trust has also commissioned bespoke Records Management training which was made available in 2021/22.

The DSPT annual submission is used to demonstrate compliance with IG standards and the national Data Security Standards. The national deadline for the annual DSPT submission is June of each year and the trust fully met all requirements.

Data quality & audit

Moorfields submitted records during 2021/22 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data (April 21 to January 22). The percentages of records in the published data, which included the patient's valid NHS number, were:

- 99.7% for admitted patient case
- 99.7% for outpatient care
- 98.6% for accident and emergency care

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

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

This year, the trust has been subject to the usual Data Quality and Performance Management audit, this has been carried out by RSM auditors. This audit showed that the trust had retained standards and was marked in the reasonable assurance category. Areas of recommendation will be worked on by the appropriate teams, with the view to making further improvements.

There have been no other external audits carried out which have included recommendations regarding data quality related issues, during 2021/22.

We have continued to hold the amalgamated Information Management and Data Quality Working Group to ensure a better synergy between the two related issues. This group continues to meet every two months and discusses core data quality areas, including audit results. Data quality is also discussed in other trust forums and evidence of data quality is provided for the Trust DSPT submissions.

Clinical Coding

Moorfields was subject to the annual Clinical Coding audit as part of the Data Security and Protection Toolkit (DSPT) during March 2022, which this year was carried out by Maxwell Stanley Coding Consultancy Ltd. The aim of these audits is to improve the data quality of clinical record coding, which underpins hospital management and planning, commissioning of services for the population, clinical research, and financial flows. The audit's objectives are to evaluate the accuracy and completeness of coded clinical data against patient case notes, or electronic patient records (EPR) and the impact of data collection procedures which underpin the coding process. This helps sustain high standards of reliable clinical information and target improvements where required.

The final report indicated there was an excellent standard of primary and secondary diagnosis and procedure coding. The accuracy rates published in the audit report were:

Audit year	Diagnosis		Procedure	
	Primary	Secondary	Primary	Secondary
DSPT Audit 21/22	98.5%	99.38%	100%	99.85%
DSPT Audit 20/21	100%	97.20%	100%	100%
DSPT Audit 19/20	99.00%	97.23%	97.94%	99.54%

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

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

Below are the key recommendations made from these audits:

• Ensure coders are following the four-step coding process for correct code assignment around sequencing of codes.
• Provide immediate training within the Clinical Coding Department to address generic errors highlighted in this audit.
• Continue to work closely with clinicians and coders with the new version of Open Eyes (expected April 2022) to record/extract the relevant co-morbidities within the Open Eyes system.

2.6 Priorities for improvement in 2022/2023

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

This quality report and our quality priorities have been developed from a wide range of information about quality from all parts and levels within the organisation. As part of our consultation process, a forum was arranged with our key external stakeholders, including representations from patients, The

RNIB, our host clinical commissioning group (CCG), Islington CCG, Healthwatch Islington, and representations from our governors. Our staff views were also sought through a survey and the priorities continue to be influenced by CQC's inspection report findings. Our host commissioners, NHS Islington CCG and other external bodies such as Healthwatch Islington have also considered the contents of the quality report and were supportive of the quality priorities for 2022/23.

The identified priorities will each have specific metrics to demonstrate and measure performance throughout year. Moorfields will continue following advice and guidance from NHS Improvement and NHS England to ensure patients continue to receive high quality care as much as possible within current limited resources and capacity which are outside organisational controls as we recover from the pandemic.

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

This quality account has been reviewed by the quality and safety committee and has been finalised as a balanced representation of the trust's priorities across the three areas of patient safety, patient experience and clinical effectiveness.

Please see table below for the list of identified priorities:

Proposed Quality Account Priority	Quality Domain	Underpinning drivers				
		Trust objective (strategic)	National initiative	Learning from SIs/ Complaints/ feedback	Themes from patient/staff engagement	Carried over from 2020/21 - Y/N
1 Implementation of the Patient Safety Strategy focusing on: • Further developing our culture of speaking up and promoting a safety culture across the organisation. • Implementing staff-training requirements outlined in the NHS Patient Safety Syllabus.	Safe	✓	✓	✓	✓	✓
2 Supporting safer care for patients undergoing invasive procedures through further development of LOCSSIPs according to National recommendations (NATSSIPs).		✓	✓	✓	✓	
3 Embed the Accessible Information Standard (AIS) across Moorfields' network.	Patient experience	✓	✓	✓	✓	
4 Further develop a positive customer care focused culture including improving our communications particularly to support our more vulnerable patients		✓		✓	✓	✓
5 Develop systems and processes to reduce health inequalities by working in partnership with our staff to 'Make Every Contact Count'.	Effective	✓	✓			
6 Explore and exploit the full potential of *Tendable* (formally *Perfect Ward*) app		✓		✓	✓	

2022/23 Quality priorities

Quality Domain: Safety Priority 1: Implementation of the National Patient Safety Strategy Priority Lead: Julie Nott	
Our priority for 2022/23 is: Implementation of the Patient Safety Strategy focusing on: • Further developing our culture of speaking up and promoting a safety culture across the organisation. • Implementing staff-training requirements outlined in the NHS Patient Safety Syllabus.	**Rationale:** The National Patient Safety Strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety. Moorfields patient safety strategy encompasses the principles of the national strategy and is being developed using a patient and staff centric approach with patient safety partners, drawn from our patients and carers. Moorfields has patient safety specialists to support and drive this agenda, and they will be key in delivering the new strategy. **What success will look like by the end of March 2023:** All requirements of the National Strategy will be in place and completed within the deadlines set by NHSEI. **What we will measure and when:** • Patient safety partners will be recruited ensuring all improvements are fully aligned with patient and service user involvement • Key measures will be developed during implementation. • It is anticipated that the patient safety incident response framework will be circulated by NHSEI in June 2022.
Background Launched by NHS England and NHS Improvement in July 2019, the national patient safety strategy describes how the NHS plans to continuously improve patient safety by building on two foundations, a **patient safety culture,** and a **patient safety system**. Three strategic aims will support the development by: ▪ improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**) ▪ equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**) ▪ designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).	

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

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

Background

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

Based on the key NatSSIPs steps, we will develop LocSSIPs to harmonise practice across the organisation, ensuring there is a consistent approach to the care of patients undergoing invasive procedures in any location or on any site.
This objective has been developed to ensure that staff are aware of the key steps to follow when standardising LocSSIPs and supports the development, purpose, and use of trust safer surgery checklists. It will also ensure that the trust is able to consistently benchmark practice across the various sites and services within.

Quality Domain: Patient experience **Priority 3: Embed the Accessible Information Standard (AIS)** **Priority Lead: Ian Tombleson**	
Our priority for 2022/23 is to: Embed the Accessible Information Standard	**Rationale:** Improve the patient experience and care of those with accessible information needs by improving the delivery of accessible information to those that need it **What success will look like by the end of March 2023:** • Improved systems and processes to manage AIS needs

(AIS) across Moorfields' network	- Good patient awareness of what service to expect in relation to accessible information - Enhanced awareness of AIS needs for staff involved in administration and care of patient on their journey - Increase the number of patients with AIS flags on our electronic systems - Improvement in the patient experience at Moorfields when we provide support for AIS needs - Develop a trajectory for improvement including measures and metrics into 2023 and beyond. **What we will measure and when:** Example improvement measures from baseline include:

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

Background

Legal and Regulatory compliance

The Accessible Information Standard is a legal right of the patient to be supported and empowered in their care by accessible information. It is also included as part of CQC's regulatory framework.

Patient Experience

- The trust has had formal complaints and legal challenge about lack of AIS provision
- Consistent PALS comments about poor customer care
- Comments coming through FFT attributed to poor support for sight loss patients
- 'Strategic' momentum across the trust to improve the patient experience and comply with the standard

Quality Domain: Patient experience **Priority 4: Further improve our customer care responsiveness and communications with our patients** **Priority Lead: Ian Tombleson and Jon Spencer**	
Our priority for 2022/23 is to: Further develop a positive customer care focused culture including improving our	**Rationale:** This will build on the work already achieved, for example, the launch of all staff sight loss training in October 2021. We know that communications with our patients can be inconsistent and that, for example, appointments management need to improve. **What success will look like by the end of March 2023:**

communications particularly to support our more vulnerable patients	Customer care and effective communication will underpin our plans for operational excellence. We will have further embedded our customer care culture by developing customer care principles, which will be used to drive our business to focus on the needs of all our patients and service users, particularly those with sight loss and other vulnerabilities. We will have a plan in place driving improvement in the way we communicate with our patients and how we evidence this is having a positive impact. A Patient Experience Strategy is being developed, which will include communicating with our patients. **What we will measure and when:** • Maintain a regular sight loss awareness campaign with our staff • Develop a set of customer care principles which will be available to use to drive improvements centrally and locally • Develop a set of clear measures to track how well we communicate with our patients • Launch new virtual reality (VR) training to increase staff awareness and drive better customer care focused behaviours to support vulnerable patients • Launch our Accessible Information Standard (AIS) project introducing new direct support for patients with AIS needs (quality priority 3)

Background

We know our customer care and communications is inconsistent. Working with a range of stakeholders Moorfields has developed sight loss awareness training; staff take up of this training has been excellent. The effectiveness of this training needs to be evaluated. We will build on this by launching immersive VR training to improve customer focus in clinical environments. We are developing a set of customer care principles which, in line with our values, will drive good staff behaviours to support all our patients, particularly those who are most vulnerable. A further driver to support our vulnerable patients is to launch our Accessible Information Standard (AIS) project, meeting the requirements of the law and those patients with AIS needs. Finally further work is taking place to improve our patient communications in key operational areas.

Quality Domain: Effective
Priority 5: Reducing health inequalities via 'Make Every Contact Count'
Priority Lead: Sarah Needham

Our priority for 2022/23 is to: Develop systems and processes to reduce health inequalities by working in partnership with our staff to 'Make Every Contact Count'.	**Rationale:** By utilising the principles of making every contact count (MECC) and our day-to-day interactions with patients to encourage changes in behaviour, we have an opportunity to have a positive effect on the health and well-being of our patients, community, and wider population. **What success will look like by the end of March 2023:** Commencing in November 2022, a scoping exercise will take place to understand how this approach will be implemented across the trust, the resources required, and a training programme scoped and developed. This will be completed in partnership with local and national key stakeholders including public health colleagues. Once this has taken place a business case will be developed.

	What we will measure and when:
	It is a challenge to measure the impact of MECC interventions. A MECC evaluation framework will be developed to support implementation:
	• A scoping exercise will take place in Quarter 3 / November 2022 to understand the need and how this could robustly be implemented across the trust. This will include an evaluation framework. This will be completed by March 2023. • A business case will be taken to BCRG in April 2023.

Background

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

The expectation is that all NHS organisations will commit to MECC. NHS England included MECC in its 2016/17 NHS Standard Contract Service Conditions which states:

The Provider must develop and maintain an organisational plan to ensure that staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance

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Quality Domain: Effective

Priority 6: Explore and exploit the full potential of Tendable

Priority Lead: Kylie Smith

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

	• All Tendable data will be linked to a Quality dashboard within Qlik sense (Q2 2022-23) • Senior staff on all sites will have received training on the use of Tendable and how to extract detailed analysis of the data (Q3 2022-23) • At least 10 nursing/quality audits will be successfully undertaken and embedded within Tendable (Q4 2022-23)

Background

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

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

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

2.7 Key indicators for 2022/23

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

Ahead of a strategic review taking place this year, the trust has undertaken an interim review of the Integrated Performance Report which is presented to the Board each month and as a result has retained the existing range of KPIs contained within that document. The indicators we are focusing on in 2022/23 can be seen on the following pages.

This list of KPIs will enable the Board to concentrate on the metrics most closely associated with returning to 'business as usual'. The balance between operational activity, patient safety, and patient experience has been maintained.

Indicator	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	2022/23 Target
Operational Metrics					
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	90.5%	94.7%	≥93%	97.9%	≥93%
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	100%	100%	≥94%	99.1%	≥94%

Indicator	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	2022/23 Target
Cancer 28 Day Faster Diagnosis Standard	-	87.2%	≥75%	93.3%	≥75%
Over 18-week pathways	-	-	< 1680	8842	< 1680
52 Week RTT Incomplete Breaches	1	-	Zero (once activity has normalised)	395	Zero (once activity has normalised)
Average Call Waiting Time	-	618*	≤ 120 Sec	237 secs	≤ 120 Sec
Call abandonment rate	-	-	15%	14.5%	15%
Median Clinic journey times in glaucoma and medical retina (mins)	New = 126 Follow Up = 105	New=102 Follow up= 85	New=91 Follow up= 85	New=81 Follow up= 83	New=91 Follow up= 85
Theatre cancellation rate (non-medical cancellations)	0.76%	0.49%	≤0.8%	0.7%	≤0.8%
Number of non-medical cancelled operations not treated within 28 days	11	-	Zero	18	Zero
Mixed Sex Accommodation Breaches	0	0	Zero Breaches	0	Zero Breaches
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	3.53%*	0%*	≤ 2.67%	1.13%	≤ 2.67%
VTE Risk Assessment	98.4%	98.5%	≥95%	98.6%	≥95%
Posterior capsule rupture rate for cataract surgery	0.85%	0.98%	≤1.95%	1.03%	≤1.95%
Quality & Safety Metrics					
Occurrence of any Never events	2	2	Zero Events	2	Zero Events
Endopthalmitis Rates - Aggregate Score (Number of Individual Endophthalmitis	-	new	0	1	0

Indicator	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	2022/23 Target
measures not achieving target)					
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	0	0	Zero Cases	0	Zero Cases
MSSA Rate - cases	0	0	Zero Cases	0	Zero Cases
Inpatient Scores from Friends and Family Test - % positive	98.4%	95.2%	≥90%	95.0%	≥90%
A&E Scores from Friends and Family Test - % positive	92.6%	94.3%	≥90%	92.7%	≥90%
Outpatient Scores from Friends and Family Test - % positive	95.0%	93.2%	≥90%	93.3%	≥90%
Paediatric Scores from Friends and Family Test - % positive	96.3%	94.7%	≥90%	93.7%	≥90%
Summary Hospital Mortality Indicator	0	0	Zero Cases	0	Zero Cases
NHS England/NHS Improvement Patient Safety Alerts breached	-	0	Zero Alerts	1	Zero Alerts
Percentage of responses to written complaints sent within 25 days	-	88.1%	≥80%	73.5% (Apr-Feb)	≥80%
Percentage of responses to written complaints acknowledged within 3 days	-	97.0%	≥80%	99.0%	≥80%
Freedom of Information Requests Responded to Within 20 Days	99.2%	95.1%	≥90%	95.3%	≥90%
Subject Access Requests (SARs) Responded To Within 28 Days	98.1%	97.9%	≥90%	96.0%	≥90%
Number of Serious incidents (SIs) open after 60 days	0	2	0	0	0
Number of Incidents (excluding Health Records	-	86	-	334	-

Indicator	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	2022/23 Target
incidents) remaining open after 28 days					
'Enabler' Metrics					
Information Governance Training Compliance	-	95.1%	≥95%	93.6%	≥95%
Appraisal Compliance	-	78.2%	≥80%	74.9%	≥80%
Staff Turnover (Rolling Annual Figure)	-	9.4%*	≤15%	13.0%	≤15%
Proportion of Temporary Staff	12.4%	6.7%	Data Only	12.2%	Data Only
Overall financial performance (In Month Var. £m)	-	-	≥0	4.58	≥0
Commercial Trading Unit Position (In Month Var. £m)	-	-	≥0	1.17	≥0
Research Metrics					
Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	-	418*	Data only	42,733	Data only
Proportion of patients participating in research studies (as a percentage of number of open pathways)	-	-	≥2%	5.6%	≥2%
Median Time To Recruitment of First Patient (Days)	-	-	70 days	KPI accuracy under review not reported	70 days
Percentage of Commercial Research Projects Achieving Time and Target	61.6%	71.9%	≥65%	93.6%	≥65%

Part 3: Other information including a statement from our commissioners

Quality Account 2021/22 - Statement from North Central London Clinical Commissioning Group

North Central London Clinical Commissioning Group (CCG) is responsible for the commissioning of Health services from Moorfields Eye Hospital NHS Foundation Trust (Moorfields) on behalf of the population of North Central London. NCL CCG welcomes the opportunity to provide a statement for Moorfields' Quality Account.

NCL CCG thanks Moorfields for sharing the 2021/22 quality account and welcomes the opportunity to provide a commissioner statement having reviewed the information contained with the account. Where possible, information has been cross referenced with data made available to commissioners during the year.

Throughout 2021/22, the CCG have continued to maintain an open and ongoing dialogue with Moorfields. Commissioners have attended the Moorfields internal Quality and Safety meetings to obtain assurance on the safety and quality of care provided by the organisation.

Commissioners note the progress outlined in the account against the 2021/22 quality priorities and continue to recognise the positive strides the Trust has taken through a number of initiatives including the increased use of diagnostic hubs to shorten appointment and waiting times for patients.

The CCG commend the Trust for the support they have provided to the NCL health and care system in response to the second year of the Covid-19 pandemic. In particular the significant mutual aid provided to other trusts, and recognise the impact this has had on your overall RTT performance. The CCG would like to thank the staff for their flexibility and responsiveness during what has continued to be a difficult time both professionally and personally.

Is it encouraging to see that the trust has positive patient responses to its services, notably the initial data on patient experiencies in relation to your cataract drives. We look forward to seeing further improvement in call response times and a reduction in the number of calls abandoned.

The CCG support the six priorities proposed by the Trust for 2022/23:

Patient Experience
- Embed the Accessible Information Standard (AIS) across Moorfields' network
- Further develop positive customer care focused culture and tools to support more vulnerable patients through initiatives such as sight loss awareness training

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North Central London CCG Chair: Dr Charlotte Benjamin
North Central London CCG Accountable Officer: Frances O'Callaghan

Safe

- Implementation of the patient safety strategy focussing on:
  - Further Developing your culture of speaking up and promoting safety culture across the organisation
  - Implementing staff-training requirements outlined in the NHS patient safety syllabus
- Supporting safer care for patients undergoing invasive procedures

Effective

- Reducing health inequalities via 'Make Every Contact Count'
- Explore and exploit the full potential of 'Tenable' to enhance and standardise the ease and efficiency of quality inspections and audit.

The ICS looks forward to hearing of progress against the Trust's chosen priorities for 2022/23 and the impact the achievements have had for patients, families, carers and staff. The ICS will continue to work collaboratively with the Trust to support transformation within Moorfields and the development of objectives within the Integrated Care System.

Yours sincerely

Charlotte Benjamin
Chair North London CCG

Frances O'Callaghan
NCL CCG Accountable Officer &
ICB Chief Executive Designate

Statement from Healthwatch Islington

"Healthwatch Islington recognise the extreme pressure that services are under, exacerbated by the pandemic. Despite that context Moorfields continues to strive for quality improvement and its positive to see such high scores for patient experience following continued work in this area.

We have worked with the Trust to ensure that problems with Non-Emergency Patient Transport issues are dealt with. This is a complex and ongoing issue influenced by a number of factors including ambiguous criteria from NHS England and a complex, multi-partner commissioning process. We are pleased to be receiving less concerns about this issue and will continue to work with the Trust on this issue.

We think the priorities listed for the year ahead make sense. Healthwatch England is also prioritising the Accessible Information Standard and we'd welcome the opportunity to collaborate on this particular theme if capacity allows."

Emma Whitby,
Chief Executive
Healthwatch Islington