Moorfields Eye Hospital NHS
NHS Foundation Trust

Report to Trust Board

Report Title	**Integrated Performance Report - January 2019**
Report from	John Quinn, Chief Operating Officer
Prepared by	Performance And Information Department
Previously discussed at	Trust Management Committee
Attachments	

Brief Summary of Report

This Integrated Performance Report highlights a series of metrics regarded as the Key Indicators of Trust Performance and cover a variety of organisational activities within Operations, Quality and Safety, Workforce, Finance, Research, Commercial and Private Patients . The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods and as a trend. Importantly, the report also identifies additional information and Remedial Action Plans for those KPIs falling short of target and requiring improvement.

Overall the Trust continues to deliver the 18 week RTT target however we have had a number of 52 week plus breaches in month mainly due to capacity at St Georges. There have been urgent cases that have required to be prioritised over long waiting patients and compounded with sickness this month meant 2 scheduled patients for January were moved into February dates.

The Trust continues to meet its annual target for 2ww for cancer patient although there was one breach in month. We have seen a large number of breaches of the 14 day standard this month which was in part expected longer term plans are being put in place to increase the availability of appointments. The COO and Medial Director have met with NHSI specialised commissioners and started a discussion about supporting the Trust in securing further medical posts.

Patient journey times for follow up patients has gone above the target this month. There are a number of factors that may have led to this which are being monitored to see if any future intervention is required.

As reported in previous months our acute slot issues (ASI's) remains a concern. Analysis highlights three specific area Paediatrics, Cataract and Strabismus, where increased demand has occurred for these services and creating additional capacity remains difficult

We are seeing an increase in hospital outpatient cancellations and theatre cancellations which requires further investigation in the next month and more detailed actions

Action Required/Recommendation

The report is primarily for information purposes but will inform discussion regarding how the Trust is performing against its key organisational measures. This may in turn generate subsequent action. As this is the first Integrated Performance Report produced in this format, the Board is also asked to provide feedback on the style and content of the report, so that these can be considered for future iterations.

For Assurance	**X**	**For decision**		**For discussion**		**To Note**	

Moorfields Eye Hospital NHS
NHS Foundation Trust

Trust Executive Summary By Strategic Objective - January 2019

		G	A	R
SO1	Referral To Treatment	1	0	1
	Accident & Emergency	2	0	0
	Cancer	2	0	3
	Clinic Management	1	0	6
	Diagnostics	1	0	0
	DNA Rates	2	0	0
	Cancellations	2	0	2
	Theatre Practice	1	1	0
	Ward Management	3	0	0
	Data Quality	5	0	1
	Mortality	1	0	0
	Infection Control	6	0	0
	Patient Safety	6	0	3
	Safer Staffing Checklist	5	0	0
	Patient Experience	6	1	1

		G	A	R
SO2	Research	4	0	0
SO3	Training Compliance	2	0	1
SO4	*No metrics available for this objective*			
SO5	Staff & Voluntary Experience	0	0	0
	Recruitment and Turnover	2	0	3
SO6	Organisational Health	2	3	0
	Capital Development	2	0	0
SO7	Annual Surplus Delivery	5	0	0
	Liquidity	3	0	0
	Use Of Resources Metrics	1	0	0
SO8	Contribution To ROI	1	0	2

'Current Rating' Key

* Red, Amber, Green ratings are used to identify whether or not a KPI is achieving target. Where there are data issues, these are highlighted in blue.
* Grey ratings represent zero return and therefore a percentage can not be calculated, or where a target has not been set or is 'tbc'
* Metrics for which data is either not available or are not applicable to reporting period (i.e. Quarterly figures) are shown as black.

'Monthly Trend' Key

Colour of symbol shows Red, Amber Green rating of current month against target.

↑	Upward Trend Compared to Previous Month
→	Stable Trend Compared to Previous Month
↓	Downward Trend Compared to Previous Month
◆	No Trend Due To Nil return for Previous Month
	No Trend Due To Nil return for Current Month

Moorfields Eye Hospital NHS
NHS Foundation Trust

Trust Executive Summary By CQC Domain - January 2019

		G	A	R
Responsive	Referral To Treatment	1	0	1
	Accident & Emergency	2	0	0
	Cancer	2	0	3
	Clinic Management	1	0	6
	Diagnostics	1	0	0
	Ward Management	1	0	0
Effective	DNA Rates	2	0	0
	Cancellations	2	0	2
	Theatre Practice	1	1	0
	Mortality	1	0	0
	Data Quality	5	0	1
Caring	Patient Experience	6	1	1
	Ward Management	1	0	0
	Infection Control	2	0	0
	Training Compliance	1	0	0
	Organisational Health	0	0	0
	Patient Safety	1	0	2

		G	A	R
Safe	Infection Control	4	0	0
	Ward Management	1	0	0
	Patient Safety	5	0	1
	Safer Staffing Checklist	5	0	0
Well-Led	Organisational Health	2	3	0
	Recruitment and Turnover	1	0	3
	Staff & Voluntary Experience	0	0	0
	Training Compliance	1	0	1
	Research	4	0	0
Use of Resources	Capital Development	2	0	0
	Liquidity	3	0	0
	Contribution To ROI	1	0	2
	Annual Surplus Delivery	5	0	0
	Recruitment and Turnover	1	0	0
	Use Of Resources Metrics	1	0	0
	Financial Metrics	0	0	0
	Carter Metrics	0	0	0

'Current Rating' Key

* Red, Amber, Green ratings are used to identify whether or not a KPI is achieving target. Where there are data issues, these are highlighted in blue.
* Grey ratings represent zero return and therefore a percentage can not be calculated, or where a target has not been set or is 'tbc'
* Metrics for which data is either not available or are not applicable to reporting period (i.e. Quarterly figures) are shown as black.

'Monthly Trend' Key

Colour of symbol shows Red, Amber Green rating of current month against target.

↑	Upward Trend Compared to Previous Month
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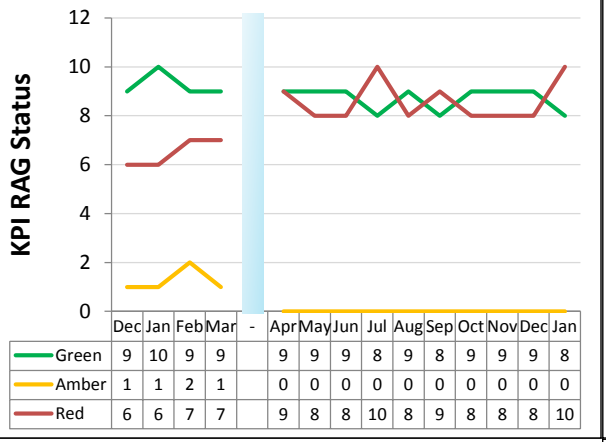
↓	Downward Trend Compared to Previous Month
◆	No Trend Due To Nil return for Previous Month
	No Trend Due To Nil return for Current Month

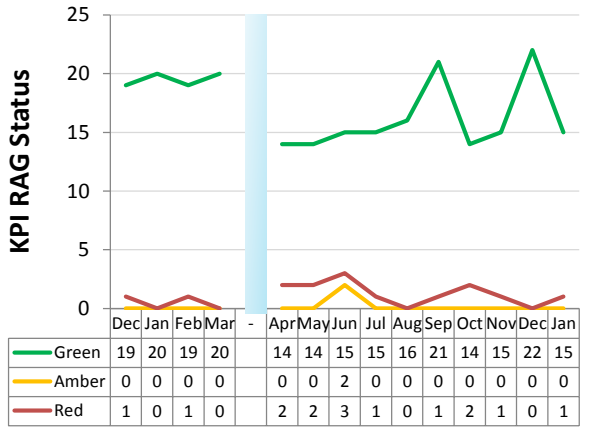
Executive Summary - CQC Domain Trends

Responsive



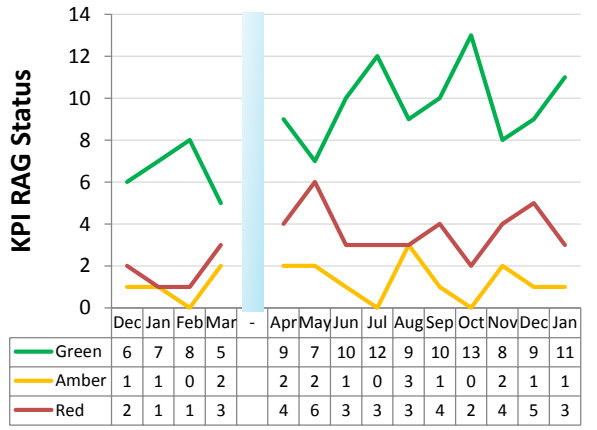
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	9	10	9	9		9	9	9	8	9	8	9	9	9	8
Amber	1	1	2	1		0	0	0	0	0	0	0	0	0	0
Red	6	6	7	7		9	8	8	10	8	9	8	8	8	10

Safe



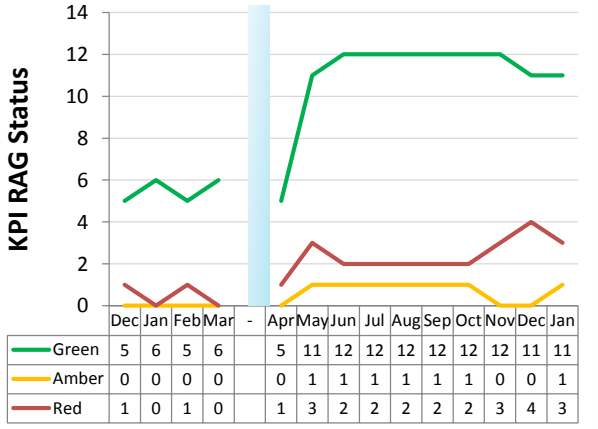
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	19	20	19	20		14	14	15	15	16	21	14	15	22	15
Amber	0	0	0	0		0	0	2	0	0	0	0	0	0	0
Red	1	0	1	0		2	2	3	1	0	1	2	1	0	1

Effective



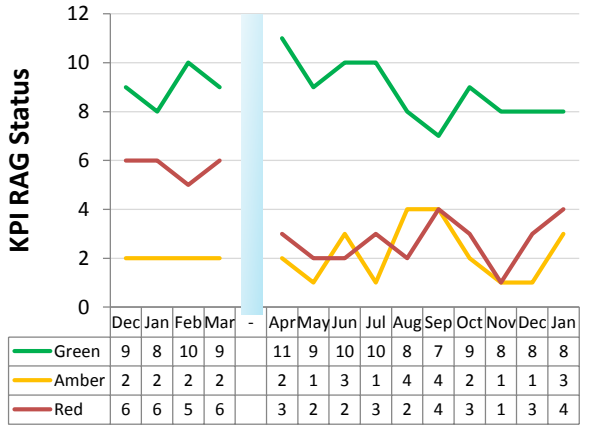
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	6	7	8	5		9	7	10	12	9	10	13	8	9	11
Amber	1	1	0	2		2	2	1	0	3	1	0	2	1	1
Red	2	1	1	3		4	6	3	3	3	4	2	4	5	3

Caring



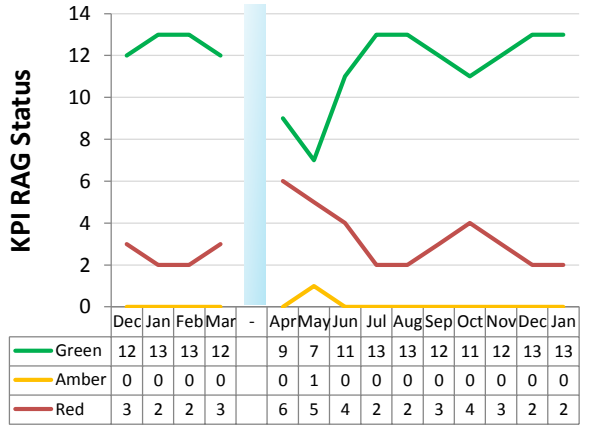
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	5	6	5	6		5	11	12	12	12	12	12	12	11	11
Amber	0	0	0	0		0	1	1	1	1	1	1	0	0	1
Red	1	0	1	0		1	3	2	2	2	2	2	3	4	3

Well-Led



	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	9	8	10	9		11	9	10	10	8	7	9	8	8	8
Amber	2	2	2	2		2	1	3	1	4	4	2	1	1	3
Red	6	6	5	6		3	2	2	3	2	4	3	1	3	4

Use of Resources



	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	12	13	13	12		9	7	11	13	13	12	11	12	13	13
Amber	0	0	0	0		0	1	0	0	0	0	0	0	0	0
Red	3	2	2	3		6	5	4	2	2	3	4	3	2	2

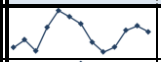
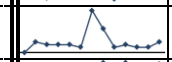
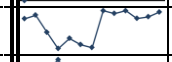
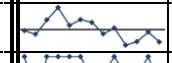
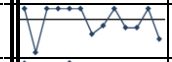
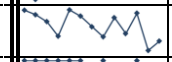
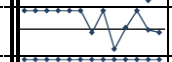
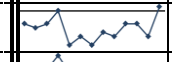
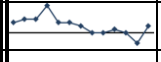
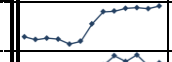
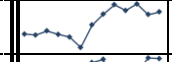
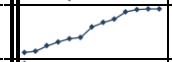
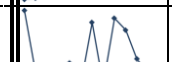
Lines split by financial year due to different number of metrics

Context - Overall Activity - January 2019

		January 2019		Monthly Variance	Year To Date		YTD Variance
		2017/18	2018/19		2017/18	2018/19	
Accident & Emergency	A&E Arrivals (All Type 2)	7,665	8,007	+ 4.5%	82,078	81,029	- 1.3%
	Number of 4 hour breaches	75	35	- 53.3%	1,223	1,258	+ 2.9%
Outpatient Activity	Number of Referrals Received	11,073	11,897	+ 7.4%	108,436	116,655	+ 7.6%
	Total Attendances	51,545	54,144	+ 5.0%	471,655	500,910	+ 6.2%
	First Appointment Attendances	11,753	12,078	+ 2.8%	106,664	113,910	+ 6.8%
	Follow Up (Subsequent) Attendances	39,792	42,066	+ 5.7%	364,991	387,000	+ 6.0%
Admission Activity	Total Admissions	3,096	3,279	+ 5.9%	30,944	32,074	+ 3.7%
	Day Case Elective Admissions	2,836	2,960	+ 4.4%	27,558	28,891	+ 4.8%
	Inpatient Elective Admissions	102	108	+ 5.9%	877	933	+ 6.4%
	Non-Elective (Emergency) Admissions	158	211	+ 33.5%	2,509	2,250	- 10.3%

These figures are not subject to any finance or commissioning business logic. They present all activity, whether chargeable or not

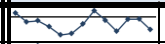
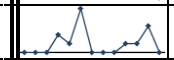
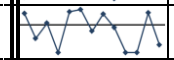
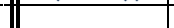
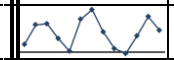
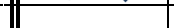
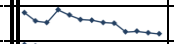
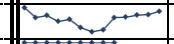
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Referral To Treatment	18 Week RTT Incomplete Performance	Responsive	≥92%	G		94.6%	Monthly	94.0%	94.6%	94.8%	94.6%		↓
	52 Week RTT Incomplete Breaches	Responsive	Zero Breaches	R	11	46	Monthly	3	2	2	4		↑
Accident & Emergency	A&E Four Hour Performance	Responsive	≥95%	G		98.4%	Monthly	99.7%	99.0%	99.2%	99.6%		↑
	A&E Unplanned Reattendance	Responsive	≤5%	G		5.0%	Monthly	4.2%	4.4%	4.9%	4.4%		↓
Cancer	Cancer 2 week waits - first appointment urgent GP referral	Responsive	≥93%	R	12	94.3%	Monthly	87.5%	87.5%	100.0%	80.0%		↓
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Responsive	≥93%	R	13	73.8%	Monthly	68.2%	87.5%	52.1%	61.0%		↑
	Cancer 31 day waits - diagnosis to first appointment	Responsive	≥96%	R		97.3%	Monthly	96.3%	100.0%	95.8%	95.2%		↓
	Cancer 31 day waits - subsequent treatment	Responsive	≥94%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 62 days from urgent GP referral to first definitive treatment	Responsive	≥85%	G		100.0%	Monthly	n/a	n/a	n/a	100.0%		♦
Clinic Management	Median Clinic Journey Times - New Patient appointments	Responsive	Mth:≤ 100m	G		95	Monthly	96	96	93	100		↑
	Median Clinic Journey Times -Follow Up Patient appointments	Responsive	Mth:≤ 90m	R	14	90	Monthly	90	89	86	91		↑
	Percentage of patients using kiosks or alternative technology on sites where they are and are embedded.	Responsive	None Set				Monthly from Oct	*In Development*					
	Data completeness for Clinic Journey Time (Total)	Responsive	Mth:≥ 85.8%	R	15	45.6%	Monthly	49.9%	50.2%	49.8%	50.8%		↑
	Data completeness for Clinic Journey Time (Glaucoma)	Responsive	Mth:≥ 87.9%	R	16	59.7%	Monthly	65.4%	69.3%	63.0%	64.6%		↑
	Data completeness for Clinic Journey Time (MR)	Responsive	Mth:≥ 87.7%	R	17	54.0%	Monthly	52.5%	54.7%	58.0%	57.9%		↓
	Percentage of GP referrals From Electronic Booking - trajectory target of 100% for Oct 2018	Responsive	100%	R	18	87.5%	Monthly	96.8%	98.8%	99.4%	99.3%		↓
	Electronic Booking Appointment Slot Issue (ASI) Rate	Responsive	≤ 4.0%	R	19	23.3%	Monthly (Month in Arrears)	27.6%	26.2%	23.0%	21.4%		
Diagnostics	Percentage of Diagnostic waiting times less than 6 weeks	Responsive	≥99%	G		100%	Monthly	100%	100%	100%	100%		→

* Provisional for January 2019

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
DNA Rates	Outpatients DNA rate - 1st appointment	Effective	≤12.3%	G		11.8%	Monthly	11.5%	12.2%	12.2%	11.6%		↓
	Outpatients DNA rate - follow up appointment	Effective	≤10.8%	G		10.5%	Monthly	10.2%	10.9%	10.6%	10.3%		↓
Cancellations	Outpatient Cancellation rate (Hospital cancellations)	Effective	≤2.85%	R	20	3.45%	Monthly	3.19%	3.11%	3.28%	3.51%		↑
	Theatre Cancellation Rate (Overall)	Effective	≤7.0%	R	21	7.2%	Monthly	6.5%	7.5%	7.3%	7.9%		↑
	Theatre Cancellation Rate (Non-Medical Cancellations)	Effective	≤0.8%	G		0.82%	Monthly	0.73%	0.93%	0.58%	0.54%		↓
	Number of non-medical cancelled operations not treated within 28 days *	Effective	Zero Breaches	G		13	Monthly	1	1	3	0		↓
Theatre Practice	Theatre Sessions starting late	Effective	≤32.7%	A	22	34.5%	Monthly	31.8%	36.6%	38.2%	34.6%		↓
	Percentage of Emergency re-admissions within 30 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Effective	≤3.77%	G		2.82%	Monthly	0.00%	0.00%	5.41%	1.02%		↓
Ward Management	Delayed Transfer of Care (Number of days)	Responsive	Zero Days	G		0	Monthly	0	0	0	0		→
	Inpatient (Overnight) Ward Staffing Fill Rate	Safe	≥90%	G		95.7%	Monthly	89.5%	95.2%	101.4%	97.0%		↓
	Mixed Sex Accommodation Breaches	Caring	Zero Breaches	G		0	Monthly	0	0	0	0		→
Data Quality	Data Quality - Ethnicity recording (Outpatient and Inpatient)	Effective	≥98%	R	23	91.3%	Monthly	90.4%	90.5%	90.4%	90.2%		↓
	Data Quality - NHS Number recording (Outpatient and Inpatient)	Effective	≥99%	G		99.5%	Monthly	99.5%	99.6%	99.5%	99.5%		→
	Data Quality - GP recording (Outpatient and Inpatient)	Effective	≥98%	G		99.9%	Monthly	99.8%	99.9%	99.9%	99.9%		→
	Data Quality - Ethnicity recording (A&E)	Effective	≥95%	G		99.8%	Not Set	99.8%	99.7%	99.7%	99.8%		↑
	Data Quality - NHS Number recording (A&E)	Effective	≥95%	G		95.0%	Not Set	95.2%	95.1%	96.0%	95.9%		↓
	Data Quality - GP recording (A&E)	Effective	≥95%	G		99.4%	Not Set	99.5%	99.6%	99.6%	99.7%		↑
Mortality	Summary Hospital Mortality Indicator	Effective	Zero Cases	G		n/a	Monthly	0	0	0	0		→

* Provisional for January 2019

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Infection Control	Endopthalmitis Rates - Cataract (per 1000 incidents)	Safe	≤0.4			0.32	Quarterly			0.33			
	Endopthalmitis Rates - Intravitreal (per 1000 incidents)	Safe	≤0.5			0.17	Quarterly			0.08			
	Endopthalmitis Rates -Glaucoma (per 1000 incidents)	Safe	≤1.0			0.57	Quarterly			0.00			
	Endopthalmitis Rates - Corneal EK procedures (per 1000 incidents)	Safe	≤3.6			3.33	Quarterly			0.00			
	Endopthalmitis Rates - Corneal PK procedures (per 1000 incidents)	Safe	≤1.6			0.00	Quarterly			0.00			
	Endopthalmitis Rates - Vitreoretinal (per 1000 incidents)	Safe	≤0.6			0.30	Quarterly			0.00			
	MRSA Bacteraemias Cases	Safe	Zero Cases	G		0	Monthly	0	0	0	0		→
	Clostridium Difficile Cases	Safe	Zero Cases	G		0	Monthly	0	0	0	0		→
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Safe	Zero Cases	G		0	Monthly	0	0	0	0		→
	MSSA Rate - cases	Safe	Zero Cases	G		0	Monthly	0	0	0	0		→
	Hand Hygiene Audit Compliance	Caring	≥95%	G		99.0%	Monthly	99.0%	99.0%	99.0%	99.0%		→
	Cleanliness Audit Compliance	Caring	≥95%	G		99.5%	Monthly	99.0%	99.0%	99.7%	99.8%		↑

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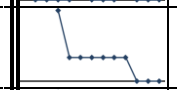
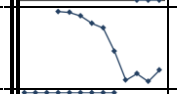
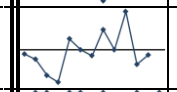
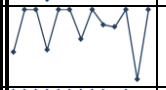
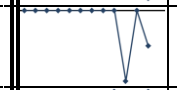
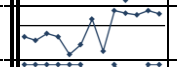
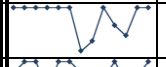
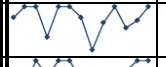
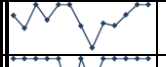
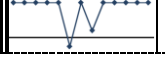
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Patient Safety	Occurrence of any Never events	Safe	Zero Events	G		2	Monthly	1	0	0	0		→
	Number of Serious Incidents remaining open after 60 days	Safe	Zero Cases	G		8	Monthly (Reporting Month)	1	0	0	0		→
	Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days	Caring	Mth ≤ 18%	R	24	n/a	Monthly (Reporting Month)	39.3%	42.9%	38.7%	44.8%		↑
	NHS England/NHS Improvement Patient Safety Alerts breached	Safe	Zero Alerts	G		n/a	Monthly	0	0	0	0		→
	VTE Risk Assessment	Safe	≥95%	G		98.1%	Monthly	97.7%	97.2%	97.9%	96.5%		↓
	Posterior Capsular Rupture rates	Safe	≤1.95%	G		0.93%	Monthly	0.77%	0.97%	0.82%	0.70%		↓
	Percentage of responses to written complaints sent within 25 days	Caring	≥80%	R	25	80.8%	Monthly (Month in Arrears)	80.0%	100.0%	72.4%	77.3%		
	Percentage of responses to written complaints acknowledged within 3 days	Caring	≥80%	G		95.5%	Monthly (Reporting Month)	95.5%	100.0%	81.8%	100.0%		↑
	Duty of Candour (Percentage of conversations informing family/carer that a patient safety incident has ocurred within 10 working days of the incident being reported to local risk management systems)	Safe	100%	R	26	97.3%	Monthly (Month in Arrears)	100.0%	82.0%	100.0%	91.0%		
Safer Staffing Checklist	Safer Surgery Checklist: Percentage of audited "Team Briefing" stage elements compliant with requirements	Safe	≥95%	G		96.3%	Monthly	99.1%	98.5%	100.0%	98.9%		↓
	Safer Surgery Checklist: Percentage of audited "Sign In" stage elements compliant with requirements	Safe	≥95%	G		99.9%	Monthly	99.9%	99.9%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Time Out" stage elements compliant with requirements	Safe	≥95%	G		99.8%	Monthly	100.0%	99.6%	99.7%	100.0%		↑
	Safer Surgery Checklist: Percentage of audited "Sign Out" stage elements compliant with requirements	Safe	≥95%	G		99.4%	Monthly	99.0%	99.5%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Team Debrief" stage elements compliant with requirements	Safe	≥95%	G		99.3%	Monthly	100.0%	100.0%	100.0%	100.0%		→

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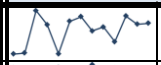
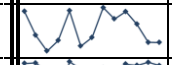
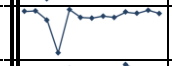
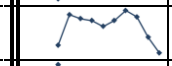
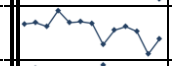
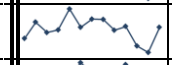
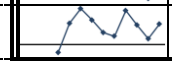
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Patient Experience	Inpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		99.4%	Monthly	99.1%	99.7%	99.5%	99.5%		→
	A&E Scores from Friends and Family Test - % positive	Caring	≥90%	G		93.9%	Monthly	95.3%	94.0%	92.1%	92.1%		→
	Outpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		96.8%	Monthly	97.3%	97.2%	97.5%	97.2%		↓
	Paediatric Scores from Friends and Family Test - % positive	Caring	≥90%	G		97.9%	Monthly	98.4%	98.2%	97.5%	97.0%		↓
	Inpatient Scores from Friends and Family Test - % response rate	Caring	≥30%	G		50.2%	Monthly	52.7%	49.2%	33.5%	44.0%		↑
	A&E Scores from Friends and Family Test - % response rate	Caring	≥20%	R	27	8.6%	Monthly	9.7%	5.3%	3.4%	9.0%		↑
	Outpatient Scores from Friends and Family Test - % response rate	Caring	≥15%	A	28	11.0%	Monthly	11.3%	8.7%	7.8%	11.1%		↑
	Paediatric Scores from Friends and Family Test - % response rate	Caring	≥15%	G		20.6%	Monthly	25.7%	21.2%	16.9%	21.5%		↑

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Remedial Action Plans for Strategic Objective 1

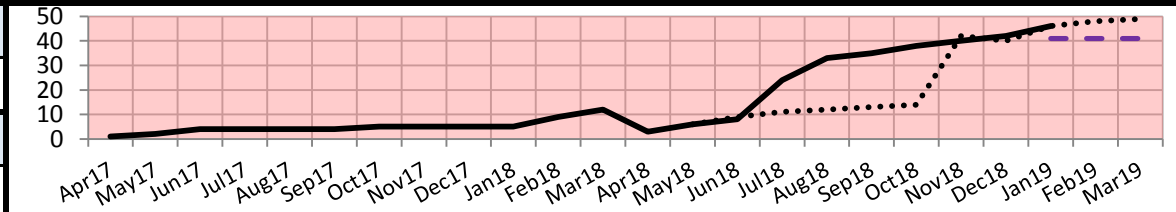
We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
52 Week RTT Incomplete Breaches	**Lead Manager**	**Andy Birmingham**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Zero Breaches	Red	46	3	2	2	4

Divisional Benchmarking (Jan 19)	City Road	North	South
	0	1	3



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Routine review of patients waiting during PTL found previous incorrect RTT status	Patient expedited for treatment and further training to be provided for those	Jan 2019	Complete
Patient requires surgery at St.George's hospital, unable to be treated on alternative sites. Surgery lists have been cancelled at short notice	Divisional Manager liaising with St George's theatre team and escalated to COO	Jan 2019	In Progress (Update)

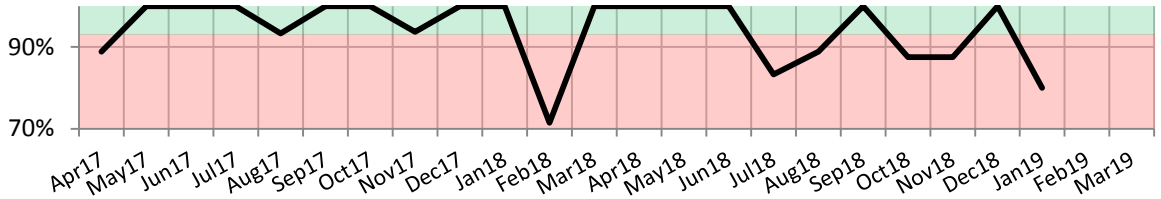
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
During routine review of patient it was found that a patient was discharged incorrectly and clock stopped in error.	Patient expidited for treatment, treatment received. Clinician informed of error in discharge, no known harm	No Further Action Required
Previously identified issues regarding capacity on surgical lists at St George's Hospital for complex and clinically urgent cases. This was further compounded this month due to surgeon sickness.	Theatre lists have been offered, patients being contacted to offer dates. Process for obtaining further surgical slots from St Georges under review.	February 2019

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Cancer 2 week waits - first appointment urgent GP referral	**Lead Manager**	**Tim Reynolds**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥93%	Red	94.3%	87.5%	87.5%	100.0%	80.0%

Divisional Benchmarking (Jan 19)	City Road	North	South
	80.0%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There was one breach to the two week wait standard in January. The breach occurred due to a lack of available capacity over then holiday period.	1)The locum consultant who has been covering will be retained allowing for additional new patient clinic capacity.	March 2019
	2) A senior fellow to take up locum consultant sessions during certain clinics to increase new patient capacity moving forward.	March 2019

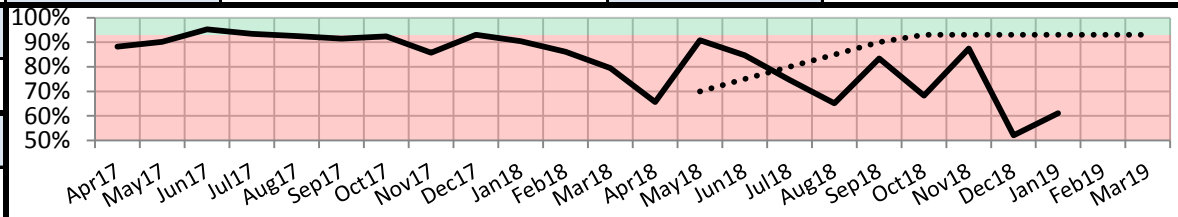
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	Tim Reynolds	Responsible Director	John Quinn

Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥93%	Red	73.8%	68.2%	87.5%	52.1%	61.0%

Divisional Benchmarking (Jan 19)	City Road	North	South
	61.0%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
There were 23 breaches to the NHSE 14-day standard during December. 18 of these were due to a lack of clinic availablity on bank holidays and pre-agreed annual leave	1)Creation of additional capacity through retention of the locum consultant	Mar 2019	In Progress (No Update)
The remaining 18 breaches were due to a lack of available capacity.	Reviewing job plans to allow all new patient clinic capacity to be covered in senior clincian's absence.	May 2019	In Progress (No Update)

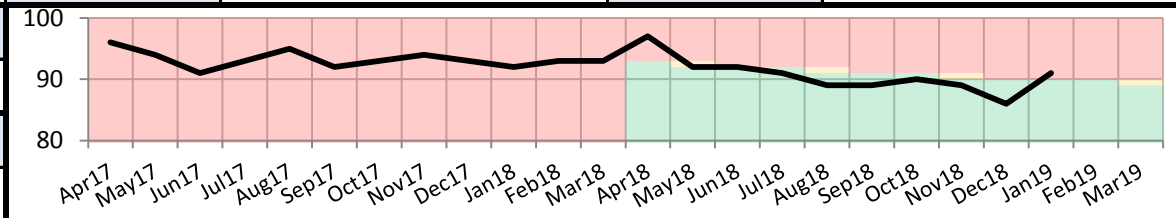
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There were 39 breaches to the NHSE 14-day standard in January. 34 were as a result of a lack of available capacity.	A senior fellow to take up locum consultant sessions during certain clinics to increase new patient capacity moving forward.	March 2019
5 breaches were due to patient choice.	Patient choice remains a factor as this is a national service with patients attending from a long distance away in some cases, meaning time is required to make travel plans. Clinical intevention continues to be sought where patients do	No Further Action Required

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Median Clinic Journey Times -Follow Up Patient appointments	**Lead Manager**	**Naomi Sheeter**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Mth:≤ 90m	Red	90	90	89	86	91

Divisional Benchmarking (Jan 19)	City Road	North	South
	105	121	80



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No specific cause for this slight dip in performance has been identified.	This may be natural variation so at this stage we have raised awareness with the operational teams of the slight increase in journey times and continue to monitor the journey times.	No Further Action Required

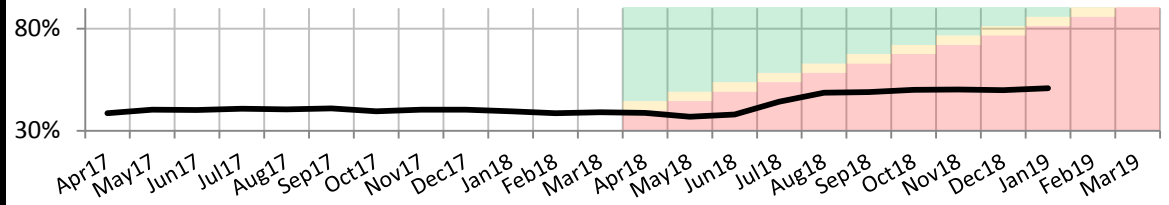
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	**Naomi Sheeter**	**Responsible Director**	**John Quinn**

Data completeness for Clinic Journey Time (Total)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Mth:≥ 85.8%	Red	45.6%	49.9%	50.2%	49.8%	50.8%

Divisional Benchmarking (Jan 19)	City Road	North	South
	55.7%	34.2%	57.5%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Variable administrative standard operating procedures in use across the Trust's sites and services.	- Administrative Standard Operating Procedures (SOPs) in use across the Trust have been reviewed and re-written to provide a single standard operating procedure trustwide. The first tranche of these have been tested and approved for release. We are holding release until mid February 2019 to coincide with the changes to health records management, so there is just one change for staff. - Services with very low data completeness have been targeted individually and have implemented changes to administrative processes throughout December and January. A data review in mid January 2019 shows an improvement in performance in these areas. - Data continues to be shared with all service managers on a weekly basis and with divisional management for performance review meetings. - Specific support is being given on site to St George's & Northwick Park sites. The work is overseen by the Clinical Administration working group which meets fortnightly and is attended by operational management, administration, L&D and service improvement teams.	Mar 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

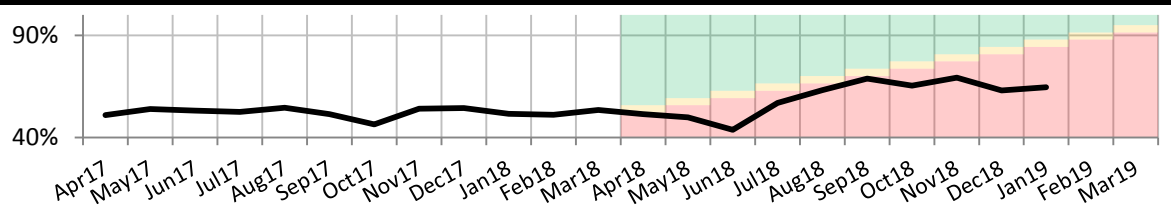
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	Naomi Sheeter	Responsible Director	John Quinn

Data completeness for Clinic Journey Time (Glaucoma)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Mth:≥ 87.9%	Red	59.7%	65.4%	69.3%	63.0%	64.6%

Divisional Benchmarking (Jan 19)	City Road	North	South
	71.5%	54.3%	63.2%



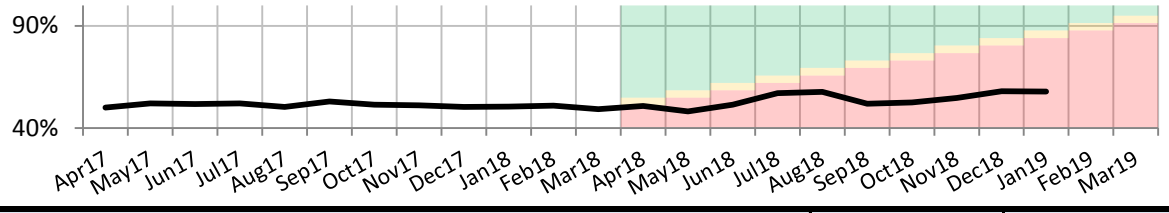
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Differing performance across the divisions, sites and services	The 2017-18 service improvement project in specific Glaucoma clinics at the City Road site resulted in improved data completeness. This project has been rolled out to sites in the North & South divisions as well as to other clinics in City Road. Data continues to be supplied weekly to the Glaucoma Service Manager to hold administrative teams to account and progress is monitored regularly by divisional management. The data is supplied fortnightly to the North & South divisions. - The North Division has a particular gap in its administrative team, which is having an impact on their performance in particular. While there are is recruitment ongoing achieving consistent improvement is difficult, however the Service Improvement team are visiting sites to support staff understanding of the value of this data and how to collect it.	Mar 2019	In Progress (No Update)
Variable administrative standard operating procedures in use across the Trust's sites and services.	- Administrative Standard Operating Procedures (SOPs) in use across the Trust have been reviewed and re-written to provide a single standard operating procedure trustwide. The first tranche of these have been tested and approved for release. We are holding release until mid February 2019 to coincide with the changes to health records management, so there is just one change for staff. - The work is overseen by the Clinical Administration working group which meets fortnightly and is attended by operational management, administration, L&D and service improvement teams.	Mar 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

Remedial Action Plan - January 2019	Strategic Objective	SO1	CQC Domain	Responsive
Data completeness for Clinic Journey Time (MR)	Lead Manager	Naomi Sheeter	Responsible Director	John Quinn

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Mth:≥ 87.7%	Red	54.0%	52.5%	54.7%	58.0%	57.9%

Divisional Benchmarking (Jan 19)	City Road	North	South
	68.8%	23.0%	74.4%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Marked difference in performance in the North division in contrast to the City Road and South divisions	- Data is being provided to all divisons on a fortnightly basis. - The North Division has a particular gap in its administrative team, which is having an impact on their performance in particular. While there are is recruitment ongoing achieving consistent improvement is difficult, however the Service Improvement team are visiting sites to support staff understanding of the value of this data and how to collect it.	Mar 2019	In Progress (No Update)
Variable administrative standard operating procedures in use across the Trust's sites and services.	- Administrative Standard Operating Procedures (SOPs) in use across the Trust have been reviewed and re-written to provide a single standard operating procedure trustwide. The first tranche of these have been tested and approved for release. We are holding release until mid February 2019 to coincide with the changes to health records management, so there is just one change for staff. - The work is overseen by the Clinical Administration working group which meets fortnightly and is attended by operational management, administration, L&D and service improvement teams.	Mar 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

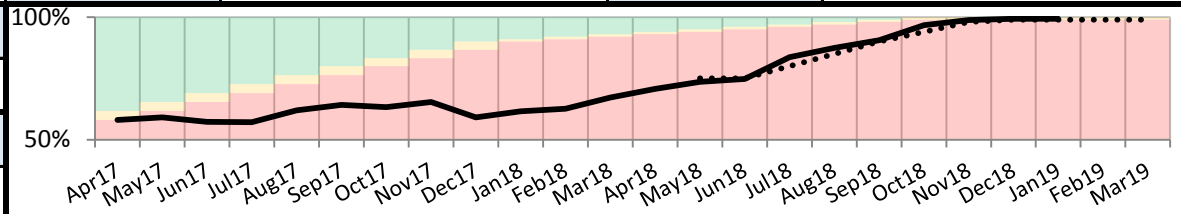
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	Lindsay Ramsey	Responsible Director	John Quinn

Percentage of GP referrals From Electronic Booking - trajectory target of 100% for Oct 2018

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
100%	Red	87.5%	96.8%	98.8%	99.4%	99.3%

Divisional Benchmarking (Jan 19)	City Road	North	South
	99.7%	99.8%	98.3%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
There remain a small number of urgent paper referrals being received and the Trust have agreed not to reject these for clinical reasons until further discussion. Until this is resolved the target of 100% will be difficult to meet.	Continue to feedback to GPs on a case by case basis to ensure that they are using the eRS to log all referrals including urgent.	Mar 2019	In Progress (No Update)

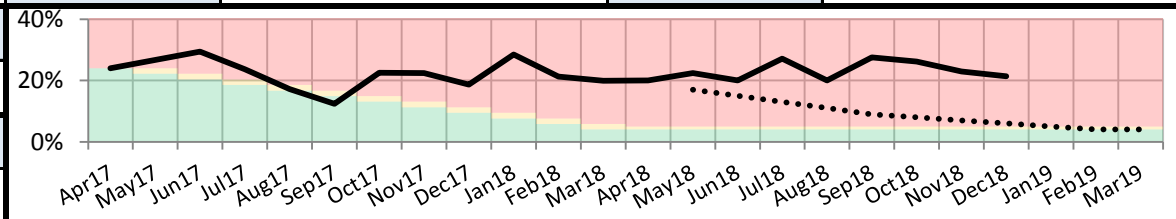
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Responsive
Electronic Booking Appointment Slot Issue (ASI) Rate (Month in Arrears)	**Lead Manager**	**Lindsay Ramsey**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤ 4.0%	Red	23.3%	27.6%	26.2%	23.0%	21.4%

Divisional Benchmarking (Dec 18)	City Road	North	South
	41.0%	8.28%	19.9%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
In the South division there are a high number of ASIs in paediatrics due to capacity issues.	Although the Paediatric fellow has now started in post. Additional paediatric clinics are being set up to clear the backlog and to create additional capacity. This will take longer than originally anticipated but will result in a lower number of ASIs for this service.	May 2019	In Progress (No Update)
Cataract City Road, there has been a lack of capacity to accommodate demand. Additional Saturday clinics no longer being regularly run which has affected the availability of slots.	Patients have been actively booked into other sites to reduce their overall waiting time and availability - including St Anns where the slot poll is much shorter- to accommodate ASIs. Work ongoing to amalgamate the services on eRS.	May 2019	In Progress (No Update)

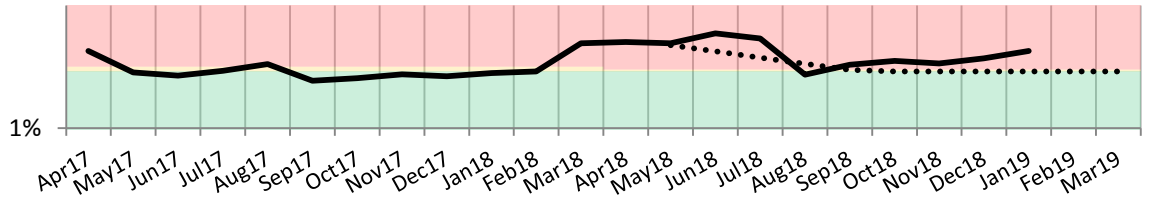
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
North Division- capacity issues in paeds and strabs due to increase in referrals. Capacity lost in cataract service due to cosultant leaving.	Continued daily monitoring of ASIs	

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Effective
Outpatient Cancellation rate (Hospital cancellations)	**Lead Manager**	**Jennifer McCole**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤2.85%	Red	3.45%	3.19%	3.11%	3.28%	3.51%

Divisional Benchmarking (Jan 19)	City Road	North	South
	1.73%	4.30%	7.68%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Changes to outpatient clinics are being made at under 6 weeks where clinics have been overbooked.	The team continue to work on capacity planning for outpatients and revising clinic templates accordingly	Feb 2019	Complete
Short notice cancellations for some areas of the trust	Further analysis of which clinics are driving this by CCG required to determine what impact this is having	Mar 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

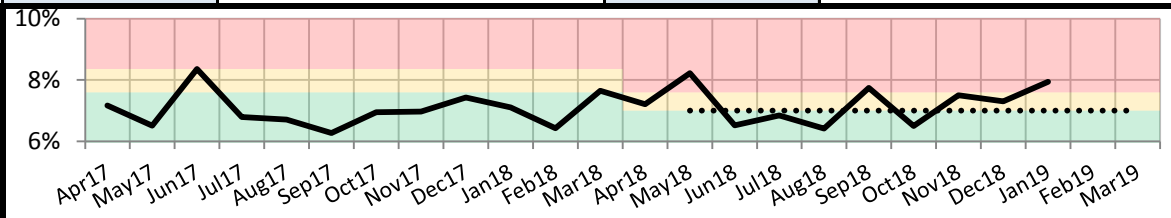
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Effective
Lead Manager	Zoe Marjoram/Alison McGirr	Responsible Director	John Quinn

Theatre Cancellation Rate (Overall)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤7.0%	Red	7.2%	6.5%	7.5%	7.3%	7.9%

Divisional Benchmarking (Jan 19)	City Road	North	South
	7.5%	7.8%	9.5%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Further delays to refurbishement of St George's operating theatres has meant that theatre cancellation rates remain higher than expected for the South Division. This is due to St Anthony's, the private hospital being used during the refurbishment works, being unable to provide the St George's theatre team with operating lists that match their current timetable.	Saturday operating lists are being run at St Anthony's every week to make up for lists that can not be run during the week. Vacant lists at other Moorfields sites are being considered to mitigate the loss of operating capacity at St Anthony's. This issue will continue until the refurbishment works at St George's have been completed.	Jan 2019	In Progress (No Update)
Process concerns in Pre-assessment have meant that some surgery has been cancelled	Detailed review of pre-assessment process to determine where theatre cancellations can be avoided	Apr 2019	In Progress (No Update)
Higher number of cancellations at City Road due to a number of factors that are difficult to prevent and relate to winter/festive season.	Monitor trends in cancellations through theatre utilsation group	Feb 2019	Complete

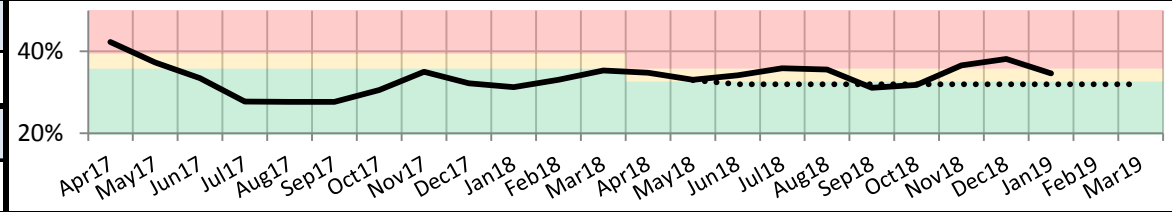
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Analysis by City Road found nearly 50% of cancellations due to patient cancellations and DNA, despite reminder calls as standard; short notice cancellations difficult to fill. Medical cancellations monitored closely with POA and any issues identified are addressed accordingly.	Monitor trends in cancellations in weekly operational performance meeting, including detailed validation of all hospital medical cancellations to identify and address any POA issues	March 2019

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Effective
Theatre Sessions starting late	**Lead Manager**	**Zoe Marjoram**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤32.7%	Amber	34.5%	31.8%	36.6%	38.2%	34.6%

Divisional Benchmarking (Jan 19)	City Road	North	South
	29.0%	17.8%	80.9%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
South - Late starts remain an issue whilst operating at St Anthony's continues. Cross site working at St George's and St Anthony's mean it is difficult for clinicians to arrive at St Anthony's in time for afternoon lists to start when scheduled.	Morning outpatient clinics to be scheduled to finish earlier, where possible, to allow sufficient time for clinicians to travel between sites.	Jan 2019	In Progress (No Update)

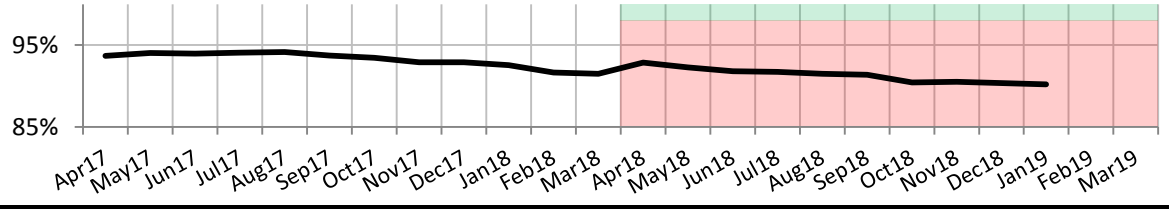
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Effective
Data Quality - Ethnicity recording (Outpatient and Inpatient)	**Lead Manager**	**Donna Flatt**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥98%	Red	91.3%	90.4%	90.5%	90.4%	90.2%

Divisional Benchmarking (Jan 19)	City Road	North	South
	91.5%	84.6%	93.2%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
This is a long standing issue for the organisation and whilst benchmark performance is better than many other trusts the national target has never been achieved and is extremely stretching. Underlying reasons include the lack of comprehensive operating procedures, customer service training and the inherent sensitivities surronding the collection if these data.	The pilot exercise carried out in the North East directorate whereby clinic clerks were supplied with prompt cards to simplify the requesting of patients ethnicity status will be extended across the Trust and linked to the Standard Operating Procedures documents currently being compiled.	Mar 2019	In Progress (No Update)
	At the June Data Quality and Information Management Group it was agreed that alongside the prompt card process being used across the trust it would be useful to have a floor walking exercise to collect ethnicity from patients and explain the reason for collecting the data. The DQ team could support this process once the prompt card pilot has been completed. Further improvements should be seen as the check-in kiosks are embedded across the trust.	Jun 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

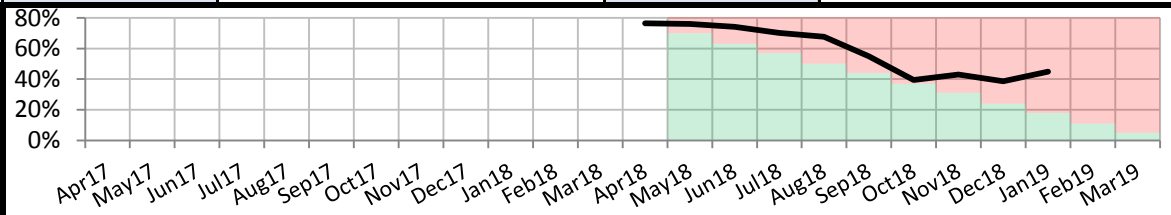
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Caring
Lead Manager	**Julie Nott**	**Responsible Director**	**Ian Tombleson**

Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
Mth ≤ 18%	Red	n/a	39.3%	42.9%	38.7%	44.8%

Divisional Benchmarking (Jan 19)	City Road	North	South
	44.2%	47.5%	31.1%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Divisions continue to show commitment to achieving their targets and the number of older incidents is decreasing, although numbers over 28 days remain similar. The central team continues to monitor performance and report weekly. New trajectories will be set where required.	The number of days by which the 28 day target is breached is reducing. The central team continues to monitor performance and report weekly. New and realistic trajectories will be established where absent	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Divisions generally continue to maintain or improve progress to resolve incidents >28 days. However Moorfields North are generating higher numbers of incidents >28 days due to a retrospective review of glaucoma patients at Bedford.	The number of days by which the 28 day target is breached is reducing. Moorfields North is developing a new plan with tracjectories. The central team is continung to support and monitor progress. New IPR indicators are being developed to better understand performance.	April 2019

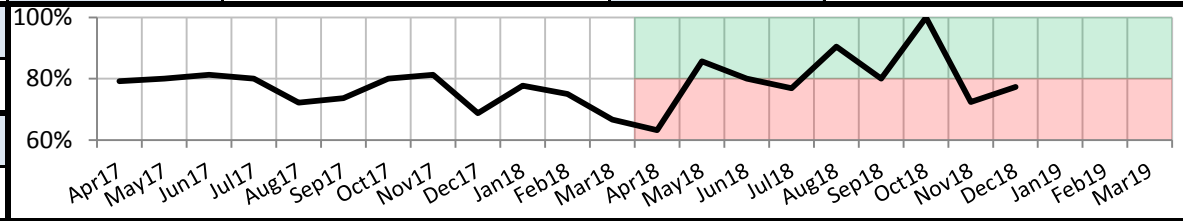
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Caring
Lead Manager	Tim Withers	Responsible Director	Ian Tombleson

Percentage of responses to written complaints sent within 25 days (Month in Arrears)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥80%	Red	80.8%	80.0%	100.0%	72.4%	77.3%

Divisional Benchmarking (Dec 18)	City Road	North	South
	84.6%	50.0%	80.0%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
The YTD performance remains above target. The 72.4% result for November was due to the increase in the number of complaints, several of them requiring complex investigations. There was a delay in some complaint investigation results not being received from CR division until after the trust response date.	There has been a drive within the CR division to meet the target dates and these are expected to be met in December and going forward. There will continue to be proactive monitoring and escalation.	Jan 2019	Complete

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The YTD performance remains above target. Of the five complaints that breeched, one was subject to a root cause analysis and therefore an extension has been agreed. With the other four these were delayed due to divisional processing issues.	The central team is launching a revised complaints handling process giving more time for divisions to produce complaints; divisions are being trained further in producing the best quality responses. Improvements are being phased over the next two months.	April 2019

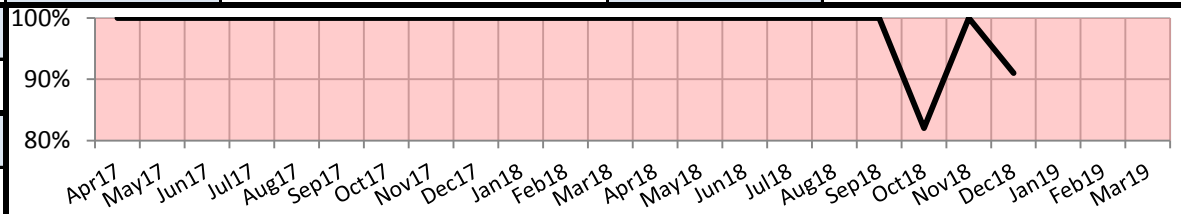
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Safe
Lead Manager	Julie Nott	Responsible Director	Ian Tombleson

Duty of Candour (Percentage of conversations informing family/carer that a patient safety incident has ocurred within

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
100%	Red	97.3%	100.0%	82.0%	100.0%	91.0%

Divisional Benchmarking (Dec 18)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
The duty of candour process has not been initiated for 2 patients.	The non-compliance has been flagged to the relevant clinicians, who have been asked to take action to resolve.	Dec 2018	Complete

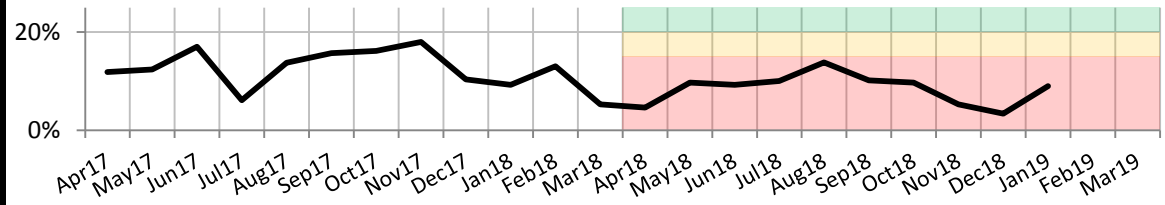
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The duty of candour process has not been initiated for 1 patient. The non-compliance relates to a case of endophthalmitis (i.e. risk associated with the surgery) rather than an avoidable error.	The patient presented at A&E for treatment, and has not yet been seen at a network site. The consultant has been made aware of the need to apologise to the patient at the next appointment.	February 2019

Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Caring
A&E Scores from Friends and Family Test - % response rate	**Lead Manager**	**Tim Withers**	**Responsible Director**	**Ian Tombleson**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥20%	Red	8.6%	9.7%	5.3%	3.4%	9.0%

Divisional Benchmarking (Jan 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Better staff engagement, new processes and commitment are required from teams to improve performance to the required level and beyond	An action plan has been developed. Actions include: Changing the point patients are asked to complete the cards. New printed cards. Posters and signs for collection boxes have been re-done. Encouraging staff to ask patients to complete the cards at discharge. Having concentrated periods with a 'push' to encourage patients to complete cards. Technological solutions are being procured to supesede manual processes in the medium term	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Performance is considerably improved from the previous two months. Volunteers have been engaged to support departmental staff. This should now improve month on month as actions from December embed.	A new system to collect FFT scores and comments by text is actively being developed subject to a business case and should replace the need for hand written cards. Bench-marking indicates this has the potential to substantially improve performance	May 2019

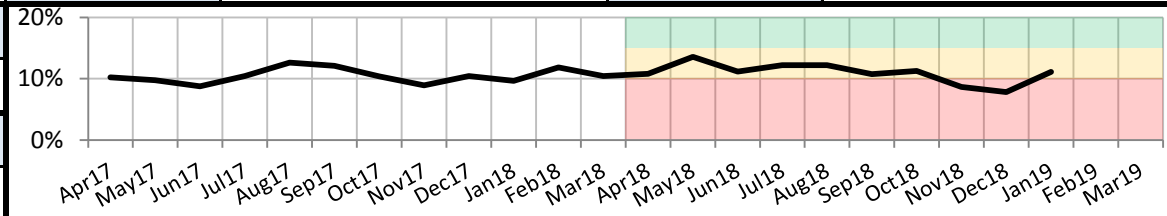
Remedial Action Plan - January 2019

Strategic Objective	SO1	CQC Domain	Caring
Lead Manager	Tim Withers	Responsible Director	Ian Tombleson

Outpatient Scores from Friends and Family Test - % response rate

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥15%	Amber	11.0%	11.3%	8.7%	7.8%	11.1%

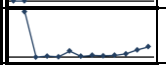
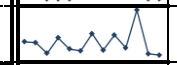
Divisional Benchmarking (Jan 19)	City Road	North	South
	13.8%	10.5%	4.3%



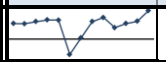
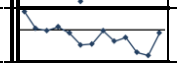
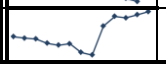
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Staff are not being managed to engage in the process of asking patients to complete the test.	DrDoctor may have a facility that allows patients to completethe test through an app and to text the test to patients following their visit. Other providers are being sourced should this not prove possible.,	Mar 2019	In Progress (No Update)
Better staff engagement, new processes and commitment are required from teams to improve performance to the required level and beyond.	Teams are having customer care training to improve their education and understanding. In the short term an action plan is being developed with similar themes to A&E. Technological solutions are being procured to supesede manual processes in the medium term.	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall performance is better than the previous two months. City road has shown marked improvement. Further staff engagment is required to improve performance across all areas.	A new system to collect FFT scores and comments by text is actively being developed subject to a business case and should replace the need for hand written cards. Bench-marking indicates this has the potential to substantially improve performance	May 2019

Objective 2	We will be at the leading edge of research, making new discoveries with our partners and patients	January 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Research	70 Day To Recruit First Research Patient	Well-Led	≥80%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	Well-Led	100%	G		113.3%	Monthly	108.3%	115.2%	134.1%	148.8%		↑
	Percentage of Research Projects Achieving Time and Target	Well-Led	≥65%	G		70.8%	Monthly	71.4%	71.4%	66.7%	66.7%		→
	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	Well-Led	≥1500	G		2769	Monthly	200	726	118	100		↓
	Percentage of Trust Patients Recruited Into Research Projects	Well-Led	None Set				Monthly	*In Development*					

Objective 3	We will innovate by sharing our knowledge and developing tomorrow's experts	January 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Training Compliance	Mandatory Training Compliance	Well-Led	≥80%	G		n/a	Monthly	83.6%	84.9%	85.7%	89.0%		↑
	Appraisal Compliance	Well-Led	≥80%	R	31	n/a	Monthly	78.8%	76.4%	75.9%	79.5%		↑
	Safeguarding - Mandatory Training Compliance	Caring	≥80%	G		n/a	Monthly	93.2%	92.9%	93.6%	94.4%		↑

Objective 4	We will collaborate to shape national policy	January 2019

There are currently no metrics available for this strategic objective

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Remedial Action Plans for Strategic Objective 2 to 4

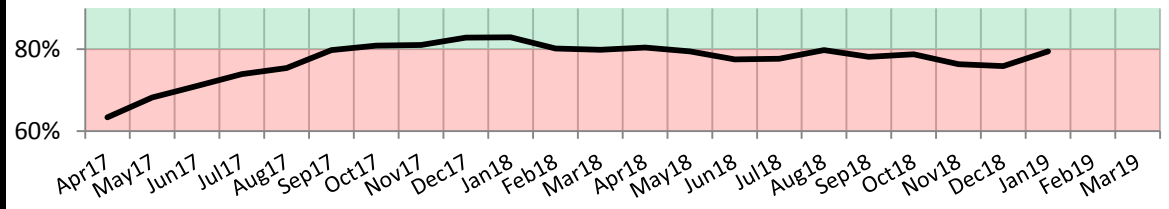
We will be at the leading edge of research, making new discoveries with our partners and patients
We will innovate by sharing our knowledge and developing tomorrow's experts
We will collaborate to shape national policy

Remedial Action Plan - January 2019

Strategic Objective	SO3	CQC Domain	Well-Led
Appraisal Compliance	**Lead Manager**	**Ruth Ball**	**Responsible Director**	**Sandi Drewett**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≥80%	Red	n/a	78.8%	76.4%	75.9%	79.5%

Divisional Benchmarking (Jan 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Staff are included in appraisal compliance figures from starting in post	Review of scoping of competence in line with managers expectations	Nov 2018	Complete
Raise awareness of non compliance across all areas.	Appraisal compliance is reported at monthly divisional meetings and any action required for non compliant teams discussed and agreed.	Mar 2019	In Progress (No Update)
Encourage proactive planning of appraisals.	Managers are sent appraisal reports on a weekly basis. City Road managers have been given access to Insight and training to enable them to download reports and appraisal data for their teams themselves and there are plans to adopt this in all areas.	Mar 2019	In Progress (No Update)
Managers are not completing appraisals when they are due.	Reminders are sent to managers in advance reminding them when their staff's appraisals are due. As additional step, non compliance reports will also be produced and included as part of the monthly dashboard data shared with the divisions.	Feb 2019	In Progress (No Update)
Some managers are still not experienced or confident in undertaking appraisal.	HR clinics continue to take place on a regular basis. Bespoke appraisal training will also be delivered in areas where compliance is lowest.	Mar 2019	In Progress (No Update)
Some appraisal reminders are going to the wrong manager	Data cleanse exercise on ESR to take place and supervisor heirarchy to be corrected as part of this.	May 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

Objective 5	We will attract, retain and develop great people	January 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Staff & Voluntary Experience	Percentage of Staff agreeing with the staff survey statement "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	Well-Led	≥90%				Quarterly	96.0%					
	Percentage of Staff agreeing with the staff survey statement "I would recommend my organisation as a place to work"	Well-Led	≥70%				Quarterly	72.2%					
Recruitment and Turnover	Staff Turnover (Rolling Annual Figure)	Well-Led	≤15%	G		n/a	Monthly	12.9%	12.8%	13.0%	13.2%		↑
	Proportion of Temporary Staff	Well-Led	RAG as per Spend	R	*	15.1%	Monthly	16.3%	14.8%	12.6%	12.7%		↑
	Temporary Staff Spend	Well-Led	≤ Plan (£)	R	*	7865	Monthly	898	782	591	632		↑
	Agency Spend v trajectory	Use of Resources	1	G		1	Monthly	1	2	1	1		→
	Number of Apprenticeship staff started within the Trust	Well-Led	Qtr:8 YTD:35	R	34	26	Quarterly			10			

For commentary, please refer to the Finance Report presented to board

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Remedial Action Plans for Strategic Objective 5

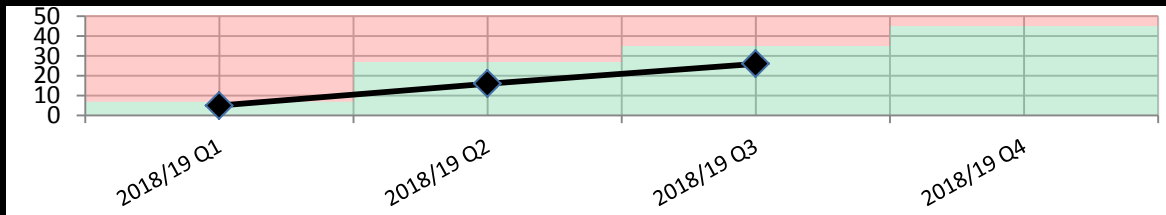
We will attract, retain and develop great people

Remedial Action Plan - January 2019

Strategic Objective	SO5	CQC Domain	Well-Led
Number of Apprenticeship staff started within the Trust	**Lead Manager**	**Nicky Wild**	**Responsible Director**	**Sandi Drewett**

Target	Rating	YTD	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Qtr:8 YTD:35	Red	26	n/a	5	11	10

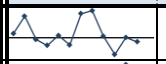
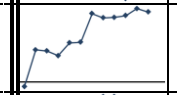
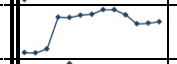
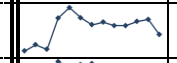
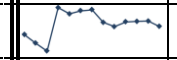
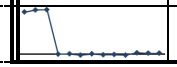
Divisional Benchmarking (2018/19 Q3)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Delayed start date for some of our apprenticeship provision (assistant practitioner apprenticeship, surveying apprenticeship, pharmacy apprenticeship).	Apprenticeship starts delayed until October and February respectively. Apprentices will start at these dates.	Mar 2019	In Progress (Update)
Delayed recruitment of apprentices due to organisational change and subsequent restructure processes.	Support managers to recruit apprentices following staffing changes and work with recruitment team to market ongoing apprenticeship vacancies.	Mar 2019	In Progress (No Update)
Internal access to development through apprentice route has been slow to progress	A variety of further communications will be used to promote apprenticeships internally across the trust. Development of apprenticeship strategy to support departments to utilise apprenticeships for workforce planning gaps.	Mar 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Assistant Practitioner apprenticeship delayed again by provider resulting in 8 starts not taking place.	New provider procured for delivery of this with aim to start in March/April 2019	April 2019
Post conversion to apprenticeship has been less than expected.	Workforce planning closely linked to education needs in business planning round for 2019/2020 to identify more strategic approach to apprenticeships.	October 2019

Objective 6	We will have an infrastructure and culture that supports innovation	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Organisational Health	Staff Sickness (Month Figure)	Well-Led	≤4%	G		n/a	Monthly	4.0%	3.6%	4.0%	3.9%		
	Staff Sickness (Rolling Annual Figure)	Well-Led	≤4%	A	37	n/a	Monthly (Month in Arrears)	4.2%	4.2%	4.2%	4.2%		
	Staff Stability	Well-Led	≥80%	G		n/a	Monthly	88.1%	86.9%	87.0%	87.2%		↑
	Staff Vacancy Rates	Well-Led	≤10%	A	38	n/a	Monthly	15.8%	16.3%	16.6%	14.6%		↓
	Staff Vacancy Rates - Nursing & AHP	Well-Led	≤10%	A	39	n/a	Monthly	15.5%	15.6%	15.6%	15.1%		↓
Capital Development	Capital Service Capacity	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Capital Expenditure (Variation To Plan forecast)	Use of Resources	≥0	G		0.40	Monthly	-0.40	0.60	0.40	0.40		→

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Remedial Action Plans for Strategic Objective 6

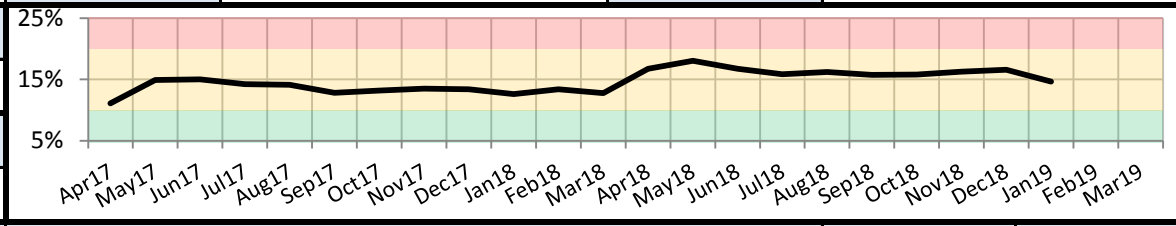
We will have an infrastructure and culture that supports innovation

Remedial Action Plan - January 2019

Strategic Objective	SO6	CQC Domain	Well-Led
Staff Vacancy Rates	**Lead Manager**	**Nicky Wild**	**Responsible Director**	**Sandi Drewett**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤10%	Amber	n/a	15.8%	16.3%	16.6%	14.6%

Divisional Benchmarking (Jan 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Hot spots are understood and include parts of Moorfields South and theatres at City Road	An admin and clerical consultation is underway in City Road and North, which proposes a review of the Administrative structure. This will fill a majority of the vacancies currently being held by Bank staff.	Oct 2018	In Progress (No Update)

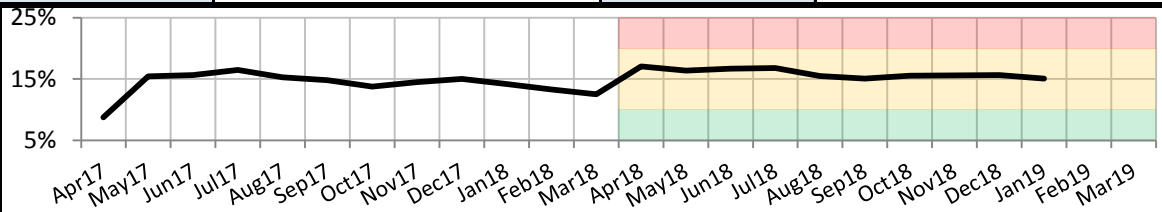
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
We are currently unable to provide accurate vacancy reports.	Project work will be undertaken in the new financial year to ensure the budgeted staffing establishment is fully and accurately recorded, and processes implemented to manage the recorded budgeted establishment going forwards – for example by ensuring that old posts are removed from the establishment following skill mix reviews. This will ensure that the budgeted establishment we are measuring against is not over-inflated, which makes vacancy rates appear to be higher than they really are.	August 2019
There is a reliance on bank staff to fill vacant posts for long periods of time.	HR and Finance will be working together to challenge those areas of the business that are habitually using a large proportion of bank and agency staff to fill their establishment [in particular Moorfields South, Access and Private]	August 2019

Remedial Action Plan - January 2019

Strategic Objective	SO6	CQC Domain	Well-Led
Staff Vacancy Rates - Nursing & AHP	**Lead Manager**	**Nicky Wild**	**Responsible Director**	**Sandi Drewett**

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤10%	Amber	n/a	15.5%	15.6%	15.6%	15.1%

Divisional Benchmarking (Jan 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Hot spots are understood and include parts of Moorfields South and theatres at City Road	Nursing open days have been held and a number of offers were made. A reconciliation of our vacancies within nursing is underway to understand where efforts are to be focused.	Sep 2018	Complete

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There are particular vacancy hotspots within the nursing workforce which may be skewing the figures, for example Theatres and Moorfields Private. Similarly, we are aware that vacancy rates for our nursing support staff are higher than that for qualified nursing staff, which may also be skewing the overall figures.	Project work planned for the new financial year will look to distinguish between qualified and non-qualified nursing so we can pinpoint the situation with greater precision	August 2019

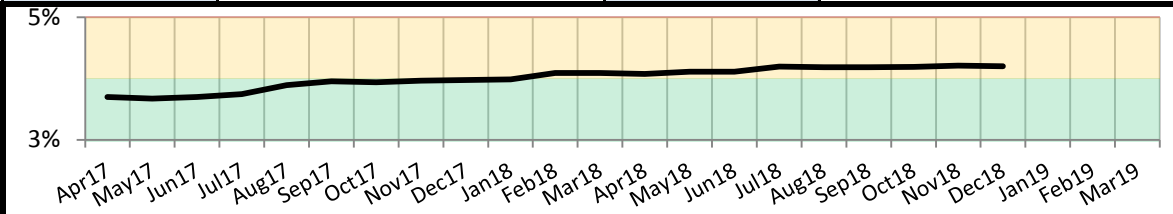
Remedial Action Plan - January 2019

Strategic Objective	SO6	CQC Domain	Well-Led
Lead Manager	Nicky Wild	Responsible Director	Sandi Drewett

Staff Sickness (Rolling Annual Figure) (Month in Arrears)

Target	Rating	YTD	Oct-18	Nov-18	Dec-18	Jan-19
≤4%	Amber	n/a	4.2%	4.2%	4.2%	4.2%

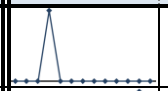
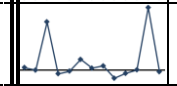
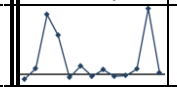
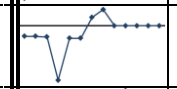
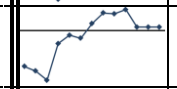
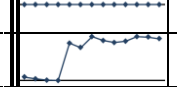
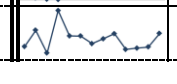
Divisional Benchmarking (Dec 18)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Ensure all managers are adequately trained in the absence management process	Roll out of sickness absence management workshops across the trust with new managers invited as part of their induction. These commenced in October 2018 and the aim is to have run these in all areas by end of March 2019.	Mar 2019	In Progress (No Update)
Raise awareness of current sickness issues in each area.	Monthly report of sickness absence and Bradford scores provided to managers who are required to confirm actions taken to address.	Ongoing (Added October 18)	In Progress (No Update)
Difficulties in reporting short and long term absences	ESR is now embedded and initial reports are being produced which will be shared with the divisions from this month.	Jan 2019	In Progress (No Update)
Ensure proactive management of sickness absence in all areas	In addition to training regular HR clinics a trustwide sickness absence audit will be undertaken.	May 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified		

Objective 7	We will have a sustainable financial model	January 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Annual Surplus Delivery	Distance from Financial Plan (Current in Trust Metric : Trust Underlying Overall Position - Surplus / Deficit)	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Overall financial performance (In Month Var. £m)	Use of Resources	≥0	G		3.84	Monthly	-0.22	0.00	3.97	-0.12		↓
	NHS Performance (In Month Var. £m)	Use of Resources	≥0	G		4.67	Monthly	-0.07	0.32	3.97	0.09		↓
	Efficiency Scheme Performance (YTD Percentage)	Use of Resources	100%	G		100%	Monthly	100%	100%	100%	100%		→
	Efficiency Scheme Performance (YTD Var. £m)	Use of Resources	≥0	G		0.10	Monthly	0.60	0.10	0.10	0.10		→
Liquidity	Liquidity (days)	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Cash Flow (In Month Variation)	Use of Resources	≥0	G		46.40	Monthly	43.60	48.80	48.20	46.40		↓
	Outstanding debtors (Total £m)	Use of Resources	≤ Plan	G		11.3	Monthly	9.6	9.8	9.9	11.3		↑

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

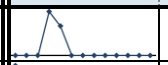
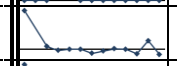
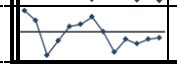
Objective 7	We will have a sustainable financial model	January 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Use Of Resources Metrics	Use of resources risk rating - combines all of above measures	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Top 10 Medicines (Cost Reduction)	Use of Resources	None Set				Monthly	*In Development*					
	Estate Cost per square metre	Use of Resources	None Set				Monthly	*In Development*					
	Overall cost per test	Use of Resources	None Set				Monthly	*In Development*					
	HR cost per £100 million turnover	Use of Resources	None Set				Monthly	*In Development*					
	Finance cost per £100 million turnover	Use of Resources	None Set				Monthly	*In Development*					
	Procurement Process Efficiency and Price Performance Score	Use of Resources	None Set				Monthly	*In Development*					

Please note there are no Remedial Action Plan generated for Strategic Objective 7. For commentary, please refer to the Finance Report presented to board

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Objective 8	We will be enterprising to support and fund our ambitions	*January 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Oct 18	Nov 18	Dec 18	Jan 19	13 Month Trend	vs. Last
Contribution To ROI	I&E Margin (Current in Trust Metric : Overall Position)	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Research & Development Position (In Month Var. £m)	Use of Resources	≥0	R		-0.15	Monthly	0.00	-0.08	0.15	-0.09		↓
	Commercial Trading Unit Position (In Month Var. £m)	Use of Resources	≥0	R		-0.68	Monthly	-0.15	-0.24	-0.15	-0.12		↑

Please note there are no Remedial Action Plan generated for Strategic Objective 8. For commentary, please refer to the Finance Report presented to board