Moorfields Eye Hospital NHS
NHS Foundation Trust

Report to Trust Board

Report Title	**Integrated Performance Report - December 2018**
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.

Executive Summary - December Performance

Overall we continue to deliver the national Access targets , we have though had a small number of 52 week breaches.

Despite a reduced capacity across the outpatient cancer clinics the 2ww standard was met, however the reduced capacity continues to affect the 14 days standard. A number of medium and longer term actions are in progress to address this underlying performance.

Our performance against eRS has stabilised and is unlikely to improve to 100% unless all urgent referrals are rejected which at this time would not be clinically acceptable. There is a corresponding number of ASIs that are being looked at on a service by service basis to reduce the ASI total. As discussed previously this is a national issue.

We continue to have issues with theatre cancellations and late starts driven by the delay to moving back into St Georges from St Anthonys. These metrics were compounded by some cancellations and late starts where patients through the winter/festive period i.e. illness on the day and DNAs. We are currently reviewing how we manage and monitor this in order to bring about improvements.

Readmissions appear on this report and have not done over the last quarter, there were four cases all reviewed and unavoidable. No patients have come to harm due to this.

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 - December 2018

		G	A	R
SO1	Referral To Treatment	1	0	1
	Accident & Emergency	2	0	0
	Cancer	2	0	2
	Clinic Management	2	0	5
	Diagnostics	1	0	0
	DNA Rates	2	0	0
	Cancellations	1	1	2
	Theatre Practice	0	0	2
	Ward Management	3	0	0
	Data Quality	5	0	1
	Mortality	1	0	0
	Infection Control	12	0	0
	Patient Safety	7	0	2
	Safer Staffing Checklist	5	0	0
	Patient Experience	6	0	2

		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	2
SO6	Organisational Health	2	1	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 - December 2018

		G	A	R
Responsive	Referral To Treatment	1	0	1
	Accident & Emergency	2	0	0
	Cancer	2	0	2
	Clinic Management	2	0	5
	Diagnostics	1	0	0
	Ward Management	1	0	0
Effective	DNA Rates	2	0	0
	Cancellations	1	1	2
	Theatre Practice	0	0	2
	Mortality	1	0	0
	Data Quality	5	0	1
Caring	Patient Experience	6	0	2
	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	10	0	0
	Ward Management	1	0	0
	Patient Safety	6	0	0
	Safer Staffing Checklist	5	0	0
Well-Led	Organisational Health	2	1	0
	Recruitment and Turnover	1	0	2
	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.

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

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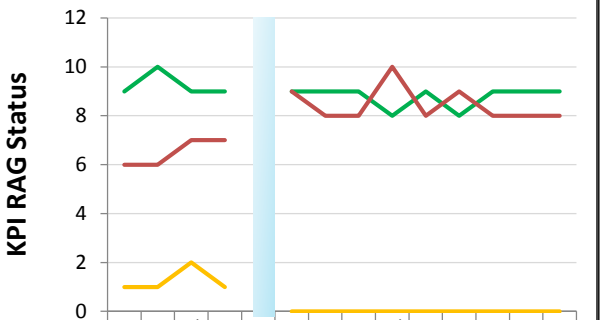
↓	Downward Trend Compared to Previous Month
◆	No Trend Due To Nil return for Previous Month
	No Trend Due To Nil return for Current Month

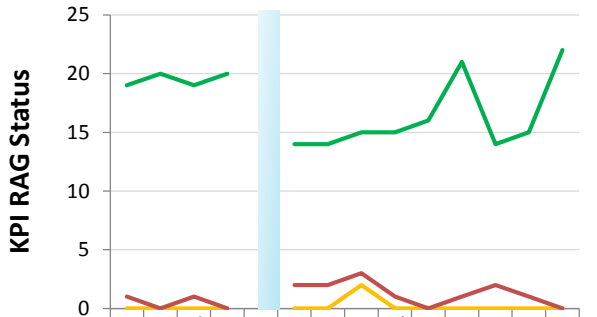
Executive Summary - CQC Domain Trends

Responsive



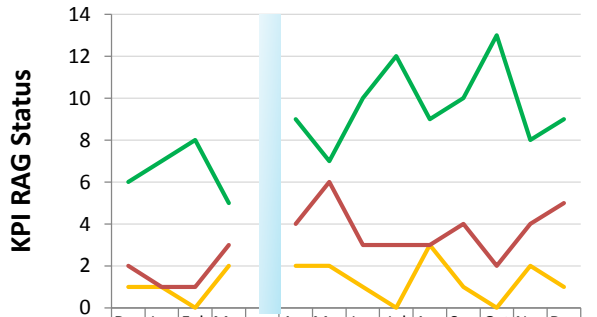
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Green	9	10	9	9		9	9	9	8	9	8	9	9	9
Amber	1	1	2	1		0	0	0	0	0	0	0	0	0
Red	6	6	7	7		9	8	8	10	8	9	8	8	8

Safe



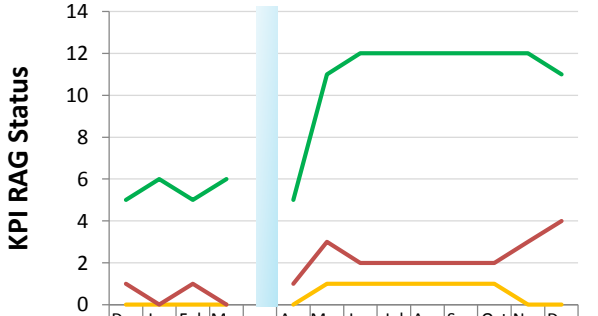
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Green	19	20	19	20		14	14	15	15	16	21	14	15	22
Amber	0	0	0	0		0	0	2	0	0	0	0	0	0
Red	1	0	1	0		2	2	3	1	0	1	2	1	0

Effective



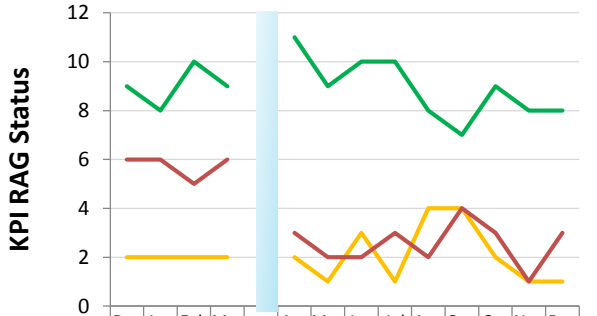
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Green	6	7	8	5		9	7	10	12	9	10	13	8	9
Amber	1	1	0	2		2	2	1	0	3	1	0	2	1
Red	2	1	1	3		4	6	3	3	3	4	2	4	5

Caring



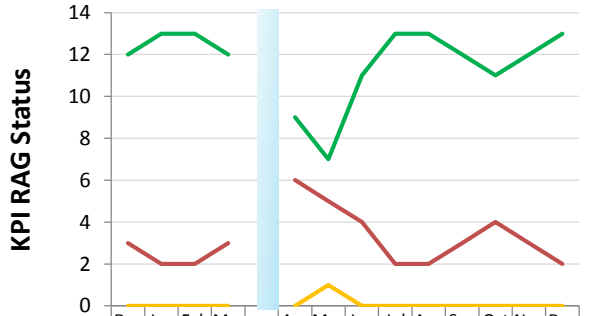
	Dec	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Green	5	6	5	6		5	11	12	12	12	12	12	12	11
Amber	0	0	0	0		0	1	1	1	1	1	1	0	0
Red	1	0	1	0		1	3	2	2	2	2	2	3	4

Well-Led



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

Use of Resources



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

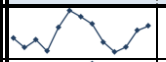
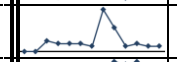
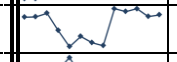
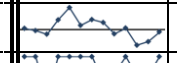
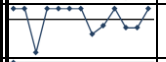
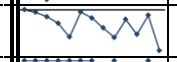
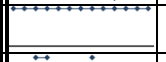
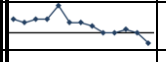
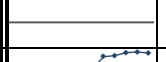
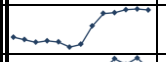
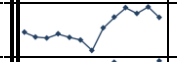
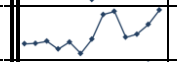
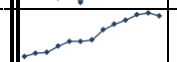
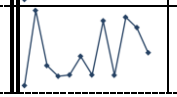
Lines split by financial year due to different number of metrics

Context - Overall Activity - December 2018

		December 2018		Monthly Variance	Year To Date		YTD Variance
		2017/18	2018/19		2017/18	2018/19	
Accident & Emergency	A&E Arrivals (All Type 2)	6,638	7,128	+ 7.4%	74,413	73,022	- 1.9%
	Number of 4 hour breaches	67	58	- 13.4%	1,148	1,223	+ 6.5%
Outpatient Activity	Number of Referrals Received	9,338	10,225	+ 9.5%	97,363	104,758	+ 7.6%
	Total Attendances	39,485	40,815	+ 3.4%	420,110	446,766	+ 6.3%
	First Appointment Attendances	9,160	9,101	- 0.6%	94,911	101,832	+ 7.3%
	Follow Up (Subsequent) Attendances	30,325	31,714	+ 4.6%	325,199	344,934	+ 6.1%
Admission Activity	Total Admissions	2,714	2,661	- 2.0%	27,848	28,795	+ 3.4%
	Day Case Elective Admissions	2,364	2,347	- 0.7%	24,722	25,931	+ 4.9%
	Inpatient Elective Admissions	75	83	+ 10.7%	775	825	+ 6.5%
	Non-Elective (Emergency) Admissions	275	231	- 16.0%	2,351	2,039	- 13.3%

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	*December 2018*

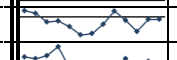
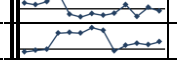
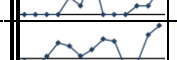
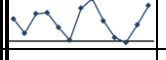
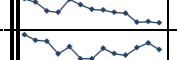
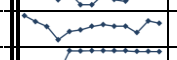
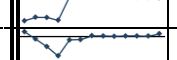
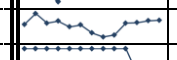
Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Referral To Treatment	18 Week RTT Incomplete Performance *	Responsive	≥92%	G		94.6%	Monthly	93.9%	94.0%	94.6%	94.8%		↑
	52 Week RTT Incomplete Breaches *	Responsive	Zero Breaches	R	11	42	Monthly	2	3	2	2		→
Accident & Emergency	A&E Four Hour Performance	Responsive	≥95%	G		98.3%	Monthly	99.4%	99.7%	99.0%	99.2%		↑
	A&E Unplanned Reattendance	Responsive	≤5%	G		5.1%	Monthly	5.1%	4.2%	4.4%	4.9%		↑
Cancer	Cancer 2 week waits - first appointment urgent GP referral	Responsive	≥93%	G		95.1%	Monthly	100.0%	87.5%	87.5%	100.0%		↑
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Responsive	≥93%	R	12	75.7%	Monthly	83.3%	68.2%	87.5%	52.1%		↓
	Cancer 31 day waits - diagnosis to first appointment	Responsive	≥96%	R	13	97.5%	Monthly	91.7%	96.3%	100.0%	95.8%		↓
	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%			100.0%	Monthly	n/a	n/a	n/a	n/a		
Clinic Management	Median Clinic Journey Times - New Patient appointments	Responsive	Mth:≤ 100m	G		94	Monthly	93	96	96	93		↓
	Median Clinic Journey Times -Follow Up Patient appointments	Responsive	Mth:≤ 90m	G		90	Monthly	89	90	89	86		↓
	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:≥ 81.2%	R	14	45.0%	Monthly	48.9%	49.9%	50.2%	49.8%		↓
	Data completeness for Clinic Journey Time (Glaucoma)	Responsive	Mth:≥ 84.3%	R	15	59.1%	Monthly	68.8%	65.4%	69.3%	63.0%		↓
	Data completeness for Clinic Journey Time (MR)	Responsive	Mth:≥ 84.0%	R	16	53.5%	Monthly	51.8%	52.5%	54.7%	58.0%		↑
	Percentage of GP referrals From Electronic Booking - trajectory target of 100% for Oct 2018	Responsive	100%	R	17	82.9%	Monthly	88.8%	93.5%	95.1%	92.5%		↓
	Electronic Booking Appointment Slot Issue (ASI) Rate	Responsive	≤ 4.0%	R	18	23.6%	Monthly (Month in Arrears)	20.0%	27.6%	26.2%	23.0%		

* Provisional For December 2018

** Provisional For Oct-Dec 2018

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	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Diagnostics	Percentage of Diagnostic waiting times less than 6 weeks	Responsive	≥99%	G		100%	Monthly	100%	100%	100%	100%		→
DNA Rates	Outpatients DNA rate - 1st appointment	Effective	≤12.3%	G		11.8%	Monthly	12.1%	11.5%	12.2%	12.2%		→
	Outpatients DNA rate - follow up appointment	Effective	≤10.8%	G		10.5%	Monthly	11.1%	10.2%	10.9%	10.6%		↓
Cancellations	Outpatient Cancellation rate (Hospital cancellations)	Effective	≤2.85%	R	19	3.44%	Monthly	3.07%	3.19%	3.11%	3.28%		↑
	Theatre Cancellation Rate (Overall)	Effective	≤7.0%	A	20	7.1%	Monthly	7.7%	6.5%	7.5%	7.3%		↓
	Theatre Cancellation Rate (Non-Medical Cancellations)	Effective	≤0.8%	G		0.86%	Monthly	1.13%	0.73%	0.93%	0.58%		↓
	Number of non-medical cancelled operations not treated within 28 days **	Effective	Zero Breaches	R		13	Monthly	0	1	1	3		↑
Theatre Practice	Theatre Sessions starting late	Effective	≤32.7%	R	21	34.5%	Monthly	31.1%	31.8%	36.6%	38.2%		↑
	Percentage of Emergency re-admissions within 30 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Effective	≤3.77%	R	22	3.11%	Monthly	3.39%	0.00%	0.00%	5.41%		↑
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		95.6%	Monthly	91.1%	89.5%	95.2%	101.4%		↑
	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	91.4%	Monthly	91.4%	90.4%	90.5%	90.4%		↓
	Data Quality - NHS Number recording (Outpatient and Inpatient)	Effective	≥99%	G		99.5%	Monthly	99.5%	99.5%	99.6%	99.5%		↓
	Data Quality - GP recording (Outpatient and Inpatient)	Effective	≥98%	G		99.9%	Monthly	99.9%	99.8%	99.9%	99.9%		→
	Data Quality - Ethnicity recording (A&E)	Effective	≥95%	G		99.8%	Not Set	99.9%	99.8%	99.7%	99.7%		→
	Data Quality - NHS Number recording (A&E)	Effective	≥95%	G		95.0%	Not Set	95.2%	95.2%	95.1%	96.0%		↑
	Data Quality - GP recording (A&E)	Effective	≥95%	G		99.4%	Not Set	99.5%	99.5%	99.6%	99.6%		→
Mortality	Summary Hospital Mortality Indicator	Effective	Zero Cases	G		n/a	Monthly	n/a	0	0	0		→

* Provisional For December 2018

** Provisional For Oct-Dec 2018

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	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Infection Control	Endopthalmitis Rates - Cataract (per 1000 incidents)	Safe	≤0.4	G		0.32	Quarterly	0.00			0.33		
	Endopthalmitis Rates - Intravitreal (per 1000 incidents)	Safe	≤0.5	G		0.17	Quarterly	0.34			0.08		
	Endopthalmitis Rates -Glaucoma (per 1000 incidents)	Safe	≤1.0	G		0.57	Quarterly	0.00			0.00		
	Endopthalmitis Rates - Corneal EK procedures (per 1000 incidents)	Safe	≤3.6	G		3.33	Quarterly	0.00			0.00		
	Endopthalmitis Rates - Corneal PK procedures (per 1000 incidents)	Safe	≤1.6	G		0.00	Quarterly	0.00			0.00		
	Endopthalmitis Rates - Vitreoretinal (per 1000 incidents)	Safe	≤0.6	G		0.30	Quarterly	0.00			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	99.8%	99.0%	99.0%	99.7%		↑

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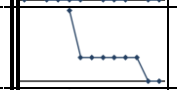
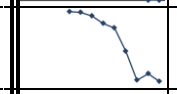
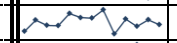
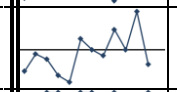
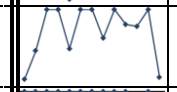
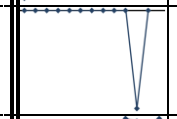
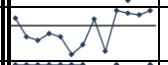
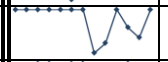
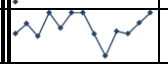
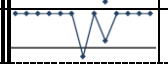
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Patient Safety	Occurrence of any Never events	Safe	Zero Events	G		2	Monthly	0	1	0	0		→
	Number of Serious Incidents remaining open after 60 days	Safe	Zero Cases	G		8	Monthly (Reporting Month)	1	1	0	0		→
	Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days	Caring	Mth ≤ 24%	R	24	n/a	Monthly (Reporting Month)	55.0%	39.3%	42.9%	38.7%		↓
	NHS England/NHS Improvement Patient Safety Alerts breached	Safe	Zero Alerts	G			Monthly	0	0	0	0		→
	VTE Risk Assessment	Safe	≥95%	G		98.3%	Monthly	98.8%	97.7%	97.2%	97.9%		↑
	Posterior Capsular Rupture rates	Safe	≤1.95%	G		0.96%	Monthly	0.99%	0.77%	0.97%	0.82%		↓
	Percentage of responses to written complaints sent within 25 days	Caring	≥80%	R	25	81.3%	Monthly (Month in Arrears)	90.5%	80.0%	100.0%	72.4%		
	Percentage of responses to written complaints acknowledged within 3 days	Caring	≥80%	G		95.1%	Monthly (Reporting Month)	96.0%	95.5%	100.0%	81.8%		↓
	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%	G			Monthly (Month in Arrears)	100.0%	100.0%	82.0%	100%		
Safer Staffing Checklist	Safer Surgery Checklist: Percentage of audited "Team Briefing" stage elements compliant with requirements	Safe	≥90%	G		95.9%	Monthly	100.0%	99.1%	98.5%	100.0%		↑
	Safer Surgery Checklist: Percentage of audited "Sign In" stage elements compliant with requirements	Safe	≥90%	G		99.9%	Monthly	100.0%	99.9%	99.9%	100.0%		↑
	Safer Surgery Checklist: Percentage of audited "Time Out" stage elements compliant with requirements	Safe	≥90%	G		99.7%	Monthly	99.7%	100.0%	99.6%	99.7%		↑
	Safer Surgery Checklist: Percentage of audited "Sign Out" stage elements compliant with requirements	Safe	≥90%	G		99.3%	Monthly	99.1%	99.0%	99.5%	100.0%		↑
	Safer Surgery Checklist: Percentage of audited "Team Debrief" stage elements compliant with requirements	Safe	≥90%	G		99.2%	Monthly	100.0%	100.0%	100.0%	100.0%		→

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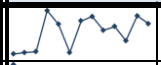
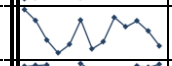
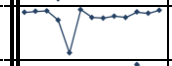
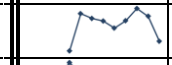
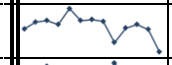
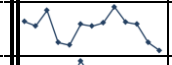
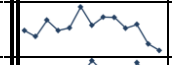
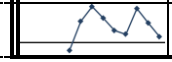
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Patient Experience	Inpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		99.4%	Monthly	99.5%	99.1%	99.7%	99.5%		↓
	A&E Scores from Friends and Family Test - % positive	Caring	≥90%	G		94.1%	Monthly	94.5%	95.3%	94.0%	92.1%		↓
	Outpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		96.8%	Monthly	96.8%	97.3%	97.2%	97.5%		↑
	Paediatric Scores from Friends and Family Test - % positive	Caring	≥90%	G		98.0%	Monthly	98.1%	98.4%	98.2%	97.5%		↓
	Inpatient Scores from Friends and Family Test - % response rate	Caring	≥30%	G		50.9%	Monthly	50.1%	52.7%	49.2%	33.5%		↓
	A&E Scores from Friends and Family Test - % response rate	Caring	≥20%	R	26	8.5%	Monthly	10.2%	9.7%	5.3%	3.4%		↓
	Outpatient Scores from Friends and Family Test - % response rate	Caring	≥15%	R	27	11.0%	Monthly	10.8%	11.3%	8.7%	7.8%		↓
	Paediatric Scores from Friends and Family Test - % response rate	Caring	≥15%	G		20.5%	Monthly	17.7%	25.7%	21.2%	16.9%		↓

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Remedial Action Plans for Strategic Objective 1

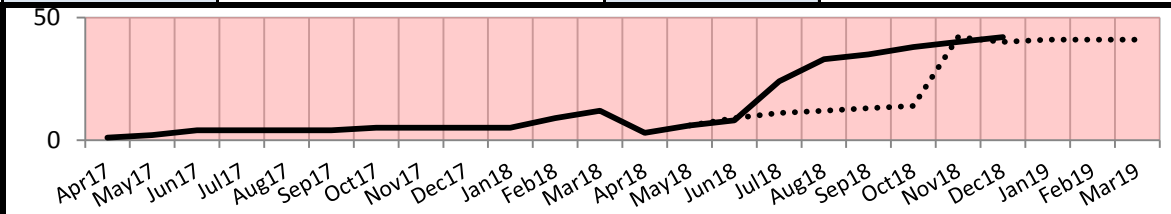
We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Remedial Action Plan - December 2018

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

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
Zero Breaches	Red	42	2	3	2	2

Divisional Benchmarking (Dec 18)	City Road	North	South
	n/a	n/a	2



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
Routine review of patients waiting during PTL found previous incorrect RTT status	Patient expedited for treatment and further training to be provided for those	January 2019
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	January 2019

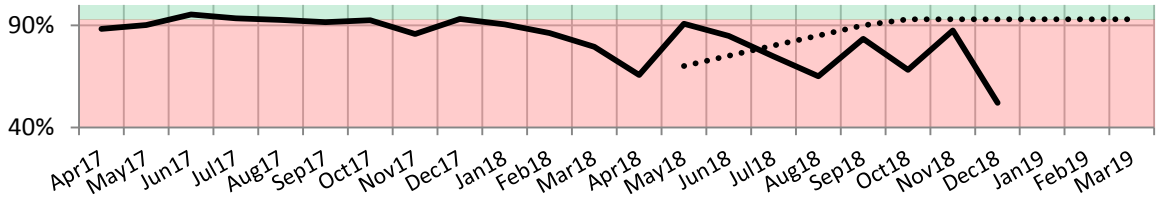
Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
≥93%	Red	75.7%	83.3%	68.2%	87.5%	52.1%

Divisional Benchmarking (Dec 18)	City Road	North	South
	52.1%	n/a	n/a



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

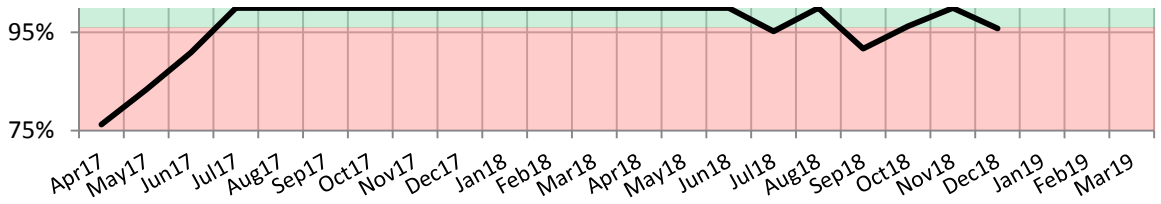
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There were 23 breaches to the NHSE 14-day standard during December. 18 of these were due to a lack of clinic availablity on bank holidays and pre-agreed annual leave	1)Creation of additional capacity through retention of the locum consultant	March 2019
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
	Business case to be worked up, with a view to appointing a third consultant, to fully meet demand	August 2019

Remedial Action Plan - December 2018

Strategic Objective	SO1	CQC Domain	Responsive
Cancer 31 day waits - diagnosis to first appointment	**Lead Manager**	**Tim Reynolds**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≥96%	Red	97.5%	91.7%	96.3%	100.0%	95.8%

Divisional Benchmarking (Dec 18)	City Road	North	South
	95.8%	n/a	n/a



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

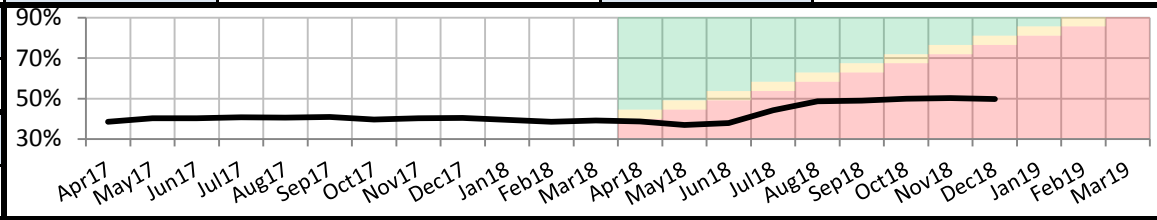
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There was 1 breach to the 31-day first treatment standard in December. This was due to availability of a suitable ruthenium plaque for surgery, from delays in ordering and delivery.	A new supply of 4 plaques are now in clinical use, with two more being procured. This will reduce admission length and it is not anticipated that there will be any further breaches for this reason.	No Further Action Required

Remedial Action Plan - December 2018

Strategic Objective	SO1	CQC Domain	Responsive
Data completeness for Clinic Journey Time (Total)	**Lead Manager**	**Naomi Sheeter**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
Mth:≥ 81.2%	Red	45.0%	48.9%	49.9%	50.2%	49.8%

Divisional Benchmarking (Dec 18)	City Road	North	South
	50.9%	39.8%	59.5%



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 are now in the final testing phase and will be released to all administrative staff in all sites once testing is complete, now set for Jan 2019. The work being done divisionally is overseen by the Clinical Administration working group which meets fortnightly and is attended by operational management, administration and service improvement teams. Services with very low data completeness have been targeted individually and are implementing changes to administrative processes throughout December and January. Data review in November showed that improving performance in Glaucoma, MR and External Disease services will have a significant impact on the trustwide target and that is the focus for specific support . Data continues to be shared with these service managers on a weekly basis and with divisional management for performance review meetings.	Jan 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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.	March 2019

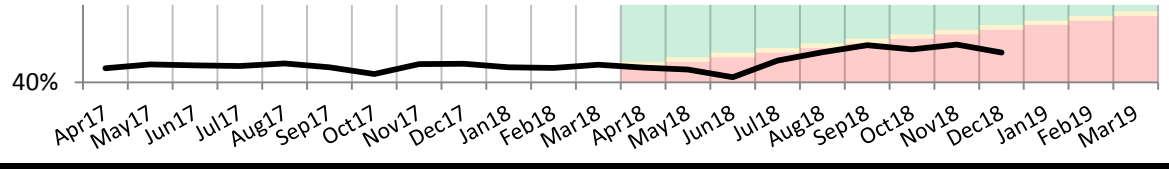
Remedial Action Plan - December 2018

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

Data completeness for Clinic Journey Time (Glaucoma)

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
Mth:≥ 84.3%	Red	59.1%	68.8%	65.4%	69.3%	63.0%

Divisional Benchmarking (Dec 18)	City Road	North	South
	67.6%	54.8%	64.8%



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 (patient stratification) in Glaucoma at City Road resulted in a significant improvement in data completeness for this site as a whole, particularly the Glaucoma service. This project has been rolled out to sites in the North and South divisions as well as to other clinics within City Road. Data is now supplied weekly to the Glaucoma Service Manager to hold administrative teams to account and progress is monitored regularly by divisional management. Data is being provided to the North and South divisons on a fortnightly basis.	Dec 2018	In Progress (Update)
Variable administrative standard operating procedures in use across the Trust's sites and services.	Administrative standard operating procedures in use across the Trust have been reviewed and rewritten to provide a single standard operating procedure trustwide. The first tranche of these are now in the final testing phase and will be released to all administrative staff in all sites once testing is complete, now set for Jan 2019. The work being done divisionally is overseen by the Clinical Administration Working Group which meets fortnightly & is attended by operational management, administration and and service improvement teams. Individual site and service data completeness is reviewed weekly and shared with the operational management teams. Rationale for collecting data is being reinforced with the operational teams to ensure buy-in, and there has been a slight improvement since a dip in performance the previous month.	Jan 2019	In Progress (Update)

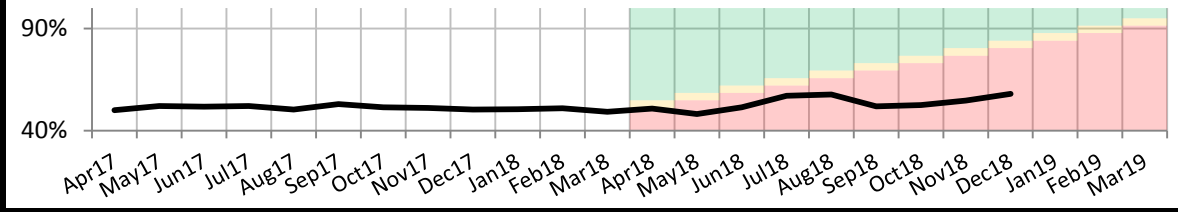
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Differing performance across the divisions, sites and services	The 2017-18 service improvement project in specific Glaucoma clinics at the City Road site resulted in improved data completeness. This project has been 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.	March 2019
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.	March 2019

Remedial Action Plan - December 2018

Strategic Objective	SO1	CQC Domain	Responsive
Data completeness for Clinic Journey Time (MR)	**Lead Manager**	**Naomi Sheeter**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
Mth:≥ 84.0%	Red	53.5%	51.8%	52.5%	54.7%	58.0%

Divisional Benchmarking (Dec 18)	City Road	North	South
	64.1%	30.5%	76.3%



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	The 2017-18 service improvement project in Glaucoma at City Road (patient stratification) resulted in a significant improvement in data completeness. This project is now being modified for MR with a focus on improving data completeness and utilising digitally enhanced clinics more effectively on a site-by-site basis. We are also providing increased support for Ealing and Northwick Park (the largest sites in the division in terms of activity) with more granular data and weekly feedback to clerical leads with the aim of improving data completeness at these sites.	Jan 2019	In Progress (Update)
Variable administrative standard operating procedures in use across the Trust's sites and services.	Administrative standard operating procedures in use across the Trust have been reviewed and rewritten to provide a single standard operating procedure trustwide. The first tranche of these are now in the final testing phase and will be released to all administrative staff in all sites once testing is complete, now set for Jan 2019. The work being done divisionally is overseen by the Clinical Administration Working Group which meets fortnightly & is attended by operational management, administration and and service improvement teams.	Jan 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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.	March 2019
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.	March 2019

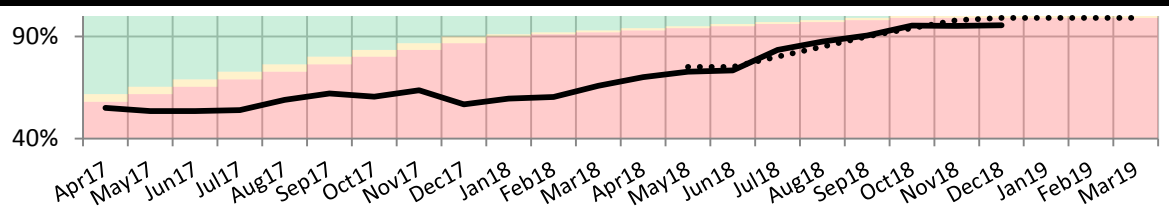
Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
100%	Red	84.9%	90.3%	95.3%	95.2%	95.5%

Divisional Benchmarking (Dec 18)	City Road	North	South
	99.2%	95.1%	95.8%



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.	Jan 2019	In Progress (Update)
This month there were a small number of routine GP referrals which were processed outside eRS.	Staff have been reminded that no routine GP referrals should be accepted outside of eRS.	Dec 2018	Complete

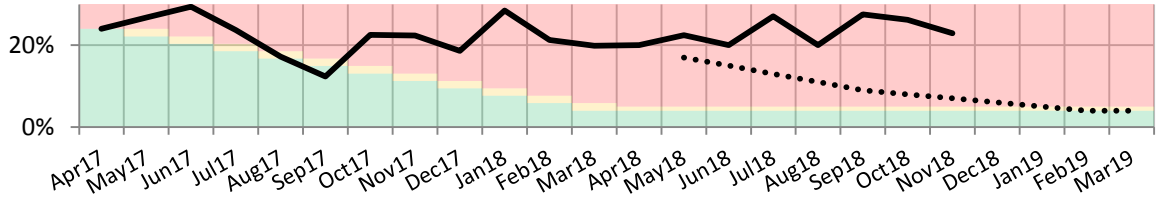
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There remain a small number of urgent paper referrals being received and the Trust have agreed not to reject these for clinical reasons until further discussion. Until this is resolved the target of 100% will be difficult 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.	March 2019

Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
≤ 4.0%	Red	23.6%	20.0%	27.6%	26.2%	23.0%

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
St Georges- high number of ASIs in paediatrics at St Georges due to capacity issues.	Paediatric fellow has been appointed, number of ASI's will reduce in the future as more new patient capacity has been created. Additional paediatric outpatient sessions being arranged on a regular basis to clear backlog of new and follow-up patients. Once this work has been completed there will be sufficient capacity within the paediatric outpatient timetable to manage ASI issues currently being experienced.	Jan 2019	

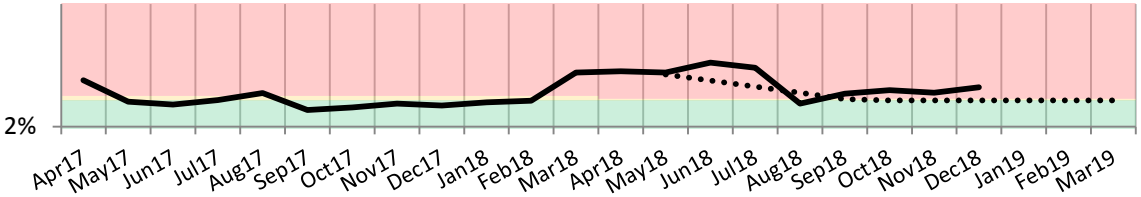
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
In the South division there are a high number of ASIs in paediatrics due to capacity issues.	Although the Paediatric fellow has now started in post. Additional paediatric clinics are being set up to clear the backlog 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
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
General Ophthalmology City Road - a number of clinics on hold which restricts the slots available for patients to book into.	General Ophthalmology admin team have reviewed the clinics on hold and these are now opened.	No Further Action Required

Remedial Action Plan - December 2018

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

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≤2.85%	Red	3.44%	3.07%	3.19%	3.11%	3.28%

Divisional Benchmarking (Dec 18)	City Road	North	South
	1.92%	2.81%	7.15%



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	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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	March 2019

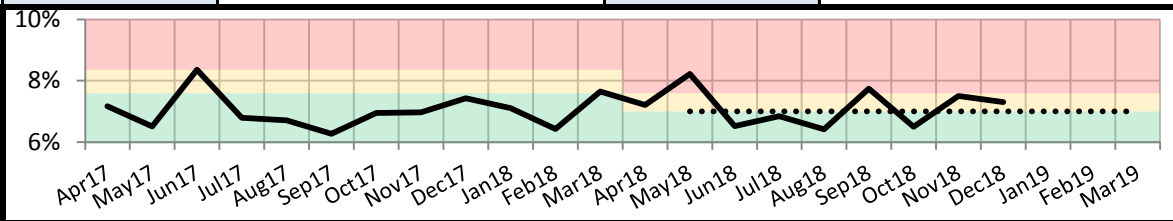
Remedial Action Plan - December 2018

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

Theatre Cancellation Rate (Overall)

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≤7.0%	Amber	7.1%	7.7%	6.5%	7.5%	7.3%

Divisional Benchmarking (Dec 18)	City Road	North	South
	7.4%	7.1%	7.4%



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 (Update)

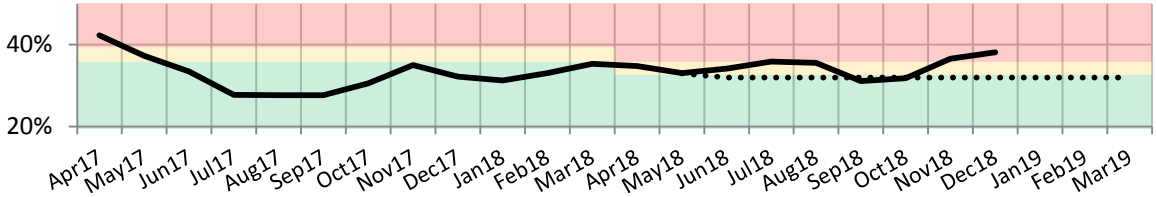
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Process concerns in Pre-assessment have meant that some surgery has been cancelled	Detailed review of pre-assessment process to determine where theatre cancellations can be avoided	April 2019
Higher number of cancellations 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	February 2019

Remedial Action Plan - December 2018

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

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≤32.7%	Red	34.5%	31.1%	31.8%	36.6%	38.2%

Divisional Benchmarking (Dec 18)	City Road	North	South
	33.2%	23.2%	78.7%



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		

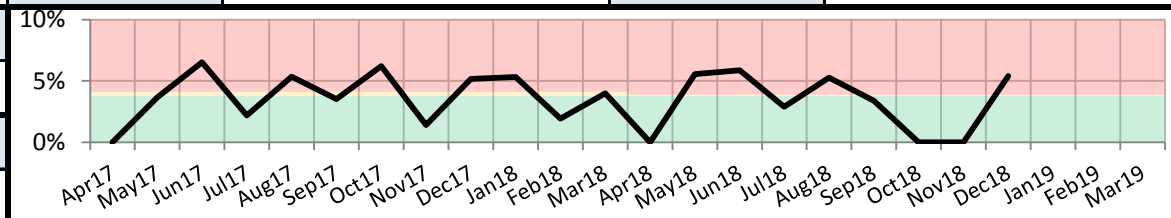
Remedial Action Plan - December 2018

Strategic Objective	SO1	CQC Domain	Effective
Lead Manager	Jack Wooding	Responsible Director	John Quinn

Percentage of Emergency re-admissions within 30 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≤3.77%	Red	3.11%	3.39%	0.00%	0.00%	5.41%

Divisional Benchmarking (Dec 18)	City Road	North	South
	7.02%	0.00%	0.00%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
There were four patient readmitted within 30 days in August; one in glaucoma and three in adnexal.	All patient notes are being reviewed by the relevant service director and any learning will be fed-back through the relevant monthly service meeting. As at the time of writing, the notes that have been reviewed indicate that the re-admissions were unavoidable.	Oct 2019	Complete

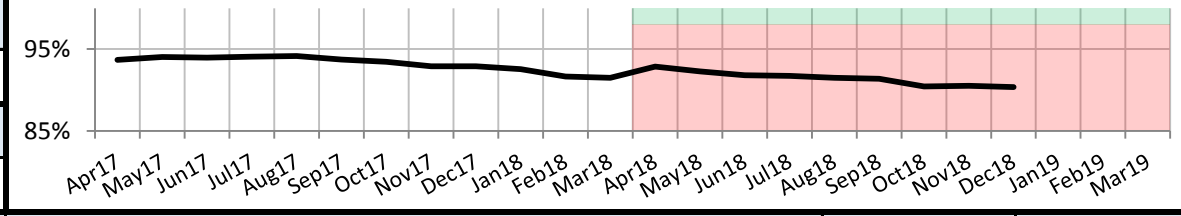
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There were four patients readmitted within 30 days in December, two in the Glaucoma service and two in the External service.	Patient notes have been reviewed by the service managers and clinical teams, and all readmissions were necessary and unavoidable. No patient harm has been identified as a result of readmission.	No Further Action Required

Remedial Action Plan - December 2018

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

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≥98%	Red	91.4%	91.4%	90.4%	90.5%	90.4%

Divisional Benchmarking (Dec 18)	City Road	North	South
	91.4%	85.3%	93.0%



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		

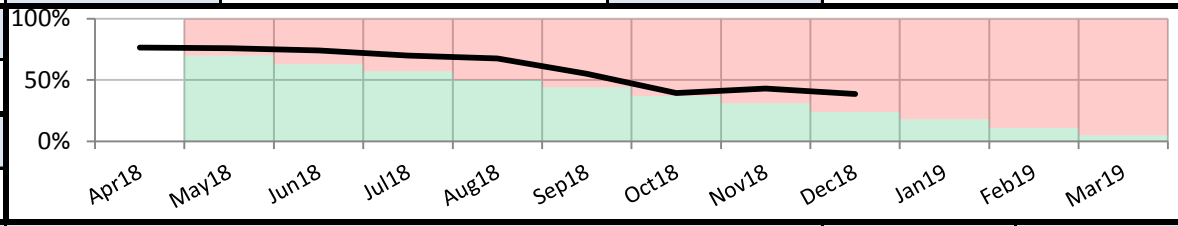
Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
Mth ≤ 24%	Red	n/a	55.0%	39.3%	42.9%	38.7%

Divisional Benchmarking (Dec 18)	City Road	North	South
	43.9%	29.0%	38.6%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Divisions are closing incidents that are less than 28 days old in addition to those that are older. The numbers of incidents that have not been investigated and closed after 28 days are at the lowest level that they have been. The KPI is under review.	Divisions show on-going commitment to achieving the target. The number of days by which the 28 day target is breached continues to reduce. The central team continues to monitor and exception report on a weekly basis	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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	March 2019

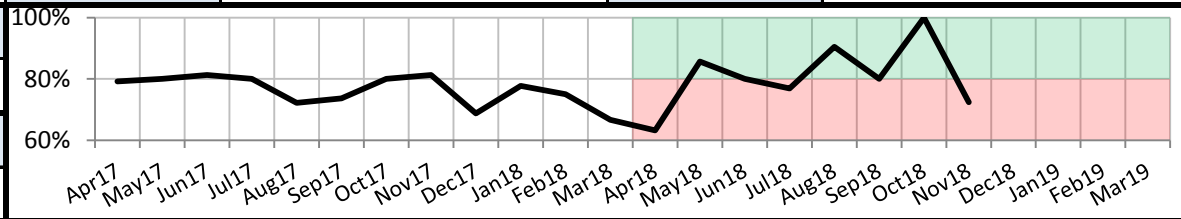
Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
≥80%	Red	81.3%	90.5%	80.0%	100.0%	72.4%

Divisional Benchmarking (Nov 18)	City Road	North	South
	61.9%	100.0%	100.0%



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

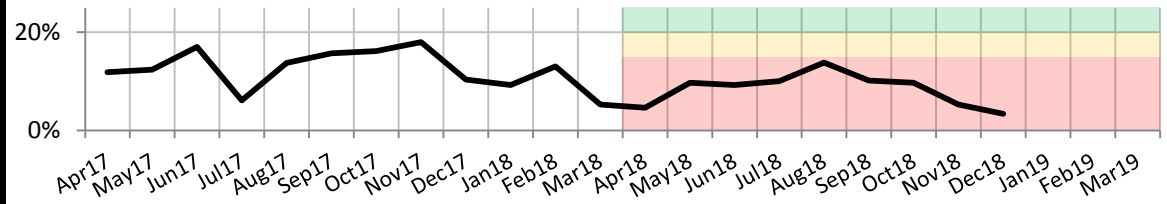
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The YTD performance remains above target. The 72.4% result for November was due to the increase in the number of complaints, several of them requiring complex investigations. There was a delay in some complaint investigation 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.	January 2019

Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
≥20%	Red	8.5%	10.2%	9.7%	5.3%	3.4%

Divisional Benchmarking (Dec 18)	City Road	North	South
	3.4%	n/a	n/a



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 (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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	March 2019

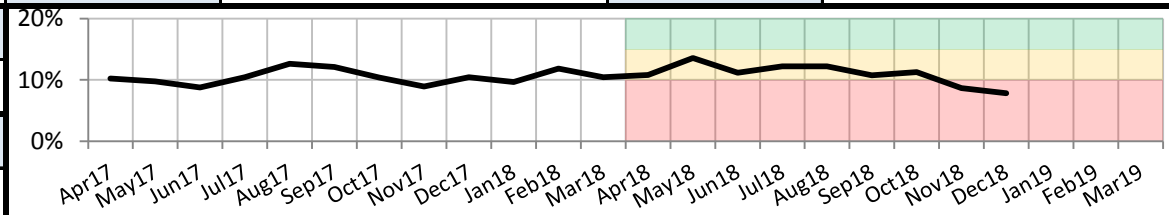
Remedial Action Plan - December 2018

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	Sep-18	Oct-18	Nov-18	Dec-18
≥15%	Red	11.0%	10.8%	11.3%	8.7%	7.8%

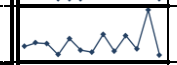
Divisional Benchmarking (Dec 18)	City Road	North	South
	9.7%	6.3%	4.4%



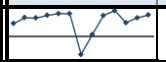
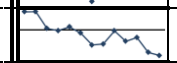
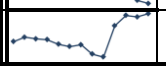
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Staff are not being managed to engage in the process of asking patients to complete the test.	DrDoctor may have a facility that allows patients to completethe test through an app and to text the test to patients following their visit. Other providers are being sourced should this not prove possible.	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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.	March 2019

Objective 2	We will be at the leading edge of research, making new discoveries with our partners and patients	December 2018

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	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		112.2%	Monthly	105.9%	108.3%	115.2%	134.1%		↑
	Percentage of Research Projects Achieving Time and Target	Well-Led	≥65%	G		71.1%	Monthly	71.4%	71.4%	71.4%	66.7%		↓
	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	Well-Led	≥1350	G		2669	Monthly	379	200	726	118		↓
	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	December 2018

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Training Compliance	Mandatory Training Compliance	Well-Led	≥80%	G		n/a	Monthly	86.9%	83.6%	84.9%	85.7%		↑
	Appraisal Compliance	Well-Led	≥80%	R	31	n/a	Monthly	78.1%	78.8%	76.4%	75.9%		↓
	Safeguarding - Mandatory Training Compliance	Caring	≥80%	G		n/a	Monthly	91.0%	93.2%	92.9%	93.6%		↑

Objective 4	We will collaborate to shape national policy	December 2018

There are currently no metrics available for this strategic objective

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

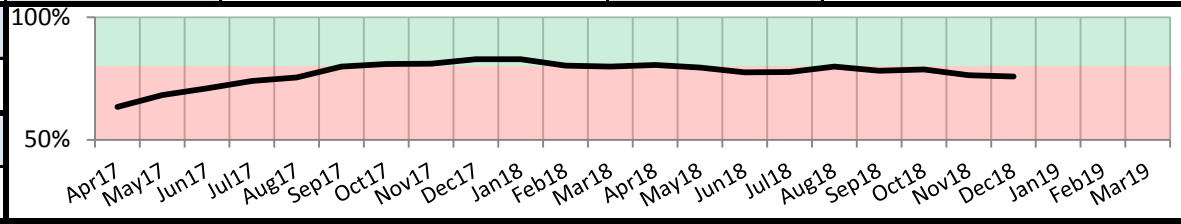
Remedial Action Plan - December 2018

Strategic Objective	SO3	CQC Domain	Well-Led
Lead Manager		Responsible Director	Sandi Drewett

Appraisal Compliance

Target	Rating	YTD	Sep-18	Oct-18	Nov-18	Dec-18
≥80%	Red	n/a	78.1%	78.8%	76.4%	75.9%

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
Staff are included in appraisal compliance figures from starting in post	Review of scoping of competence in line with managers expectations	Nov 2018	In Progress (No Update)
Support managers not experienced or confident in undertaking appraisals.	Regular HR clinics are taking place with all staff encouraged to attend and managers are allocated slots. Appraisal compliance is discussed at these and training needs for appraising managers identified and put in place.	Mar 2019	In Progress (Update)
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)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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.	February 2019
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.	March 2019
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

Objective 5	We will attract, retain and develop great people	December 2018

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	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			Monthly	12.8%	12.9%	12.8%	13.0%		↑
	Proportion of Temporary Staff	Well-Led	RAG as per Spend	R		15.3%	Monthly	14.6%	16.3%	14.8%	12.6%		↓
	Temporary Staff Spend	Well-Led	≤ Plan (£)	R		7233	Monthly	780	898	782	591		↓
	Agency Spend v trajectory	Use of Resources	1	G		1	Monthly	1	1	2	1		↓
	Number of Apprenticeship staff started within the Trust	Well-Led	Qtr:8 YTD:35			16	Quarterly	11			*Due Feb*		

**** For commentary, please refer to the Finance Report presented to board, there are no Remedial Action Plan generated for Strategic Objective 5***

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

Objective 6	We will have an infrastructure and culture that supports innovation	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	13 Month Trend	vs. Last
Organisational Health	Staff Sickness (Month Figure)	Well-Led	≤4%	G			Monthly	4.6%	4.0%	3.6%	4.0%		
	Staff Sickness (Rolling Annual Figure)	Well-Led	≤4%	A	33	n/a	Monthly (Month in Arrears)	4.2%	4.2%	4.2%	4.2%		
	Staff Stability	Well-Led	≥80%	G			Monthly	88.8%	88.1%	86.9%	87.0%		↑
	Staff Vacancy Rates	Well-Led	≤10%				Monthly	15.8%	n/a	16.3%	*Due Feb*		
	Staff Vacancy Rates - Nursing & AHP	Well-Led	≤10%				Monthly	15.0%	n/a	15.6%	*Due Feb*		
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	-0.20	-0.40	0.60	0.40		↓

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

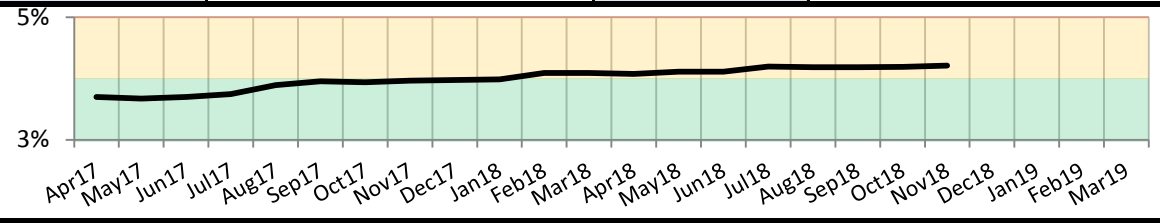
Remedial Action Plan - December 2018

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

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

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

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



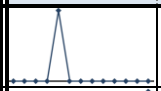
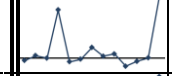
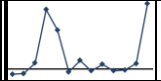
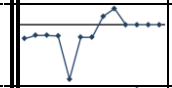
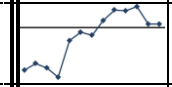
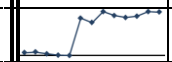
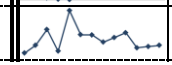
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Difficulties in reporting short term and long term absences	Introduction of ESR in November 2018 will improve reporting for services on long term and short term absence and reasons for absence enabling managers and HR to work together to resolve issues	Nov 2018	In Progress (Update)
Encourage proactive management of sickness absence in all areas	Regular HR clinics are taking place with all staff encouraged to attend and managers are allocated slots. Sickness absence is discussed at these and training needs or support required for managers is identified and put in place.	Ongoing (Added October 18)	In Progress (Update)
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)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
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.	January 2019
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

Remedial Action Plans for Strategic Objective 6

We will have an infrastructure and culture that supports innovation

Objective 7	We will have a sustainable financial model	December 2018

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	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		3.96	Monthly	-0.52	-0.22	0.00	3.97		↑
	NHS Performance (In Month Var. £m)	Use of Resources	≥0	G		4.53	Monthly	-0.12	-0.07	0.32	3.97		↑
	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	0.48	0.60	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		48.20	Monthly	42.20	43.60	48.80	48.20		↓
	Outstanding debtors (Total £m)	Use of Resources	≤ Plan	G		9.9	Monthly	11.3	9.6	9.8	9.9		↑

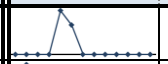
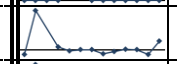
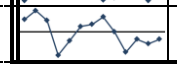
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Objective 7	We will have a sustainable financial model	December 2018

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	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

Objective 8	We will be enterprising to support and fund our ambitions	*December 2018*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Sep 18	Oct 18	Nov 18	Dec 18	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		-0.04	Monthly	0.01	0.00	-0.08	0.15		↑
	Commercial Trading Unit Position (In Month Var. £m)	Use of Resources	≥0	R		-0.53	Monthly	-0.41	-0.15	-0.24	-0.15		↑

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