Moorfields Eye Hospital NHS
NHS Foundation Trust

Report to Trust Board

Report Title	**Integrated Performance Report - February 2019**
Report from	John Quinn, Chief Operating Officer
Prepared by	Performance And Information Department
Previously discussed at	
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

Overall performance remains good in terms of national access targets and also green against CQC domains. Activity remains up in outpatients and admissions with the A&E still slightly down and predicted to be 97,000 attendances for the year.

There are four 52 week plus patients who are the known patients from the previous month and these have booked appointments in March.

The 14 day locally agreed cancer target is below target however there has been a positive improvement from recent months. Capacity remains challenging as previously reported solutions are being sought to improve staffing capacity.

The Follow Up Clinic Journey Times remain one minute above target and is being monitored.

GP referral through electronic booking remains good. ASI rates have now started to come down to levels previously reported however further improvement will be sought.

Cancellations rates are above the stated thresholds. This is predominately driven by the South division which in part is due to issues regarding theatre availability. However wider plans to address demand and capacity are being worked on in addition to the move back from St Anthony's to Duke Elder.

Friends and family test response rate remain challenging. A business case to move to text based responses has been approved in March and it is hoped that this will address the historical reporting rates.

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 - February 2019

		G	A	R
SO1	Referral To Treatment	1	0	1
	Accident & Emergency	1	0	1
	Cancer	4	0	1
	Clinic Management	1	1	5
	Diagnostics	1	0	0
	DNA Rates	2	0	0
	Cancellations	1	1	2
	Theatre Practice	2	0	0
	Ward Management	3	0	0
	Data Quality	5	0	1
	Mortality	1	0	0
	Infection Control	6	0	0
	Patient Safety	8	0	1
	Safer Staffing Checklist	5	0	0
	Patient Experience	6	1	1

		G	A	R
SO2	Research	3	0	0
SO3	Training Compliance	3	0	0
SO4	*No metrics available for this objective*			
SO5	Staff & Voluntary Experience	0	0	0
	Recruitment and Turnover	2	0	2
SO6	Organisational Health	1	4	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	2	0	1

'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 - February 2019

		G	A	R
Responsive	Referral To Treatment	1	0	1
	Accident & Emergency	1	0	1
	Cancer	4	0	1
	Clinic Management	1	1	5
	Diagnostics	1	0	0
	Ward Management	1	0	0
Effective	DNA Rates	2	0	0
	Cancellations	1	1	2
	Theatre Practice	2	0	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	2	0	1

		G	A	R
Safe	Infection Control	4	0	0
	Ward Management	1	0	0
	Patient Safety	6	0	0
	Safer Staffing Checklist	5	0	0
Well-Led	Organisational Health	1	4	0
	Recruitment and Turnover	1	0	2
	Staff & Voluntary Experience	0	0	0
	Training Compliance	2	0	0
	Research	3	0	0
Use of Resources	Capital Development	2	0	0
	Liquidity	3	0	0
	Contribution To ROI	2	0	1
	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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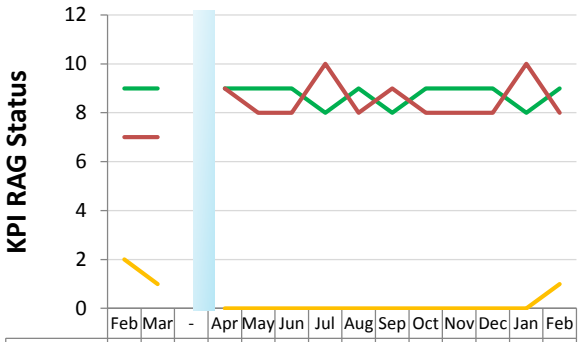
↓	Downward Trend Compared to Previous Month
◆	No Trend Due To Nil return for Previous Month
	No Trend Due To Nil return for Current Month

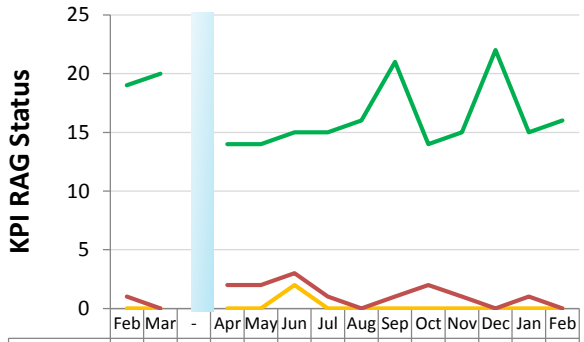
Executive Summary - CQC Domain Trends

Responsive



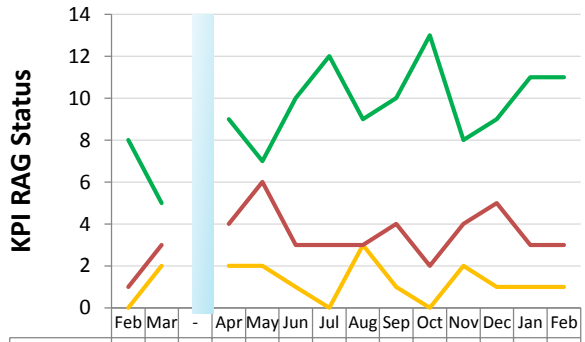
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Green	9	9		9	9	9	8	9	8	9	9	9	8	9
Amber	2	1		0	0	0	0	0	0	0	0	0	0	1
Red	7	7		9	8	8	10	8	9	8	8	8	10	8

Safe



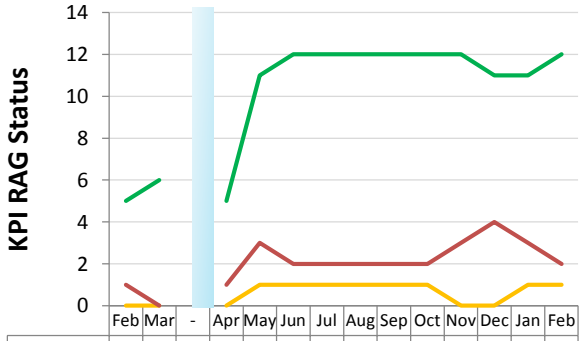
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Green	19	20		14	14	15	15	16	21	14	15	22	15	16
Amber	0	0		0	0	2	0	0	0	0	0	0	0	0
Red	1	0		2	2	3	1	0	1	2	1	0	1	0

Effective



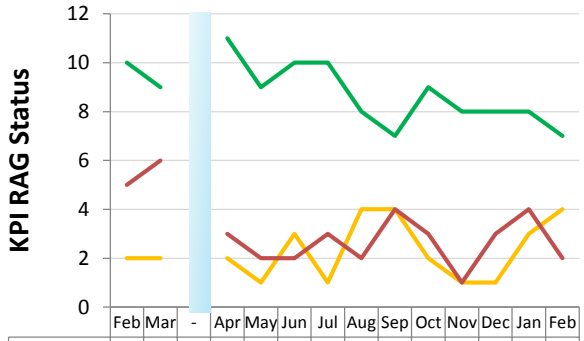
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Green	8	5		9	7	10	12	9	10	13	8	9	11	11
Amber	0	2		2	2	1	0	3	1	0	2	1	1	1
Red	1	3		4	6	3	3	3	4	2	4	5	3	3

Caring



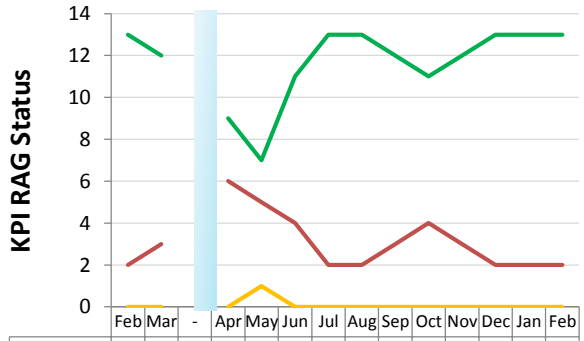
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Green	5	6		5	11	12	12	12	12	12	12	11	11	12
Amber	0	0		0	1	1	1	1	1	1	0	0	1	1
Red	1	0		1	3	2	2	2	2	2	3	4	3	2

Well-Led



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

Use of Resources



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

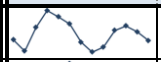
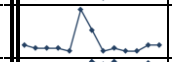
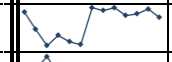
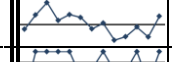
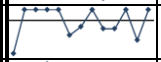
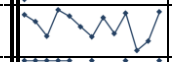
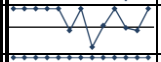
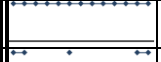
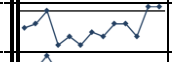
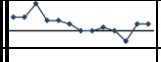
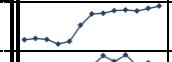
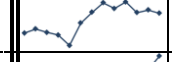
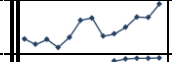
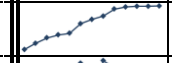
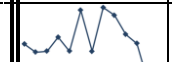
Lines split by financial year due to different number of metrics

Context - Overall Activity - February 2019

		February 2019		Monthly Variance	Year To Date		YTD Variance
		2017/18	2018/19		2017/18	2018/19	
Accident & Emergency	A&E Arrivals (All Type 2)	6,915	7,461	+ 7.9%	88,993	88,490	- 0.6%
	Number of 4 hour breaches	47	82	+ 74.5%	1,270	1,340	+ 5.5%
Outpatient Activity	Number of Referrals Received	10,494	11,442	+ 9.0%	118,930	128,097	+ 7.7%
	Total Attendances	46,107	48,739	+ 5.7%	517,762	549,649	+ 6.2%
	First Appointment Attendances	10,308	10,993	+ 6.6%	116,972	124,903	+ 6.8%
	Follow Up (Subsequent) Attendances	35,799	37,746	+ 5.4%	400,790	424,746	+ 6.0%
Admission Activity	Total Admissions	3,048	3,172	+ 4.1%	33,992	35,246	+ 3.7%
	Day Case Elective Admissions	2,786	2,841	+ 2.0%	30,344	31,732	+ 4.6%
	Inpatient Elective Admissions	87	112	+ 28.7%	964	1,045	+ 8.4%
	Non-Elective (Emergency) Admissions	175	219	+ 25.1%	2,684	2,469	- 8.0%

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	*February 2019*

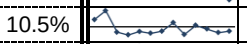
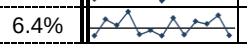
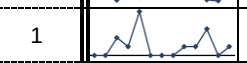
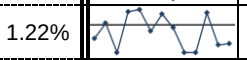
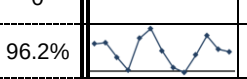
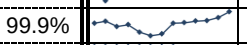
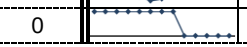
Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
Referral To Treatment	18 Week RTT Incomplete Performance *	Responsive	≥92%	G		94.6%	Monthly	94.6%	94.8%	94.6%	94.3%		↓
	52 Week RTT Incomplete Breaches *	Responsive	Zero Breaches	R	11	50	Monthly	2	2	4	4		→
Accident & Emergency	A&E Four Hour Performance	Responsive	≥95%	G		98.5%	Monthly	99.0%	99.2%	99.6%	98.9%		↓
	A&E Unplanned Reattendance	Responsive	≤5%	R	12	5.0%	Monthly	4.4%	4.9%	4.4%	5.4%		↑
Cancer	Cancer 2 week waits - first appointment urgent GP referral	Responsive	≥93%	G		94.8%	Monthly	87.5%	100.0%	80.0%	100.0%		↑
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Responsive	≥93%	R	13	75.1%	Monthly	87.5%	52.1%	61.0%	88.7%		↑
	Cancer 31 day waits - diagnosis to first appointment	Responsive	≥96%	G		97.6%	Monthly	100.0%	95.8%	95.2%	100.0%		↑
	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	100.0%	100.0%		→
Clinic Management	Median Clinic Journey Times - New Patient appointments	Responsive	Mth:≤ 100m	G		n/a	Monthly	96	93	100	100		→
	Median Clinic Journey Times -Follow Up Patient appointments	Responsive	Mth:≤ 90m	R	14	n/a	Monthly	89	86	91	91		→
	Percentage of patients using kiosks or alternative technology on sites where they are and are embedded.	Responsive	None Set			n/a	Monthly from Oct	*In Development*					
	Data completeness for Clinic Journey Time (Total)	Responsive	Mth:≥ 90.4%	R	15	46.2%	Monthly	50.2%	49.8%	50.8%	51.7%		↑
	Data completeness for Clinic Journey Time (Glaucoma)	Responsive	Mth:≥ 91.4%	R	16	59.9%	Monthly	69.3%	63.0%	64.6%	62.6%		↓
	Data completeness for Clinic Journey Time (MR)	Responsive	Mth:≥ 91.3%	R	17	54.7%	Monthly	54.7%	58.0%	57.9%	62.2%		↑
	Percentage of GP referrals From Electronic Booking - trajectory target of 100% for Oct 2018	Responsive	100%	A	18	88.5%	Monthly	98.8%	99.3%	99.3%	99.6%		↑
	Electronic Booking Appointment Slot Issue (ASI) Rate	Responsive	≤ 4.0%	R	19	22.3%	Monthly (Month in Arrears)	26.2%	23.0%	21.4%	14.6%		
Diagnostics	Percentage of Diagnostic waiting times less than 6 weeks	Responsive	≥99%	G		100%	Monthly	100%	100%	100%	100%		→

* Figures Provisional for Feb 2019

** Figures Provisional For Jan-Feb 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	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
DNA Rates	Outpatients DNA rate - 1st appointment	Effective	≤12.3%	G		11.7%	Monthly	12.2%	12.2%	11.6%	10.8%		↓
	Outpatients DNA rate - follow up appointment	Effective	≤10.8%	G		10.5%	Monthly	10.9%	10.6%	10.3%	10.5%		↑
Cancellations	Outpatient Cancellation rate (Hospital cancellations)	Effective	≤2.85%	R	20	3.45%	Monthly	3.11%	3.28%	3.51%	3.51%		→
	Theatre Cancellation Rate (Overall)	Effective	≤7.0%	G		7.1%	Monthly	7.5%	7.3%	7.9%	6.4%		↓
	Theatre Cancellation Rate (Non-Medical Cancellations)	Effective	≤0.8%	A	21	0.83%	Monthly	0.93%	0.58%	0.54%	0.90%		↑
	Number of non-medical cancelled operations not treated within 28 days **	Effective	Zero Breaches	R	22	13	Monthly	1	3	0	1		
Theatre Practice	Theatre Sessions starting late	Effective	≤32.7%	G		34.2%	Monthly	36.6%	38.2%	34.6%	31.5%		↓
	Percentage of Emergency re-admissions within 30 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Effective	≤3.77%	G		2.66%	Monthly	0.00%	5.41%	1.02%	1.22%		↑
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		95.8%	Monthly	95.2%	101.4%	97.0%	96.2%		↓
	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	91.2%	Monthly	90.5%	90.4%	90.2%	89.9%		↓
	Data Quality - NHS Number recording (Outpatient and Inpatient)	Effective	≥99%	G		99.5%	Monthly	99.6%	99.5%	99.5%	99.5%		→
	Data Quality - GP recording (Outpatient and Inpatient)	Effective	≥98%	G		99.9%	Monthly	99.9%	99.9%	99.9%	99.8%		↓
	Data Quality - Ethnicity recording (A&E)	Effective	≥95%	G		99.8%	Not Set	99.7%	99.7%	99.8%	99.9%		↑
	Data Quality - NHS Number recording (A&E)	Effective	≥95%	G		95.1%	Not Set	95.1%	96.0%	95.9%	95.3%		↓
	Data Quality - GP recording (A&E)	Effective	≥95%	G		99.5%	Not Set	99.6%	99.6%	99.7%	99.9%		↑
Mortality	Summary Hospital Mortality Indicator	Effective	Zero Cases	G		n/a	Monthly	0	0	0	0		→

* Figures Provisional for Feb 2019

** Figures Provisional For Jan-Feb 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	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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		n/a	Monthly	0	0	0	0		→
	Clostridium Difficile Cases	Safe	Zero Cases	G		n/a	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%	99.7%	99.8%	99.8%		→

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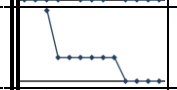
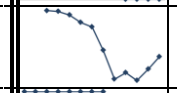
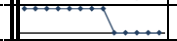
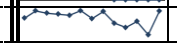
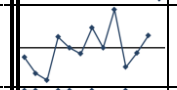
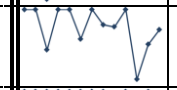
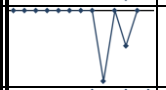
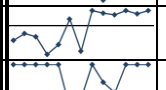
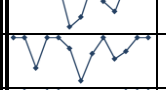
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
Patient Safety	Occurrence of any Never events	Safe	Zero Events	G		2	Monthly	0	0	0	0		→
	Number of Serious Incidents remaining open after 60 days	Safe	Zero Cases	G		8	Monthly (Reporting Month)	0	0	0	0		→
	Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days	Caring	Mth ≤ 11%	R	24	n/a	Monthly (Reporting Month)	42.9%	38.7%	44.8%	51.6%		↑
	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		98.2%	Monthly	97.2%	97.9%	96.5%	98.9%		↑
	Posterior Capsular Rupture rates	Safe	≤1.95%	G		0.88%	Monthly	0.97%	0.82%	0.70%	0.44%		↓
	Percentage of responses to written complaints sent within 25 days	Caring	≥80%	G		81.0%	Monthly (Month in Arrears)	100.0%	70.0%	77.3%	86.4%		
	Percentage of responses to written complaints acknowledged within 3 days	Caring	≥80%	G		94.6%	Monthly (Reporting Month)	100.0%	81.8%	90.9%	94.7%		↑
	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		97.5%	Monthly (Month in Arrears)	82.0%	100.0%	91.0%	100.0%		
Safer Staffing Checklist	Safer Surgery Checklist: Percentage of audited "Team Briefing" stage elements compliant with requirements	Safe	≥95%	G		96.8%	Monthly	98.5%	100.0%	98.9%	100.0%		↑
	Safer Surgery Checklist: Percentage of audited "Sign In" stage elements compliant with requirements	Safe	≥95%	G		100.0%	Monthly	99.9%	100.0%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Time Out" stage elements compliant with requirements	Safe	≥95%	G		99.8%	Monthly	99.6%	99.7%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Sign Out" stage elements compliant with requirements	Safe	≥95%	G		99.5%	Monthly	99.5%	100.0%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Team Debrief" stage elements compliant with requirements	Safe	≥95%	G		99.2%	Monthly	100.0%	100.0%	100.0%	98.1%		↓

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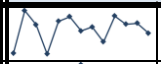
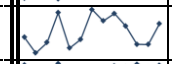
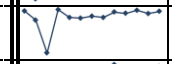
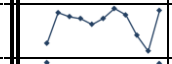
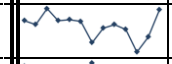
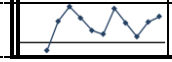
Objective 1	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
Patient Experience	Inpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		99.4%	Monthly	99.7%	99.5%	99.5%	99.3%		↓
	A&E Scores from Friends and Family Test - % positive	Caring	≥90%	G		93.9%	Monthly	94.0%	92.1%	92.1%	94.2%		↑
	Outpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		96.9%	Monthly	97.2%	97.5%	97.2%	97.4%		↑
	Paediatric Scores from Friends and Family Test - % positive	Caring	≥90%	G		97.9%	Monthly	98.2%	97.5%	97.0%	98.3%		↑
	Inpatient Scores from Friends and Family Test - % response rate	Caring	≥30%	G		50.2%	Monthly	49.2%	33.5%	44.0%	63.7%		↑
	A&E Scores from Friends and Family Test - % response rate	Caring	≥20%	R	25	8.6%	Monthly	5.3%	3.4%	9.0%	12.5%		↑
	Outpatient Scores from Friends and Family Test - % response rate	Caring	≥15%	A	26	11.0%	Monthly	8.7%	7.8%	11.1%	11.9%		↑
	Paediatric Scores from Friends and Family Test - % response rate	Caring	≥15%	G		20.6%	Monthly	21.2%	16.9%	21.5%	23.2%		↑

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Remedial Action Plans for Strategic Objective 1

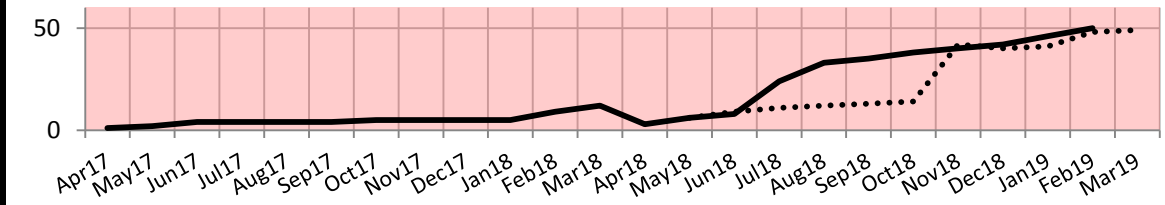
We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Remedial Action Plan - February 2019

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

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
Zero Breaches	Red	50	2	2	4	4

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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.	Feb 2019	In Progress (Update)

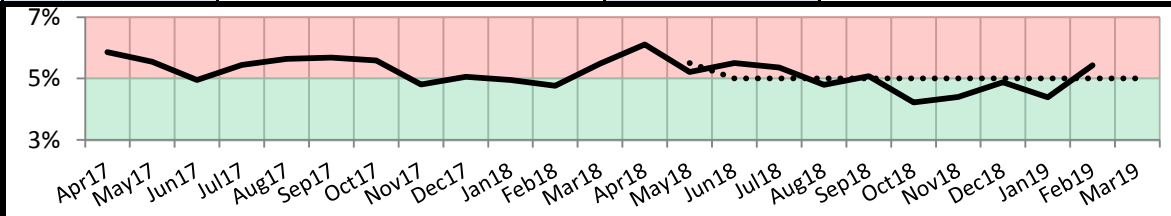
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The three south patients are the same from the previous report, with surgical lists at St George's being the cause.	HDU lists at ST Anthony's have now been agreed and the patient's have been dated in March. One patient is yet to be dated as it is a complex consultant to do and the consultant is on leave and will agree a date upon return.	March 2019
A patient was found to have been discharged for inappropriate reasons within the North division. The patient has come to no harm and is awaiting their surgery date	The staff member who made the error has received training on the error. This was an individual error rather than a systematic failure.	No Further Action Required

Remedial Action Plan - February 2019

Strategic Objective	SO1	CQC Domain	Responsive
A&E Unplanned Reattendance	**Lead Manager**	**Jack Wooding**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
≤5%	Red	5.0%	4.4%	4.9%	4.4%	5.4%

Divisional Benchmarking (Feb 19)	City Road	North	South
	5.4%	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
Further investigation required	Further investigation required	March 2019

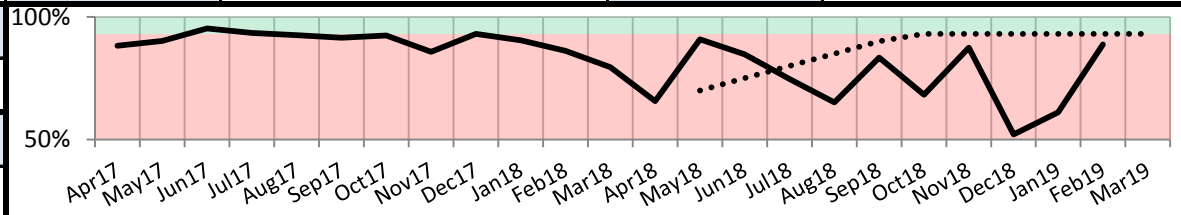
Remedial Action Plan - February 2019

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	Nov-18	Dec-18	Jan-19	Feb-19
≥93%	Red	75.1%	87.5%	52.1%	61.0%	88.7%

Divisional Benchmarking (Feb 19)	City Road	North	South
	88.7%	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 (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)
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.	Mar 2019	Complete

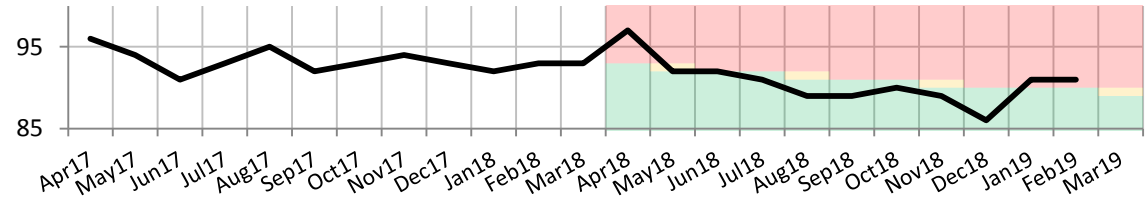
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There were 8 breaches to the NHSE 14-day standard in February. 6 were as a result of patient choice.	Patient choice remains a significant a factor as this is a national service with patients attending from a long distance away in some cases, meaning time is required to make travel plans.	No Further Action Required
1 breach occurred as the patient referred was deemed at scrutiny to need the input of a specific clinician anf there was no availability within 14 days.	This breach was unavoidable and in the patient's best interests.	No Further Action Required
The final breach was due to a delay in referral processing. GP booked appointment in General Ophtalmology via e-referral. By the time that the referral had been scrutinised and redirected to Ocular Oncology, the breach was inevitable.	Investigation into referral process delays occuring	March 2019

Remedial Action Plan - February 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	Nov-18	Dec-18	Jan-19	Feb-19
Mth:≤ 90m	Red	n/a	89	86	91	91

Divisional Benchmarking (Feb 19)	City Road	North	South
	102	115	83



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

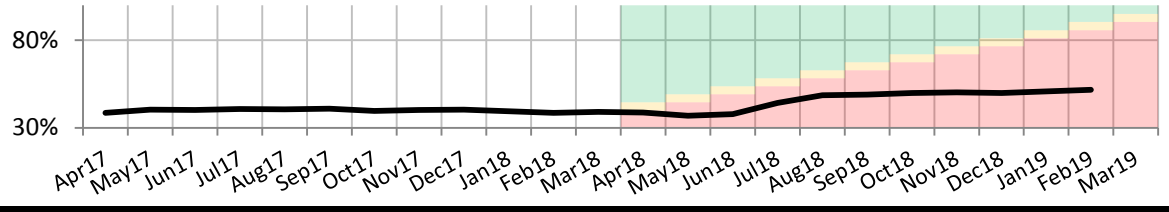
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall increase in journey times across all sites and services for the last 2 months, now 1 minute over 2018/19 target	Actions to date: - Detailed review of data for all sites and services does not demonstrate one single site or service with a significant increase in journey times. Although there is notable variation by division, this pattern has not changed significantly in the last few months. - There was also no evidence of any one site or service with a particular increase in activity or data completeness linked to extended journey times. - There is a potential impact from the overall 2% increase in data completeness over the same period. This may therefore be a more accurate indication of patient journey times. Next steps: - Site and service level journey time data shared with divisions for their areas to support them in addressing long waits. - We are supporting the ongoing roll-out of agreed sub-specialty clinical stratification, which will reduce outpatient journey times.	April 2019

Remedial Action Plan - February 2019

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

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
Mth:≥ 90.4%	Red	46.2%	50.2%	49.8%	50.8%	51.7%

Divisional Benchmarking (Feb 19)	City Road	North	South
	56.9%	37.6%	55.1%



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 (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. - Bank Partners training for admin teams to be reviewed to ensure that the need for data completeness is emphasised.	May 2019

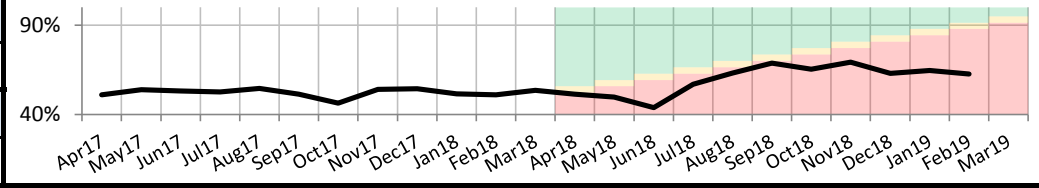
Remedial Action Plan - February 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager		Responsible Director	

Data completeness for Clinic Journey Time (Glaucoma)

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
Mth:≥ 91.4%	Red	59.9%	69.3%	63.0%	64.6%	62.6%

Divisional Benchmarking (Feb 19)	City Road	North	South
	68.2%	56.0%	58.9%



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 (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 (Update)

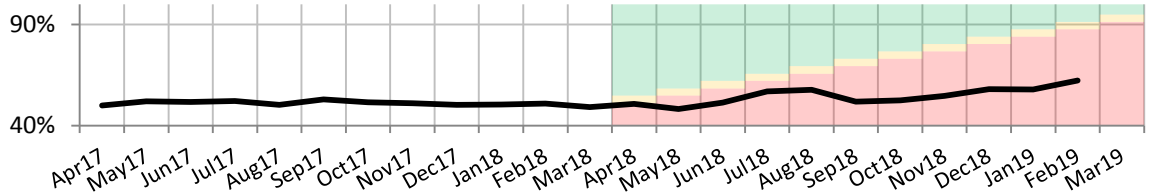
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Differing performance across the divisions, sites and services	The 2017-18 service improvement project in specific Glaucoma clinics at the City Road site resulted in improved data completeness. This project has been 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. Recruitment has been successful, but until new starters are in post 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. - Bank Partners training for admin teams to be reviewed to ensure that the need for data completeness is emphasised.	May 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.	May 2019

Remedial Action Plan - February 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	Nov-18	Dec-18	Jan-19	Feb-19
Mth:≥ 91.3%	Red	54.7%	54.7%	58.0%	57.9%	62.2%

Divisional Benchmarking (Feb 19)	City Road	North	South
	73.4%	28.3%	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 (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 (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 & 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. Recruitment has been successful, but until new starters are in post 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. - Bank Partners training for admin teams to be reviewed to ensure that the need for data completeness is emphasised.	May 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.	May 2019

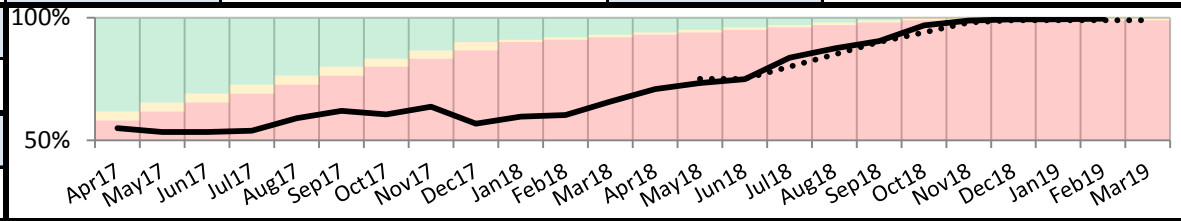
Remedial Action Plan - February 2019

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	Nov-18	Dec-18	Jan-19	Feb-19
100%	Amber	88.5%	98.8%	99.3%	99.3%	99.6%

Divisional Benchmarking (Feb 19)	City Road	North	South
	99.7%	99.9%	98.7%



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 (Update)

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.	Discuss plan for process of urgent referrals with CQRG	May 2019

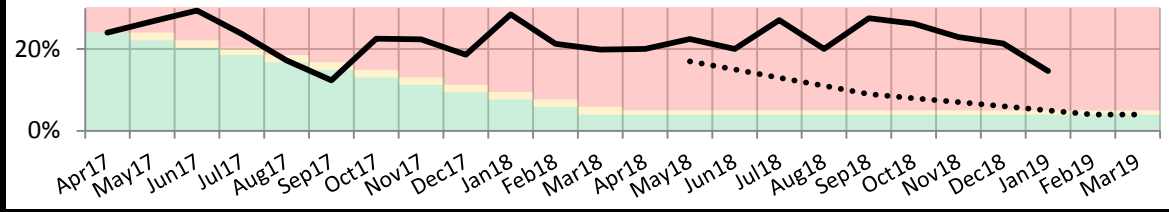
Remedial Action Plan - February 2019

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

Electronic Booking Appointment Slot Issue (ASI) Rate (Month in Arrears)

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
≤ 4.0%	Red	22.3%	26.2%	23.0%	21.4%	14.6%

Divisional Benchmarking (Jan 19)	City Road	North	South
	16.7%	12.7%	14.9%



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)
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	Mar 2019	In Progress (No Update)

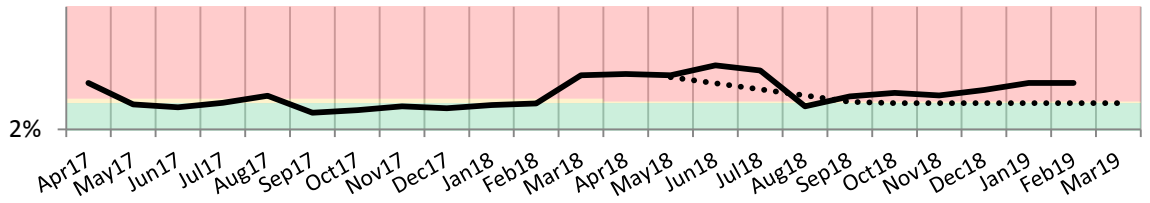
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Croydon ASIs- reduction in clinic capacity due to reduction in number of new slots in order to accommodate post-ops, plus impact of reduction of consultant sessions.	1) Reinstate Purley new appointment slots, additional 4 per week 2) Arrange permanent additional post-operative clinics to minimise impact on cataract new appointment capacity.	June 2019
St Georges- General Ophthalmology- reduced capacity due to reduced number of ad-hoc Saturday clinics being run.	Ad-hoc Saturday clinics to be established as required. Locum consultant started in February which will result in increased capacity to see patients.	May 2019

Remedial Action Plan - February 2019

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

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

Divisional Benchmarking (Feb 19)	City Road	North	South
	1.78%	4.55%	7.23%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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	Complete

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The South high outpatient hospital cancellation rate is being driven predominantly by St George's glaucoma service.	We have a new Glaucoma ophthalmology specialist joining in May, and we have plans to develop the Nelson site, to increase capacity	June 2019

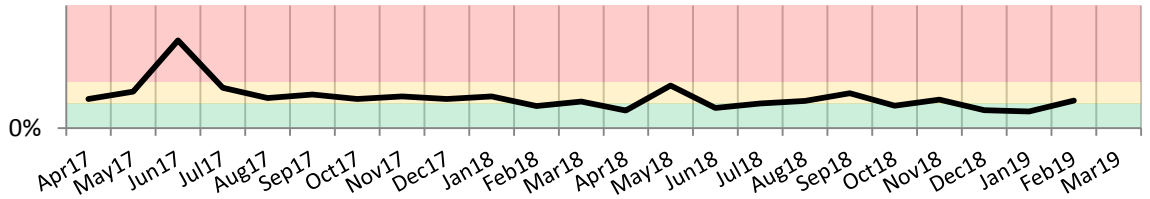
Remedial Action Plan - February 2019

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

Theatre Cancellation Rate (Non-Medical Cancellations)

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
≤0.8%	Amber	0.83%	0.93%	0.58%	0.54%	0.90%

Divisional Benchmarking (Feb 19)	City Road	North	South
	0.94%	0.27%	2.17%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Current underperformance within the South Division is due to ongoing issues with lack of theatre capacity at St Anthony's and the short notice cancellation of operating lists.	There is a risk of ongoing underperformance whilst refurbishment works at St George's are completed. Additional theatre lists at weekends and other Moorfields sites will continue to mitigate this risk.	Jan 2019	In Progress (Update)

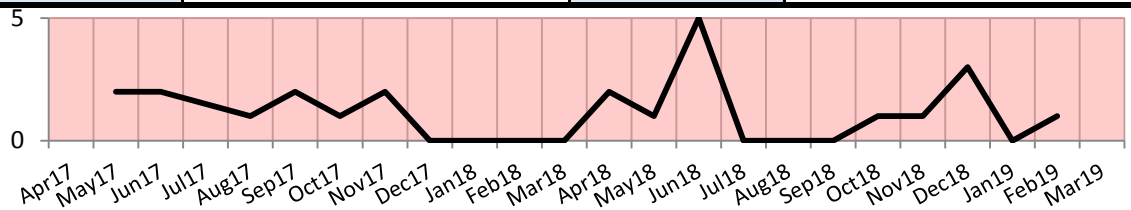
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Theatre cancellations are due to a combination of emergency cases taking priority, St George's anaesthetist unavailability (on-call overnight), equipment failure, as well as travel time between sites (St Anthony's) impacting on operating time.	Plans to return to St Georges hospital in progress which will improve performance, plus actions above	May 2019
City Road: Some exclusions should apply e.g. emergency patients, admin error and patient choice. Performance complies with target otherwise but includes 4 cases with delays due to correct lens implant not being available.	Issues identified with communication between medical teams, theatres and admissions regarding lens implants required, Deputy Divisional Manager addressing these issues with clinical teams	March 2019

Remedial Action Plan - February 2019

Strategic Objective	SO1	CQC Domain	Effective
Number of non-medical cancelled operations not treated within 28 days	**Lead Manager**	**Jennifer McCole**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
Zero Breaches	Red	14	1	3	0	1

Divisional Benchmarking (Feb 19)	City Road	North	South
	1	0	0



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Specific special lenses were not available on day of TCI and could not be ordered within 28 days of cancelled operation date.	Internal processes reviewed as corrective measure to future cancellations	April 2019

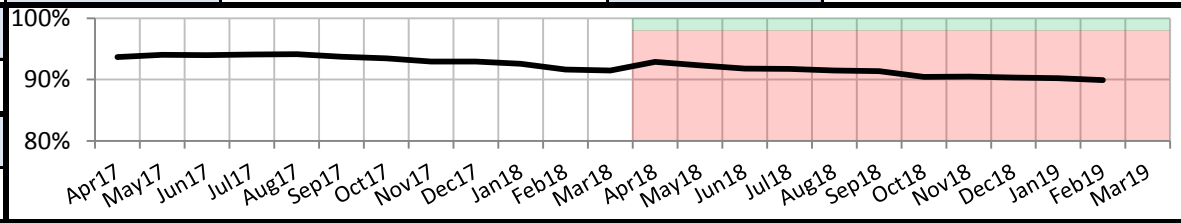
Remedial Action Plan - February 2019

Strategic Objective	SO1	CQC Domain	Effective
Lead Manager		**Responsible Director**	

Data Quality - Ethnicity recording (Outpatient and Inpatient)

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
≥98%	Red	91.2%	90.5%	90.4%	90.2%	89.9%

Divisional Benchmarking (Feb 19)	City Road	North	South
	91.0%	84.8%	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.	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	
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	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
As above	The Data Quality team have been tasked with an Ethnicity data improvement project.	August 2019

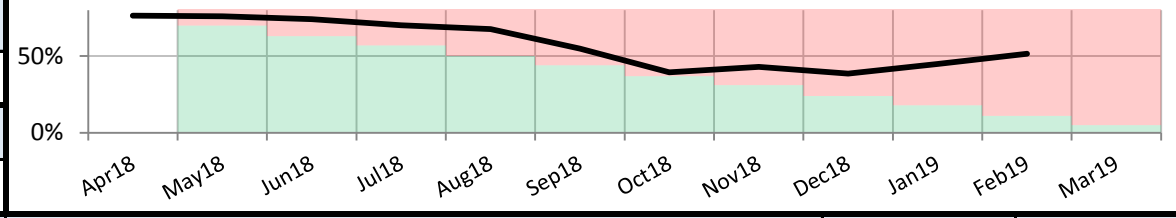
Remedial Action Plan - February 2019

Strategic Objective	SO1	CQC Domain	Caring
Lead Manager		Responsible Director	

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

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
Mth ≤ 11%	Red	n/a	42.9%	38.7%	44.8%	51.6%

Divisional Benchmarking (Feb 19)	City Road	North	South
	26.5%	64.6%	22.4%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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.	Apr 2019	In Progress (Update)

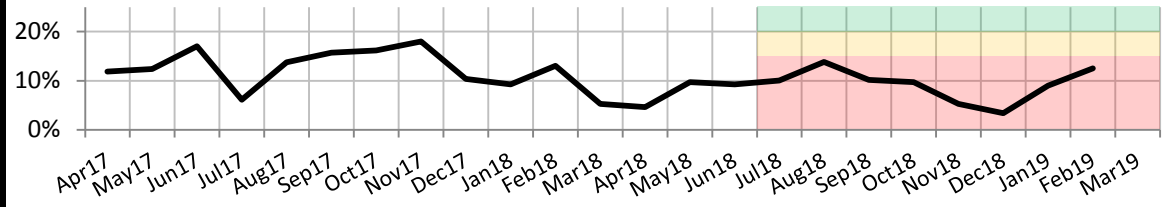
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall management of incidents >28days has improved - the current indicator is not giving the full picture.The trust wide position is being adversely affected by the quantity of open incidents in the North division (as a result of a retrospective review of glaucoma patients). Other divisions continue to maintain or improve performance against the 28 day target.	The central team in collaboration with the divisions are currently reviewing the target for this KPI to ensure continuous improvement in the reduction of incidents investigated within 28 days within a realistic target. The proposal is to move away from percentage reduction to total numbers over 28 days.	May 2019

Remedial Action Plan - February 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	Nov-18	Dec-18	Jan-19	Feb-19
≥20%	Red	8.6%	5.3%	3.4%	9.0%	12.5%

Divisional Benchmarking (Feb 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)
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	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Performance is considerably improved from the previous three months. Volunteers have been engaged to support departmental staff. Improvement is occurring month on month as actions from December embed.	A new system to collect FFT scores and comments by text is actively being implemented over the next 1 to 2 months and should replace the need for hand written cards. Bench-marking indicates this has the potential to substantially improve performance	

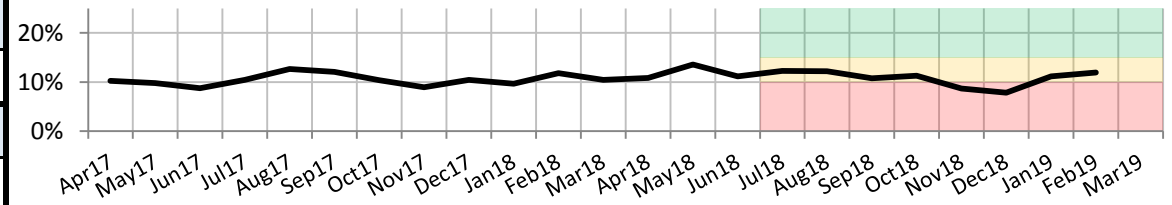
Remedial Action Plan - February 2019

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	Nov-18	Dec-18	Jan-19	Feb-19
≥15%	Amber	11.0%	8.7%	7.8%	11.1%	11.9%

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



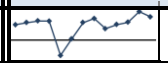
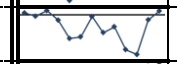
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Staff are not being managed to engage in the process of asking patients to complete the test.	DrDoctor may have a facility that allows patients to completethe test through an app and to text the test to patients following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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall performance is better than the previous three months and work continues to further engage staff to further improve performance.	A new system to collect FFT scores and comments by text is actively being implemented over the next 1 to 2 months and should replace the need for hand written cards. Bench-marking indicates this has the potential to substantially improve performance	June 2019

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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%			113.3%	Monthly	115.2%	134.1%	148.8%	n/a		
	Percentage of Research Projects Achieving Time and Target	Well-Led	≥65%	G		70.6%	Monthly	71.4%	66.7%	66.7%	66.7%		→
	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	Well-Led	≥1650	G		4187	Monthly	726	118	100	1418		↑
	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	February 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
Training Compliance	Mandatory Training Compliance	Well-Led	≥80%	G		n/a	Monthly	84.9%	85.7%	89.0%	87.4%		↓
	Appraisal Compliance	Well-Led	≥80%	G		n/a	Monthly	76.4%	75.9%	79.5%	80.4%		↑
	Safeguarding - Mandatory Training Compliance	Caring	≥80%	G		n/a	Monthly	92.9%	93.6%	94.4%	94.8%		↑

Objective 4	We will collaborate to shape national policy	February 2019

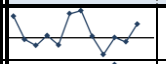
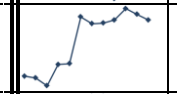
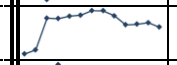
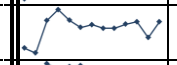
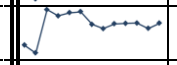
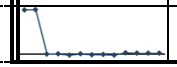
There are currently no metrics available for this strategic objective

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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						
	Percentage of Staff agreeing with the staff survey statement "I would recommend my organisation as a place to work"	Well-Led	≥70%				Quarterly						
Recruitment and Turnover	Staff Turnover (Rolling Annual Figure)	Well-Led	≤15%	G			Monthly	12.8%	13.0%	13.2%	13.1%		↓
	Proportion of Temporary Staff	Well-Led	RAG as per Spend	R		15.1%	Monthly	14.8%	12.6%	12.7%	13.2%		↑
	Temporary Staff Spend	Well-Led	≤ Plan (£)	R		7865	Monthly	782	591	632	603		↓
	Agency Spend v trajectory	Use of Resources	1	G		n/a	Monthly	2	1	1	1		
	Number of Apprenticeship staff started within the Trust	Well-Led	Qtr:10 YTD:45			26	Quarterly		10				

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	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 19	13 Month Trend	vs. Last
Organisational Health	Staff Sickness (Month Figure)	Well-Led	≤4%	A	31		Monthly	3.6%	4.0%	3.9%	4.3%		
	Staff Sickness (Rolling Annual Figure)	Well-Led	≤4%	A	32		Monthly (Month in Arrears)	4.2%	4.2%	4.2%	4.2%		
	Staff Stability	Well-Led	≥80%	G			Monthly	86.9%	87.0%	87.2%	86.6%		↓
	Staff Vacancy Rates	Well-Led	≤10%	A	33	n/a	Monthly	16.3%	16.6%	14.6%	16.6%		↑
	Staff Vacancy Rates - Nursing & AHP	Well-Led	≤10%	A	34	n/a	Monthly	15.6%	15.6%	15.1%	15.6%		↑
Capital Development	Capital Service Capacity	Use of Resources	1	G		n/a	Monthly	1	1	1	1		
	Capital Expenditure (Variation To Plan forecast)	Use of Resources	≥0	G		0.4	Monthly	0.6	0.4	0.4	0.4		→

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

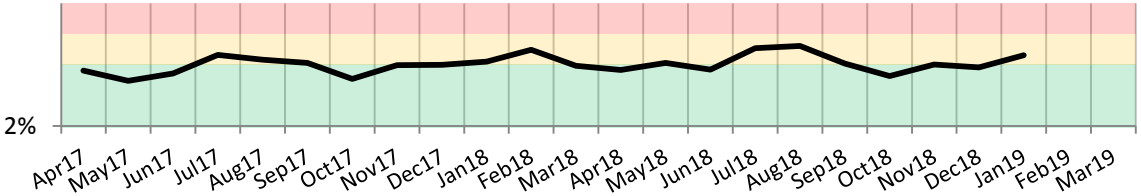
Remedial Action Plan - February 2019

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

Staff Sickness (Month Figure) (Month in Arrears)

Target	Rating	YTD	Nov-18	Dec-18	Jan-19	Feb-19
≤4%	Amber	n/a	3.6%	4.0%	3.9%	4.3%

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
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Ensure all managers are adequately trained in the absence management process	Development of a monthly manager induction to train new leaders in proactive sickness absence management processes	March 2019

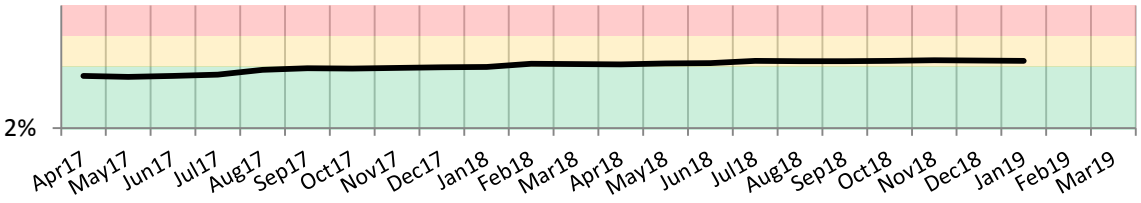
Remedial Action Plan - February 2019

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

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

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

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
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	
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)	Complete
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
Ensure all managers are adequately trained in the absence management process	Development of a monthly manager induction to train new leaders in proactive sickness absence management processes	March 2019

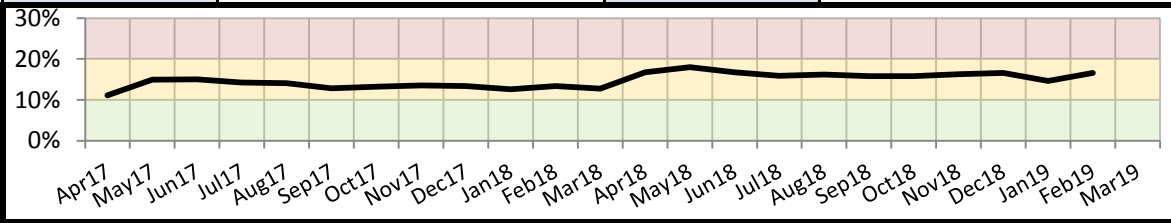
Remedial Action Plan - February 2019

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

Staff Vacancy Rates

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

Divisional Benchmarking (Feb 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	Complete
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.	Aug 2019	In Progress (Update)
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]	Aug 2019	In Progress (Update)

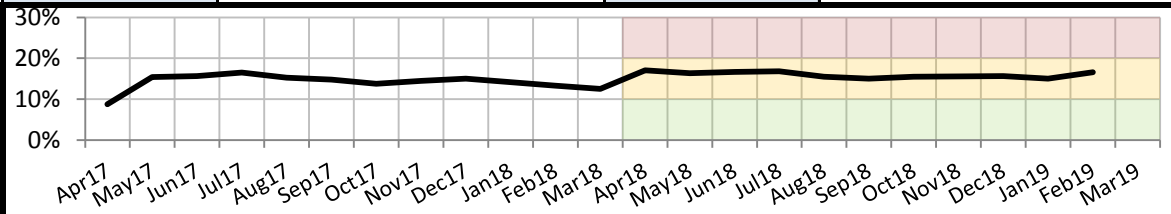
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
	All actions remain on-going	August 2019

Remedial Action Plan - February 2019

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

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

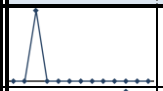
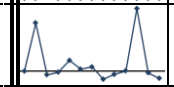
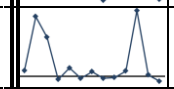
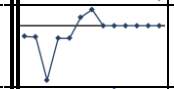
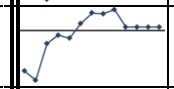
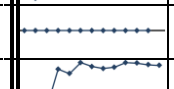
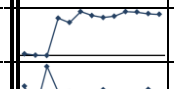
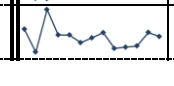
Divisional Benchmarking (Feb 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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	Aug 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
	All actions remain on-going	August 2019

Objective 7	We will have a sustainable financial model	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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		3.34	Monthly	0	3.97	-0.12	-0.47		↓
	NHS Performance (In Month Var. £m)	Use of Resources	≥0	G		4.35	Monthly	0.32	3.97	0.09	-0.29		↓
	Efficiency Scheme Performance (YTD Percentage)	Use of Resources	1	G		100%	Monthly	100%	100%	100%	100%		→
	Efficiency Scheme Performance (YTD Var. £m)	Use of Resources	≥0	G		0.1	Monthly	0.1	0.1	0.1	0.1		→
Liquidity	Liquidity (days)	Use of Resources	1	G		n/a	Monthly	1	1	1	1		
	Cash Flow (In Month Variation)	Use of Resources	≥0	G		45.7	Monthly	48.8	48.2	46.4	45.7		↓
	Outstanding debtors (Total £m)	Use of Resources	≤ Plan	G		10.9	Monthly	9.8	9.9	11.3	10.9		↓

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

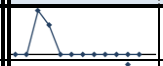
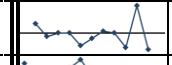
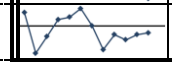
Objective 7	We will have a sustainable financial model	February 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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*					

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	*February 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Nov 18	Dec 18	Jan 19	Feb 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	G		-0.07	Monthly	-0.08	0.15	-0.09	0.1		↑
	Commercial Trading Unit Position (In Month Var. £m)	Use of Resources	≥0	R		-0.94	Monthly	-0.24	-0.15	-0.12	-0.28		↓

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'