Moorfields Eye Hospital NHS Foundation Trust

Report to Trust Board	
Report Title	**Integrated Performance Report - March 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

The Trust continues to deliver a strong performance position for the month and has delivered all the nationally mandated access targets for the year. This is against a background of further increased activity for outpatients and electives for the year. A&E activity was slightly up for the month and we have finished the year where we thought we would.

The Trust had no patients waiting more than 52 weeks at the end of the financial year. Although as can be seen there had been a number throughout the year hence the year to date position being red.

Cancer has finished the year delivering all the national access targets for the year. This has been a challenging year for the cancer team and they have done a great job to deliver this.

The waiting times targets have been met for the year. There has been a slight increase in these over the past couple of months hence further vigilance is required but the target for the year has been met.

Ward fill rate has flagged as red this month. The national requirement is that 80% of shifts meet the safe staffing levels required and the Trust met this target. Our more stringent internal standard was not met however a review has been undertaken and patients were safe.

Open incidents remain higher than expected. The issues with Bedford skewing the data is known. City Road remains a concern and this is being followed up through divisional performance reviews.

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 Foundation Trust

Trust Executive Summary By Strategic Objective - March 2019

		G	A	R
SO1	Referral To Treatment	1	0	1
	Accident & Emergency	1	0	1
	Cancer	3	0	1
	Clinic Management	0	1	6
	Diagnostics	1	0	0
	DNA Rates	2	0	0
	Cancellations	2	0	2
	Theatre Practice	2	0	0
	Ward Management	2	0	1
	Data Quality	4	0	2
	Mortality	1	0	0
	Infection Control	10	0	0
	Patient Safety	6	0	3
	Safer Staffing Checklist	5	0	0
	Patient Experience	6	2	0

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

'Current Rating' Key

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

'Monthly Trend' Key

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

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

Moorfields Eye Hospital NHS Foundation Trust

Trust Executive Summary By CQC Domain - March 2019

		G	A	R
Responsive	Referral To Treatment	1	0	1
	Accident & Emergency	1	0	1
	Cancer	3	0	1
	Clinic Management	0	1	6
	Diagnostics	1	0	0
	Ward Management	1	0	0
Effective	DNA Rates	2	0	0
	Cancellations	2	0	2
	Theatre Practice	2	0	0
	Mortality	1	0	0
	Data Quality	4	0	2
Caring	Patient Experience	6	2	0
	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	8	0	0
	Ward Management	0	0	1
	Patient Safety	5	0	1
	Safer Staffing Checklist	5	0	0
Well-Led	Organisational Health	2	3	0
	Recruitment and Turnover	1	0	3
	Staff & Voluntary Experience	0	0	0
	Training Compliance	1	0	1
	Research	3	1	0
Use of Resources	Capital Development	2	0	0
	Liquidity	3	0	0
	Contribution To ROI	1	0	2
	Annual Surplus Delivery	5	0	0
	Recruitment and Turnover	1	0	0
	Use Of Resources Metrics	1	0	0
	Financial Metrics	0	0	0
	Carter Metrics	0	0	0

'Current Rating' Key

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

'Monthly Trend' Key

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

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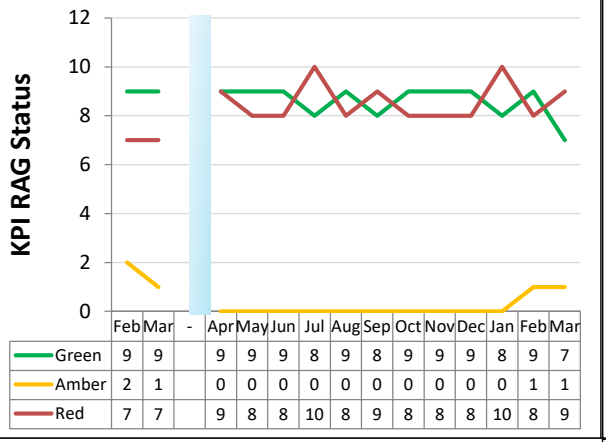
	No Trend Due To Nil return for Current Month

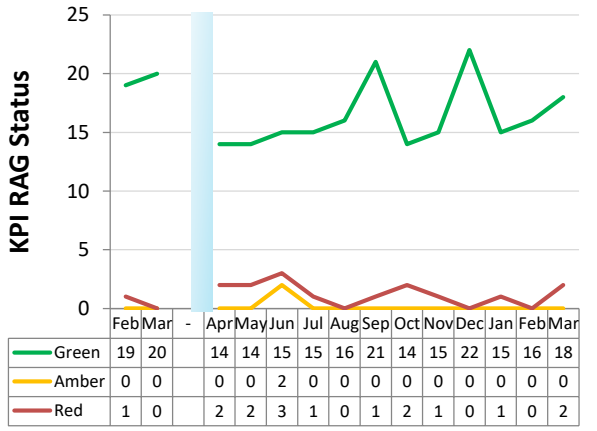
Executive Summary - CQC Domain Trends

Responsive



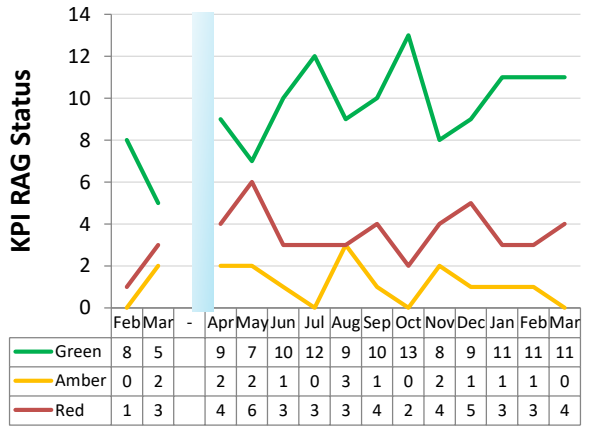
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Green	9	9		9	9	9	8	9	8	9	9	9	8	9	7
Amber	2	1		0	0	0	0	0	0	0	0	0	0	1	1
Red	7	7		9	8	8	10	8	9	8	8	8	10	8	9

Safe



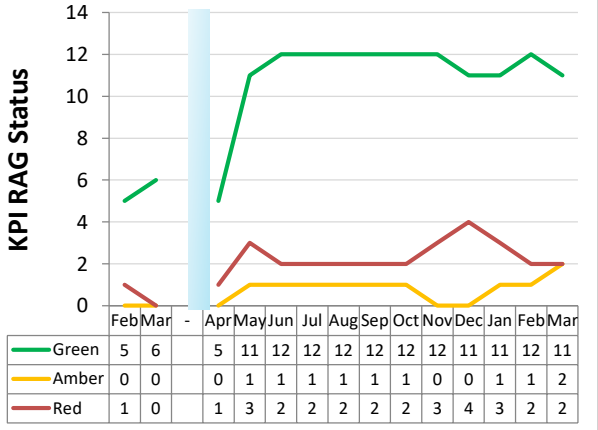
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Green	19	20		14	14	15	15	16	21	14	15	22	15	16	18
Amber	0	0		0	0	2	0	0	0	0	0	0	0	0	0
Red	1	0		2	2	3	1	0	1	2	1	0	1	0	2

Effective



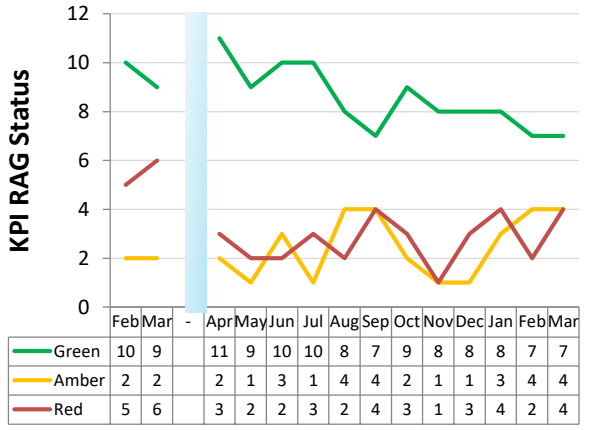
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Green	8	5		9	7	10	12	9	10	13	8	9	11	11	11
Amber	0	2		2	2	1	0	3	1	0	2	1	1	1	0
Red	1	3		4	6	3	3	3	4	2	4	5	3	3	4

Caring



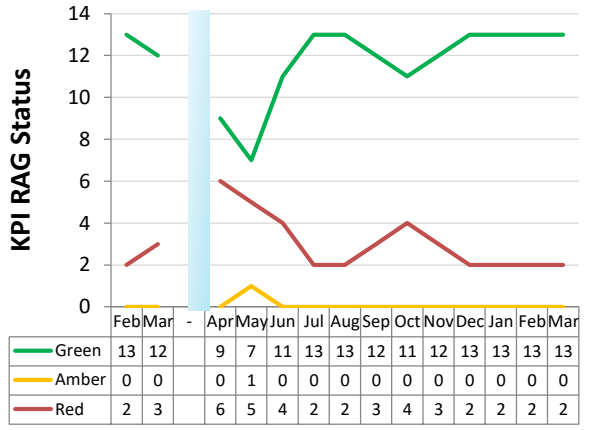
	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Green	5	6		5	11	12	12	12	12	12	12	11	11	12	11
Amber	0	0		0	1	1	1	1	1	1	0	0	1	1	2
Red	1	0		1	3	2	2	2	2	2	3	4	3	2	2

Well-Led



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

Use of Resources



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

Lines split by financial year due to different number of metrics

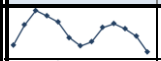
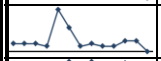
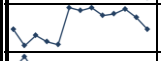
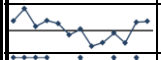
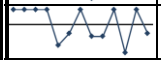
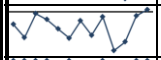
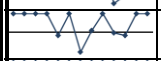
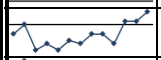
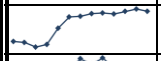
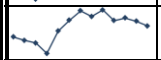
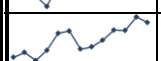
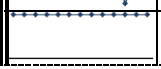
Moorfields Eye Hospital NHS Foundation Trust

Context - Overall Activity - March 2019

		March 2019		Monthly Variance	Year To Date		YTD Variance
		2017/18	2018/19		2017/18	2018/19	
Accident & Emergency	A&E Arrivals (All Type 2)	7,963	8,727	+ 9.6%	96,956	97,217	+ 0.3%
	Number of 4 hour breaches	162	177	+ 9.3%	1,432	1,517	+ 5.9%
Outpatient Activity	Number of Referrals Received	11,191	12,384	+ 10.7%	130,121	140,481	+ 8.0%
	Total Attendances	46,293	50,396	+ 8.9%	564,055	600,045	+ 6.4%
	First Appointment Attendances	10,398	11,130	+ 7.0%	127,370	136,033	+ 6.8%
	Follow Up (Subsequent) Attendances	35,895	39,266	+ 9.4%	436,685	464,012	+ 6.3%
Admission Activity	Total Admissions	3,122	3,333	+ 6.8%	37,114	38,579	+ 3.9%
	Day Case Elective Admissions	2,815	3,081	+ 9.4%	33,159	34,813	+ 5.0%
	Inpatient Elective Admissions	93	108	+ 16.1%	1,057	1,153	+ 9.1%
	Non-Elective (Emergency) Admissions	214	144	- 32.7%	2,898	2,613	- 9.8%

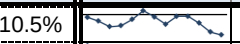
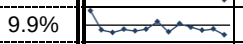
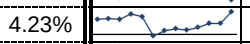
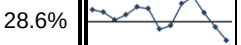
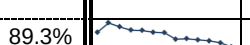
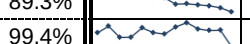
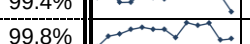
These figures are not subject to any finance or commissioning business logic. They present all activity, whether chargeable or not

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Referral To Treatment	18 Week RTT Incomplete Performance	Responsive	≥92%	G		94.5%	Monthly	94.8%	94.6%	94.3%	93.6%		↓
	52 Week RTT Incomplete Breaches	Responsive	Zero Breaches	R	11	50	Monthly	2	4	4	0		↓
Accident & Emergency	A&E Four Hour Performance	Responsive	≥95%	G		98.4%	Monthly	99.2%	99.6%	98.9%	97.9%		↓
	A&E Unplanned Reattendance	Responsive	≤5%	R	12	5.1%	Monthly	4.9%	4.4%	5.4%	5.5%		↑
Cancer	Cancer 2 week waits - first appointment urgent GP referral	Responsive	≥93%	R	13	94.3%	Monthly	100.0%	80.0%	100.0%	88.9%		↓
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Responsive	≥93%	G		76.9%	Monthly	52.1%	61.0%	88.7%	95.2%		↑
	Cancer 31 day waits - diagnosis to first appointment	Responsive	≥96%	G		97.8%	Monthly	95.8%	95.2%	100.0%	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%			100.0%	Monthly	n/a	100.0%	100.0%	n/a		
Clinic Management	Median Clinic Journey Times - New Patient appointments	Responsive	Mth:≤ 99m	R	14	96	Monthly	93	100	100	103		↑
	Median Clinic Journey Times -Follow Up Patient appointments	Responsive	Mth:≤ 89m	R	15	90	Monthly	86	91	91	91		→
	Percentage of patients using kiosks or alternative technology on sites where they are and are embedded.	Responsive	None Set				Monthly from Oct	*In Development*					
	Data completeness for Clinic Journey Time (Total)	Responsive	Mth:≥ 95.0%	R	16	46.6%	Monthly	49.8%	50.8%	51.7%	50.8%		↓
	Data completeness for Clinic Journey Time (Glaucoma)	Responsive	Mth:≥ 95.0%	R	17	59.9%	Monthly	63.0%	64.6%	62.6%	59.9%		↓
	Data completeness for Clinic Journey Time (MR)	Responsive	Mth:≥ 95.0%	R	18	55.2%	Monthly	58.0%	57.9%	62.2%	60.4%		↓
	Percentage of GP referrals From Electronic Booking - trajectory target of 100% for Oct 2018	Responsive	100%	A	19	89.4%	Monthly	99.3%	99.3%	99.6%	99.4%		↓
	Electronic Booking Appointment Slot Issue (ASI) Rate	Responsive	≤ 4.0%	R	20	22.1%	Monthly (Month in Arrears)	23.0%	21.4%	14.6%	19.8%		
Diagnostics	Percentage of Diagnostic waiting times less than 6 weeks	Responsive	≥99%	G		100%	Monthly	100%	100%	100%	100%		→

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	*March 2019*

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
DNA Rates	Outpatients DNA rate - 1st appointment	Effective	≤12.3%	G		11.6%	Monthly	12.2%	11.6%	10.8%	10.5%		↓
	Outpatients DNA rate - follow up appointment	Effective	≤10.8%	G		10.4%	Monthly	10.6%	10.3%	10.5%	9.9%		↓
Cancellations	Outpatient Cancellation rate (Hospital cancellations)	Effective	≤2.85%	R	21	3.52%	Monthly	3.28%	3.51%	3.51%	4.23%		↑
	Theatre Cancellation Rate (Overall)	Effective	≤7.0%	G		7.1%	Monthly	7.3%	7.9%	6.4%	6.1%		↓
	Theatre Cancellation Rate (Non-Medical Cancellations)	Effective	≤0.8%	G		0.80%	Monthly	0.58%	0.54%	0.90%	0.51%		↓
	Number of non-medical cancelled operations not treated within 28 days	Effective	Zero Breaches	R	22	16	Monthly	3	0	1	2		↑
Theatre Practice	Theatre Sessions starting late	Effective	≤32.7%	G		33.8%	Monthly	38.2%	34.6%	31.5%	28.6%		↓
	Percentage of Emergency re-admissions within 30 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Effective	≤3.77%	G		2.64%	Monthly	5.41%	1.02%	1.22%	2.44%		↑
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%	R	23	94.4%	Monthly	101.4%	97.0%	96.2%	84.1%		↓
	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	24	91.0%	Monthly	90.4%	90.2%	89.9%	89.3%		↓
	Data Quality - NHS Number recording (Outpatient and Inpatient)	Effective	≥99%	G		99.5%	Monthly	99.5%	99.5%	99.5%	99.4%		↓
	Data Quality - GP recording (Outpatient and Inpatient)	Effective	≥98%	G		99.9%	Monthly	99.9%	99.9%	99.8%	99.8%		→
	Data Quality - Ethnicity recording (A&E)	Effective	≥95%	G		99.8%	Not Set	99.7%	99.8%	99.9%	99.8%		↓
	Data Quality - NHS Number recording (A&E)	Effective	≥95%	R	25	95.0%	Not Set	96.0%	95.9%	95.3%	94.6%		↓
	Data Quality - GP recording (A&E)	Effective	≥95%	G		99.5%	Not Set	99.6%	99.7%	99.9%	99.4%		↓
Mortality	Summary Hospital Mortality Indicator	Effective	Zero Cases	G		n/a	Monthly	0	0	0	0		→

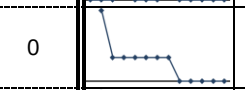
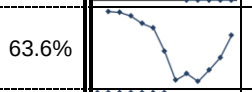
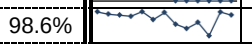
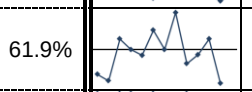
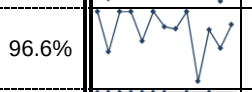
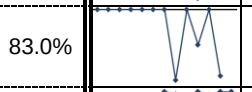
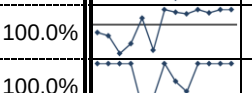
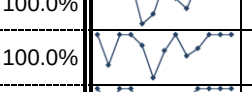
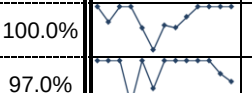
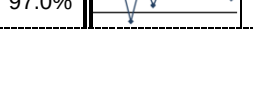
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Infection Control	Endopthalmitis Rates - Cataract (per 1000 incidents)	Safe	≤0.4			0.35	Quarterly	0.33			0.43		
	Endopthalmitis Rates - Intravitreal (per 1000 incidents)	Safe	≤0.5	G		0.17	Quarterly	0.08			0.17		
	Endopthalmitis Rates -Glaucoma (per 1000 incidents)	Safe	≤1.0			0.73	Quarterly	0.00			1.35		
	Endopthalmitis Rates - Corneal EK procedures (per 1000 incidents)	Safe	≤3.6	G		2.58	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		0.22	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	99.7%	99.8%	99.8%	99.4%		↓

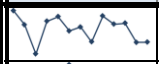
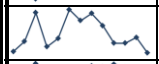
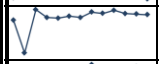
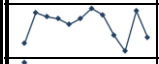
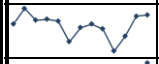
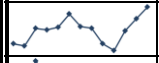
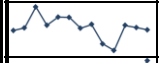
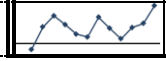
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 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 ≤ 5%	R	26	n/a	Monthly (Reporting Month)	38.7%	44.8%	51.6%	63.6%		↑
	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	97.9%	96.5%	98.9%	98.6%		↓
	Posterior Capsular Rupture rates	Safe	≤1.95%	G		0.87%	Monthly	0.82%	0.70%	0.44%	0.71%		↑
	Percentage of responses to written complaints sent within 25 days	Caring	≥80%	R	27	79.5%	Monthly (Month in Arrears)	72.4%	77.3%	85.7%	61.9%		
	Percentage of responses to written complaints acknowledged within 3 days	Caring	≥80%	G		94.9%	Monthly (Reporting Month)	81.8%	95.2%	90.5%	96.6%		↑
	Duty of Candour (Percentage of conversations informing family/carer that a patient safety incident has ocurred within 10 working days of the incident being reported to local risk management systems)	Safe	100%	R	28	96.3%	Monthly (Month in Arrears)	100.0%	91.0%	100.0%	83.0%		
Safer Staffing Checklist	Safer Surgery Checklist: Percentage of audited "Team Briefing" stage elements compliant with requirements	Safe	≥95%	G		97.0%	Monthly	100.0%	98.9%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Sign In" stage elements compliant with requirements	Safe	≥95%	G		100.0%	Monthly	100.0%	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	99.7%	100.0%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Sign Out" stage elements compliant with requirements	Safe	≥95%	G		99.5%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Safer Surgery Checklist: Percentage of audited "Team Debrief" stage elements compliant with requirements	Safe	≥95%	G		99.0%	Monthly	100.0%	100.0%	98.1%	97.0%		↓

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	March 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Patient Experience	Inpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		99.4%	Monthly	99.5%	99.5%	99.1%	99.1%		→
	A&E Scores from Friends and Family Test - % positive	Caring	≥90%	G		93.3%	Monthly	92.1%	92.1%	92.7%	91.0%		↓
	Outpatient Scores from Friends and Family Test - % positive	Caring	≥90%	G		96.9%	Monthly	97.5%	97.2%	97.1%	97.1%		→
	Paediatric Scores from Friends and Family Test - % positive	Caring	≥90%	G		97.9%	Monthly	97.5%	97.0%	98.3%	97.4%		↓
	Inpatient Scores from Friends and Family Test - % response rate	Caring	≥30%	G		51.6%	Monthly	33.5%	44.0%	58.2%	59.1%		↑
	A&E Scores from Friends and Family Test - % response rate	Caring	≥20%	A	29	9.5%	Monthly	3.4%	9.0%	12.5%	15.8%		↑
	Outpatient Scores from Friends and Family Test - % response rate	Caring	≥15%	A	30	11.0%	Monthly	7.8%	11.1%	10.9%	10.6%		↓
	Paediatric Scores from Friends and Family Test - % response rate	Caring	≥15%	G		21.6%	Monthly	16.9%	21.5%	23.2%	30.6%		↑

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 1

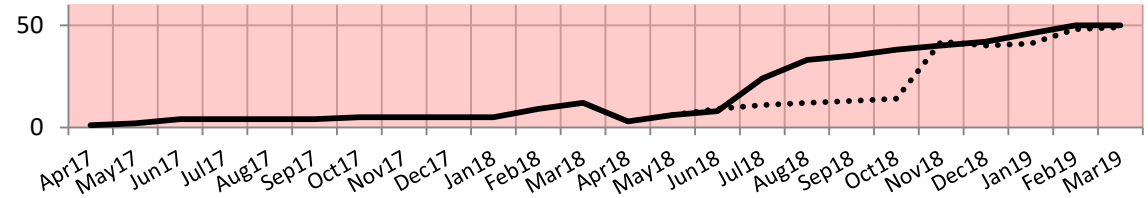
We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
Zero Breaches	Red	50	2	4	4	0

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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.	Mar 2019	Complete

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Breaches Reported in March	No Breaches Reported in March	No Further Action Required

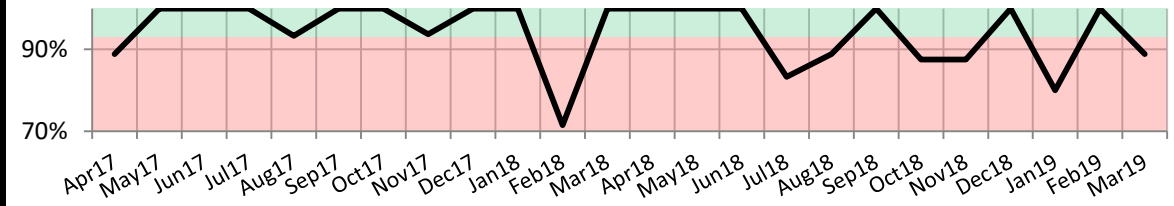
Remedial Action Plan - March 2019

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

Cancer 2 week waits - first appointment urgent GP referral

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥93%	Red	94.3%	100.0%	80.0%	100.0%	88.9%

Divisional Benchmarking (Mar 19)	City Road	North	South
	88.9%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
There was one breach to the two week wait standard in January. The breach occurred due to a lack of available capacity over then holiday period.	1)The locum consultant who has been covering will be retained allowing for additional new patient clinic capacity.	Mar 2019	In Progress (No Update)

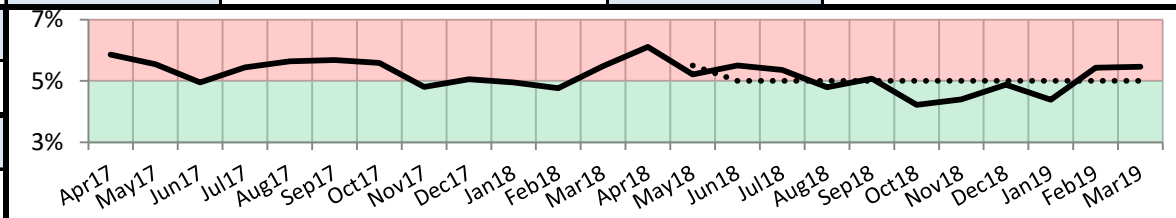
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There was a single breach to the two week wait standard in March. The patient was initially scheduled to attend within two weeks. The patient then requested to be rescheduled as she was away.	This was an unavoidable patient choice breach. The patient was seen in clinic on the earliest date she was available.	No Further Action Required

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≤5%	Red	5.1%	4.9%	4.4%	5.4%	5.5%

Divisional Benchmarking (Mar 19)	City Road	North	South
	5.5%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Patients are, in some instances, being registered as unplanned returns when in fact they are planned.	Training ongoing and hoping to see reduction back to plan next month.	Oct 2018	In Progress (No Update)
Further investigation required following February 2019 Performance	Further investigation required following February 2019 Performance	Mar 2019	In Progress (No Update)

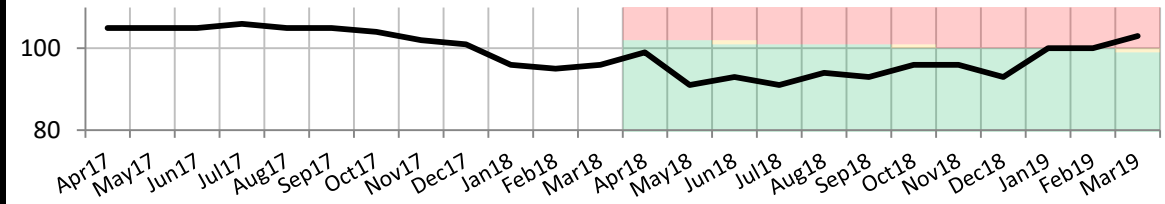
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The patient returns to A&E within seven days of previous attendance	There have been a number of changes and additions to A&E pathways, including the trial of rapid access Medical Retina and Cornea clinics, which have contributed to the numbers of unplanned returns. The number of unplanned returns over 5% is not expected to be a recurrent monthly theme. The Performance and Information team have set-up a bespoke daily report which is sent to the A&E management team, which will allow the service to proactively monitor the number of patients registered as unplanned returns, and action accordingly.	May 2019

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
Mth:≤ 99m	Red	96	93	100	100	103

Divisional Benchmarking (Mar 19)	City Road	North	South
	107	118	86



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

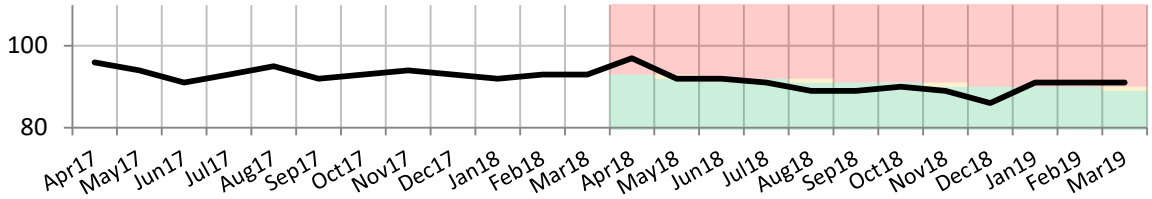
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall increase in journey times across all sites and services from December - 4 minutes over 2018/19 target Detailed review of data for all sites and services shows that journey times have increased across the board; this pattern has not changed significantly in the last few months. One contributory factor was in the Glaucoma service at City Road showed a significant increase in FU patient journey times as while patient numbers were stable, staff number were reduced in March due to planned leave coinciding with significant unplanned leave (in both clinical and administrative staff).	Next steps: - Site and service level journey time data shared with divisions for their areas to support them in addressing long waits - City Road Glaucoma - additional managerial support in place - We are supporting the ongoing roll-out of agreed sub-specialty clinical stratification, which will reduce outpatient journey times - focussing on medical retina and glaucoma	May 2019

Remedial Action Plan - March 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	Dec-18	Jan-19	Feb-19	Mar-19
Mth:≤ 89m	Red	90	86	91	91	91

Divisional Benchmarking (Mar 19)	City Road	North	South
	98	93	73



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

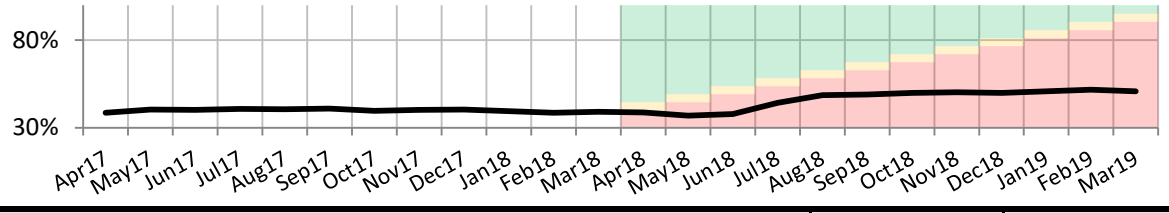
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall increase in journey times across all sites and services from December - 4 minutes over 2018/19 target Detailed review of data for all sites and services shows that journey times have increased across the board; this pattern has not changed significantly in the last few months. One contributory factor was in the Glaucoma service at City Road showed a significant increase in FU patient journey times as while patient numbers were stable, staff number were reduced in March due to planned leave coinciding with significant unplanned leave (in both clinical and administrative staff).	Next steps: - Site and service level journey time data shared with divisions for their areas to support them in addressing long waits - City Road Glaucoma - additional managerial support in place - We are supporting the ongoing roll-out of agreed sub-specialty clinical stratification, which will reduce outpatient journey times - focussing on medical retina and glaucoma	May 2019

Remedial Action Plan - March 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	Dec-18	Jan-19	Feb-19	Mar-19
Mth:≥ 95.0%	Red	46.6%	49.8%	50.8%	51.7%	50.8%

Divisional Benchmarking (Mar 19)	City Road	North	South
	55.1%	37.1%	56.0%



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. - Bank Partners training for admin teams to be reviewed to ensure that the need for data completeness is emphasised.	May 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	- The first tranche of SOPs have been tested and approved for release. Release has been held to coincide with the changes to health records management. - Services with very low data completeness have been targeted individually and have implemented changes to administrative processes. A data review in mid January 2019 showed an improvement in performance in these areas; this has now plateued with the change to health records management but with this project now nearing completion performance is expected to improve from April. - Data review is owned by service managers and monitored on a weekly basis and is shared with divisional management for performance review meetings. The North division are introducing weekly performace review meetings from 1 April and data completeness will be a standing agenda item.	May 2019

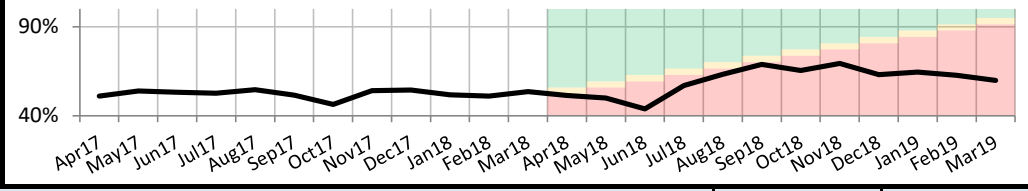
Moorfields Eye Hospital NHS Foundation Trust

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
Mth:≥ 95.0%	Red	59.9%	63.0%	64.6%	62.6%	59.9%

Divisional Benchmarking (Mar 19)	City Road	North	South
	60.7%	56.0%	64.2%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Differing performance across the divisions, sites and services	The 2017-18 service improvement project in specific Glaucoma clinics at the City Road site resulted in improved data completeness. This project has been rolled out to sites in the North & South divisions as well as to other clinics in City Road. Data continues to be supplied weekly to the Glaucoma Service Manager to hold administrative teams to account and progress is monitored regularly by divisional management. The data is supplied fortnightly to the North & South divisions. - The North Division has a particular gap in its administrative team, which is having an impact on their performance in particular. 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	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.	May 2019	In Progress (Update)

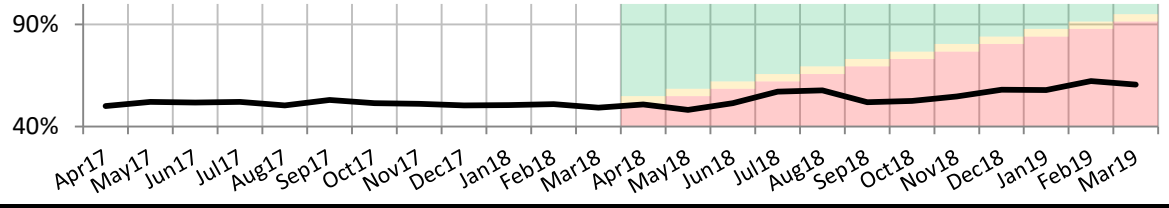
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Differing performance across the divisions, sites and services	- Further glaucoma stratification work is planned for 2019/20, with a focus on St George's and Ealing. - Data is now monitored by the Glaucoma Service Manager, with monthly Service Improvement review to hold administrative teams to account. Progress is monitored regularly by divisional management. The data is supplied fortnightly to the South divisions and weekly to the North division with the introduction of weekly North performance review meetings.	May 2019
Variable administrative standard operating procedures in use across the Trust's sites and services.	- The first tranche of SOPs have been tested and approved for release. Release has been held to coincide with the changes to health records management. - All staff PAS training for admin teams is being reviewed to ensure that the need for data completeness is emphasised.	May 2019
The Glaucoma service at City Road	The Glaucoma service at City Road showed a significant increase in FU patient journey times as while patient numbers were stable, staff number were reduced in March due to planned leave coinciding with significant unplanned leave (in both clinical and administrative staff). Additional managerial support in place	April 2019

Remedial Action Plan - March 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	Dec-18	Jan-19	Feb-19	Mar-19
Mth:≥ 95.0%	Red	55.2%	58.0%	57.9%	62.2%	60.4%

Divisional Benchmarking (Mar 19)	City Road	North	South
	69.6%	28.0%	76.7%



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 & 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	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.	May 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	- The City Road divison is now monitoring data weekly; the South are provided with data on a fortnightly basis. - The North division are reviewing data weekly in team performance reviews from 1st April; particular focus will be on Ealing and Northwick Park.	May 2019
Variable administrative standard operating procedures in use across the Trust's sites and services.	- The first tranche of SOPs have been tested and approved for release. Release has been held to coincide with the changes to health records management.. - All staff PAS training for admin teams is being reviewed to ensure that the need for data completeness is emphasised.	May 2019

Moorfields Eye Hospital NHS Foundation Trust

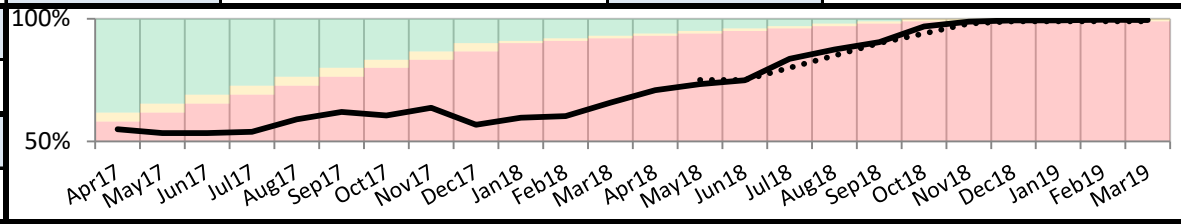
Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	Alex Stamp	Responsible Director	John Quinn

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
100%	Amber	89.4%	99.3%	99.3%	99.6%	99.4%

Divisional Benchmarking (Mar 19)	City Road	North	South
	99.8%	99.8%	97.9%



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.	Discuss plan for process of urgent referrals with CQRG	May 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Action as per previously identified issues list.		

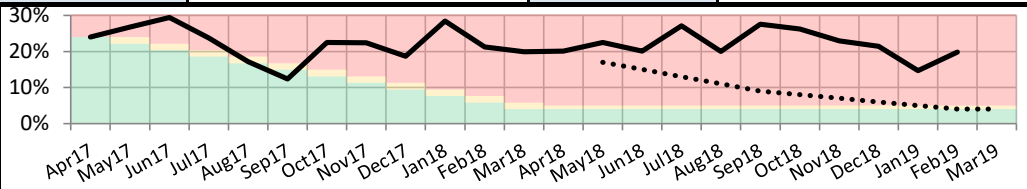
Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Responsive
Lead Manager	Alex Stamp	Responsible Director	John Quinn

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≤ 4.0%	Red	22.1%	23.0%	21.4%	14.6%	19.8%

Divisional Benchmarking (Feb 19)	City Road	North	South
	14.9%	21.5%	26.7%



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 (Update)
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. 3) Arrange ad-hoc cataract clinics to deal with current ASI backlog. Unable to confirm which dates during the week as there is no space, would have to be scheduled around doctors annual leave. Additional Saturday sessions could be arranged as there is capacity in the outpatient department.	Jun 2019	In Progress (No Update)
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	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
North division - Cataract new patient clinic has been lost due to consultant going on unplanned leave. Paediatric services at DVH and NWP under pressure for capacity. General Ophthalmology at NWP experiencing high demand due to referrals not being diverted correctly to subspecialties.	Cataract demand at NWP currently being reviewed with Cataract service for extra consultant post and optimisation of existing posts. Paeds services being closely monitored.	June 2019

Moorfields Eye Hospital NHS Foundation Trust

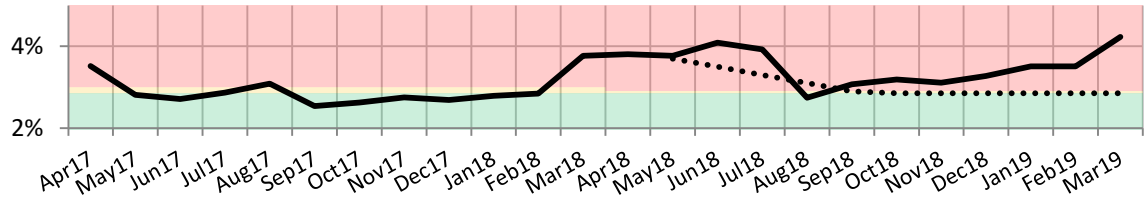
Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Effective
Lead Manager	**Alex Stamp**	**Responsible Director**	**John Quinn**

Outpatient Cancellation rate (Hospital cancellations)

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≤2.85%	Red	3.52%	3.28%	3.51%	3.51%	4.23%

Divisional Benchmarking (Mar 19)	City Road	North	South
	2.32%	5.13%	8.45%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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	Jun 2019	In Progress (No Update)

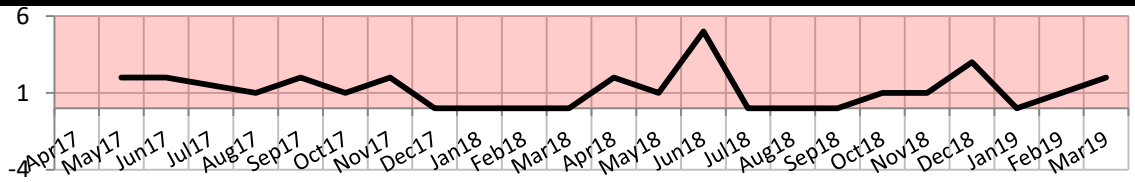
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
North position is predominately due to the glaucoma capacity issues at Barking, St Ann's, Ealing and NWP resulting in a high number of cancellations. Furthermore, a number of new clinic profiles have been set up which has meant more cancellations in order to move patients into new clinic profiles.	Stable monitoring clinics in North East being developed to offset.	July 2019

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
Zero Breaches	Red	16	3	0	1	2

Divisional Benchmarking (Mar 19)	City Road	North	South
	1	1	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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	Apr 2019	In Progress (No Update)

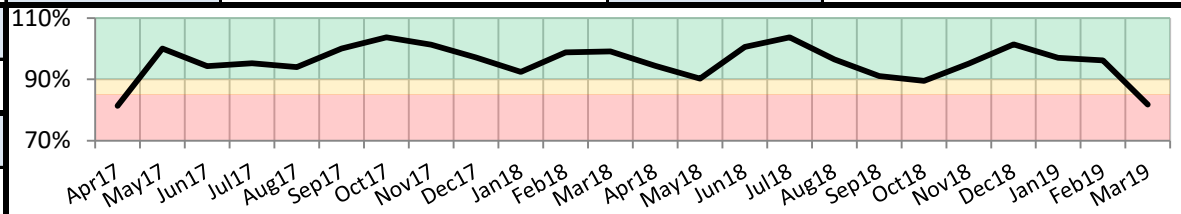
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
North division cancellation was due to lack of consultant cover in March 2019 when was listed for consultant only. Team are reviewing diaries to ensure if cancelled on the day.	Reviewing cancellations and admissions team processes.	May 2019

Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Safe
Inpatient (Overnight) Ward Staffing Fill Rate	**Lead Manager**	**Sarah Needham**	**Responsible Director**	**Tracy Luckett**

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥90%	Red	94.4%	101.4%	97.0%	96.2%	84.1%

Divisional Benchmarking (Mar 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			

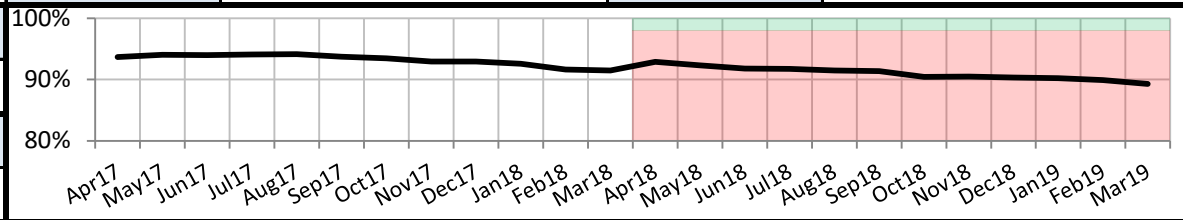
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Duke Elder (St Anthonys) Ward fill rate was reported as 77% which has resulted in a reduction in the trusts overall performance of 84.1%.	The reduction in trust performance has not impacted on patient care and systems are in place to gain assurance that staffing levels meet the dependency and acuity of our patients.	No Further Action Required

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥98%	Red	91.0%	90.4%	90.2%	89.9%	89.3%

Divisional Benchmarking (Mar 19)	City Road	North	South
	90.8%	83.2%	92.5%



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	In Progress (No Update)
	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)
	The Data Quality team have been tasked with an Ethnicity data improvement project.	Aug 2019	In Progress (No Update)

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

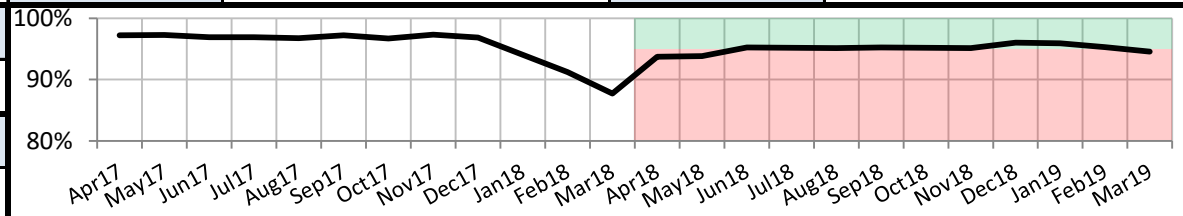
Moorfields Eye Hospital NHS Foundation Trust

Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Effective
Data Quality - NHS Number recording (A&E)	**Lead Manager**	**Donna Flatt**	**Responsible Director**	**John Quinn**

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥95%	Red	95.0%	96.0%	95.9%	95.3%	94.6%

Divisional Benchmarking (Mar 19)	City Road	North	South
	94.6%	n/a	n/a



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

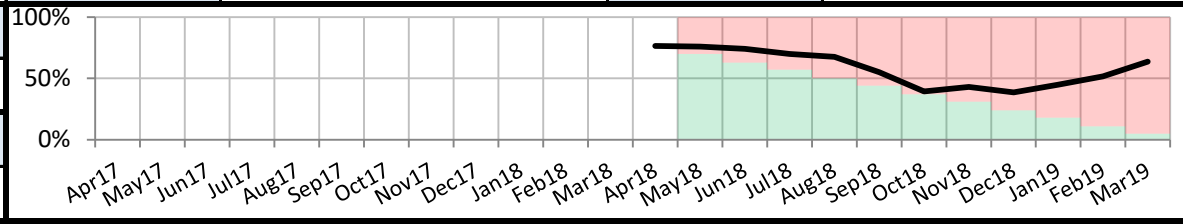
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Due to Resourcing issues in the department and the recruitment of new staff still in a training phase the retrospective work to improve NHS numbers has been delayed	Newly recruited staff are being trained on the process and this should begin to show improvement	June 2019

Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Caring
Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days	**Lead Manager**	**Julie Nott**	**Responsible Director**	**Ian Tombleson**

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
Mth ≤ 5%	Red	n/a	38.7%	44.8%	51.6%	63.6%

Divisional Benchmarking (Mar 19)	City Road	North	South
	49.4%	72.8%	26.5%



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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
All divisions continue to experience challenges. The trust wide position continues to be significantly affected by the quantity of open incidents in the North division as a consequence of the retrospective review of glaucoma patients.	Divisions are committed to continuously improving performance and have mechanisms in place to ensure that open incidents are reviewed at least weekly - possible breaches are communicated incident leads. This includes delegation of actions during periods of leave, specifically in the absence of the head of nursing. Examples of specific actions are a review of the function of the quality forum so that incidents requiring multi-disciplinary input can be reviewed and closed at the meeting. Improvement will be further supported when the quality partner vacancy for the South is filled from 1 May. The IPR indicator is being revised to be more informative	July 2019

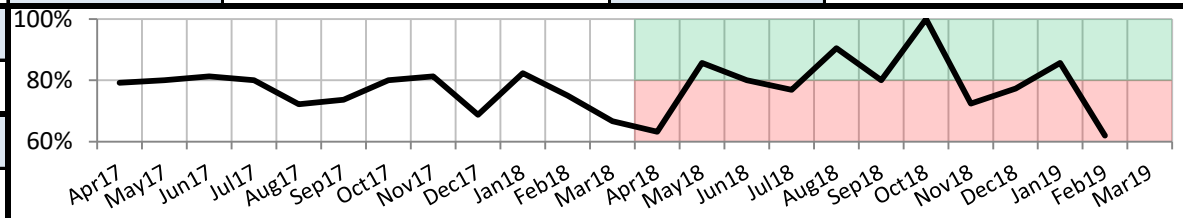
Remedial Action Plan - March 2019

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

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥80%	Red	79.5%	72.4%	77.3%	85.7%	61.9%

Divisional Benchmarking (Feb 19)	City Road	North	South
	53.8%	100.0%	50.0%



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

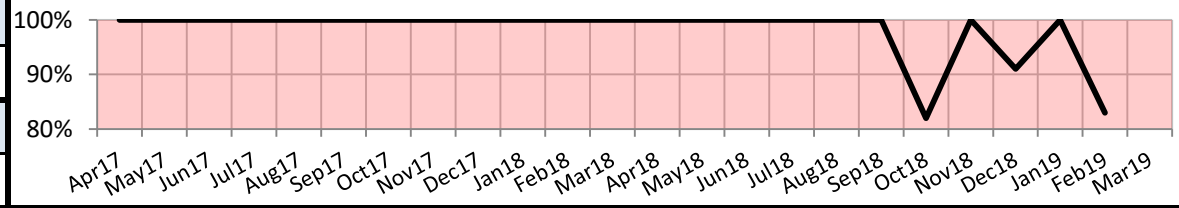
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The volume of complaints in Q3 and Q4 has increased compared to and divisions are experiencing challenges in maintaining the deadlines	The central team continues to work with divisions to streamline the complaints process ensuring that it is timely and efficient. Divisions are strengthening local monitoring mechanisms. A new escalation report is being taken to the operational SMT meeting chaired by the COO. A new quarterly patient expereince report is being started in 2019/20.	May 2019

Remedial Action Plan - March 2019

Strategic Objective	SO1	CQC Domain	Safe
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) (Month in Arrears)	**Lead Manager**	**Julie Nott**	**Responsible Director**	**Ian Tombleson**

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
100%	Red	96.3%	100.0%	91.0%	100.0%	83.0%

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

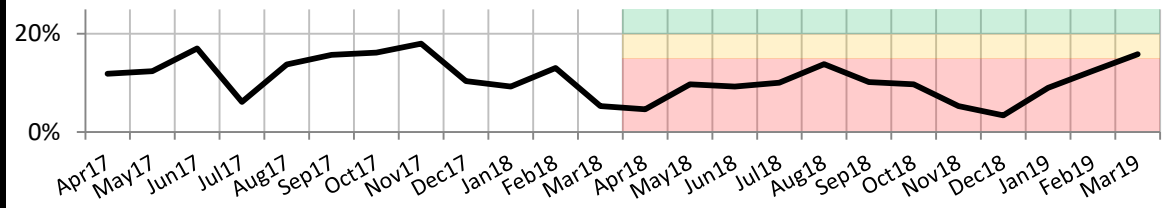
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The duty of candour process had not been initiated for 1 patient at Bedford. The incident has been reviewed at the SI panel and arrangements have now been made for a consultant to speak with the patient and/or spouse. The level of harm is yet to be confirmed.	The consultant met with the patient and his wife on 15 April 2019 and apologised and provided an explanation. The investigation remains on-going	April 2019

Remedial Action Plan - March 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	Dec-18	Jan-19	Feb-19	Mar-19
≥20%	Amber	9.5%	3.4%	9.0%	12.5%	15.8%

Divisional Benchmarking (Mar 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 (No Update)
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	May 2019	In Progress (No Update)

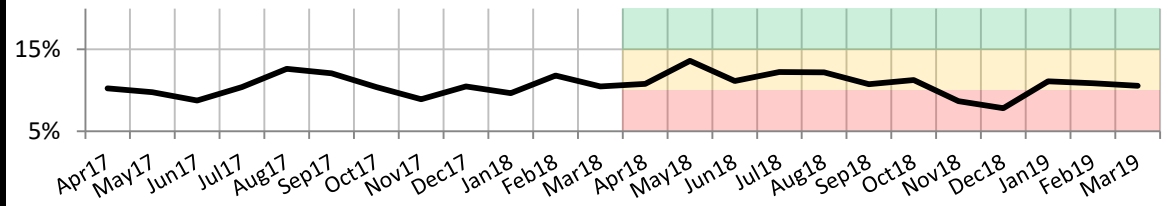
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or actions		

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥15%	Amber	11.0%	7.8%	11.1%	10.9%	10.6%

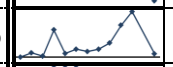
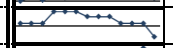
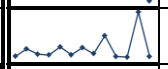
Divisional Benchmarking (Mar 19)	City Road	North	South
	n/a	n/a	n/a



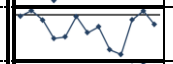
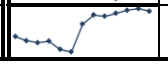
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Overall performance is better than the previous three months and work continues to further engage staff to further improve performance.	A new system to collect FFT scores and comments by text is actively being implemented 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	Jun 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Overall performance has dropped very slightly but continues to be on an improvement trajectory - work continues to 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	May 2019

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Research	70 Day To Recruit First Research Patient	Well-Led	≥80%	G		99.0%	Monthly	100.0%	100.0%	100.0%	87.5%		↓
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	Well-Led	100%	G		110.5%	Monthly	134.1%	148.8%	n/a	103.4%		◆
	Percentage of Research Projects Achieving Time and Target	Well-Led	≥65%	A	33	70.0%	Monthly	66.7%	66.7%	66.7%	57.1%		↓
	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	Well-Led	≥1800	G		4304	Monthly	118	100	1418	117		↓
	Percentage of Trust Patients Recruited Into Research Projects	Well-Led	None Set				Monthly	*In Development (Apr 2019)*					

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Training Compliance	Mandatory Training Compliance	Well-Led	≥80%	G			Monthly	85.7%	89.0%	87.4%	88.3%		↑
	Appraisal Compliance	Well-Led	≥80%	R	34		Monthly	75.9%	79.5%	80.4%	79.0%		↓
	Safeguarding - Mandatory Training Compliance	Caring	≥80%	G			Monthly	93.6%	94.4%	94.8%	94.1%		↓

Objective 4	We will collaborate to shape national policy	March 2019

There are currently no metrics available for this strategic objective

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

Remedial Action Plans for Strategic Objective 2 to 4

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

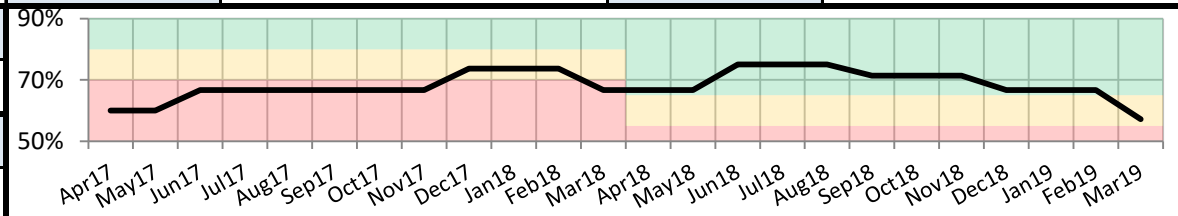
Remedial Action Plan - March 2019

Strategic Objective	SO2	CQC Domain	Well-Led
Lead Manager	**Julian Hughes**	**Responsible Director**	**Maria Hassard**

Percentage of Research Projects Achieving Time and Target

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥65%	Amber	70.0%	66.7%	66.7%	66.7%	57.1%

Divisional Benchmarking (Mar 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
4 studies successful and 3 studies unsuccessful in reaching recruitment target during the reporting period. 1. CLAJ1012 (The Efficacy and Safety of Bimatoprost SR in Patients With Open-angle Glaucoma or Ocular Hypertension; Clarke): 0/1 recruited (i) Patients did not want to receive an injection for the study; (ii) Patients from mile end did not want to travel to city road for assessments; (iii) Patients reported the study visits were too long and onerous and interfered with work commitments due to the length of visits. 2. SIVS1039 (A dose-ranging study of intravitreal OPT-302 in combination with ranibizumab, compared with ranibizumab alone, in participants with neovascular age-related macular degeneration wet AMD; Sivaprasad): 1/4 patients recruited. Contract negotiations for costings delayed initial opening of the study and study closed 3 weeks early as global recruitment target was met. Study had high screening failure rate i.e. most patients ineligible as vision was too good or had previous injections. 3. Mauv 1011 (Post-Market Clinical Investigation of the Clareon« IOL; Maurino): 3/10 recruited. (i) study ended up opening during the summer months when theatre space was at a low as well as maintenance works in theatre limiting availabilityl (ii) Difficulty finding eligible patients with bilateral cataracts with no other condition.	Internal feasibility analysis will enable the setting of better targets in potentially difficult to recruit to studies. Negotiations with partners will in future develop target ranges which will allows us to report against both the lower and upper ends of that range. This will cater for those occasions where we are opening as a site later than most other international sites and avoid the risk of having studies close early before we have been able to meet our agreed target locally. We are also looking at predicted closure dates 6 months in advance and engaging with sponsors early to try to avoid missing future recruitment targets.	July 2019

Moorfields Eye Hospital NHS Foundation Trust

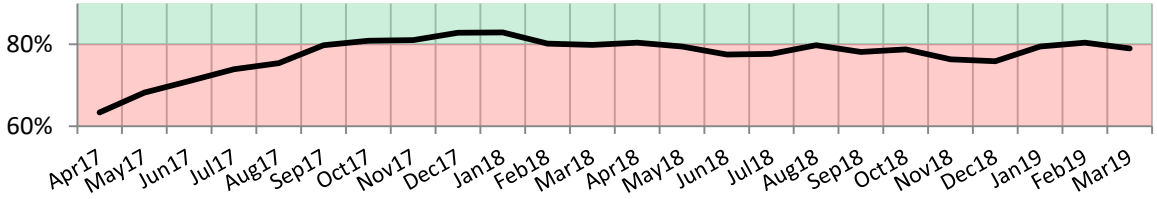
Remedial Action Plan - March 2019

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

Appraisal Compliance

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≥80%	Red	n/a	75.9%	79.5%	80.4%	79.0%

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
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	
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	
Managers are not completing appraisals when they are due.	Reminders are sent to managers in advance reminding them when their staff's appraisals are due. As additional step, non compliance reports will also be produced and included as part of the monthly dashboard data shared with the divisions.	Feb 2019	
Some managers are still not experienced or confident in undertaking appraisal.	HR clinics continue to take place on a regular basis. Bespoke appraisal training will also be delivered in areas where compliance is lowest.	Mar 2019	
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	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Compliance remains between the 78-80% range, we update Appraisal dates daily on INSIGHT, at the same time staff are falling out of compliance daily. Keeping us in this cycle.	We are sending out weekly reminders to staff who are non compliant , aswell as sending out personal reminders to capture those staff who will be falling out over the next 60 days. HR Managers have been kept up to date on the compliance for their areas. We are working weekly to get the figures up.	May 2019

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 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		n/a	Monthly	13.0%	13.2%	13.1%	12.7%		↓
	Proportion of Temporary Staff	Well-Led	RAG as per Spend	R	*	15.4%	Monthly	12.6%	12.7%	13.2%	20.0%		↑
	Temporary Staff Spend	Well-Led	≤ Plan (£)	R	*	9922	Monthly	591	632	603	1454		↑
	Agency Spend v trajectory	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Number of Apprenticeship staff started within the Trust	Well-Led	Qtr:10 YTD:45	R	37	33	Quarterly	10			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'

Remedial Action Plans for Strategic Objective 5

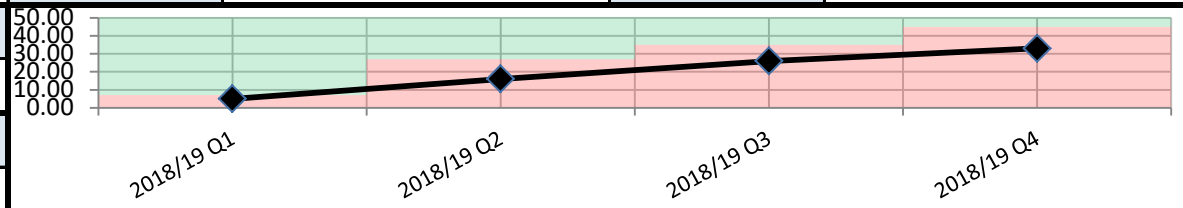
We will attract, retain and develop great people

Remedial Action Plan - March 2019

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

Target	Rating	YTD	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Qtr:10 YTD:45	Red	26	5	11	10	7

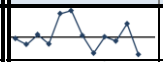
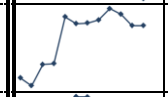
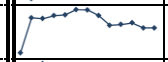
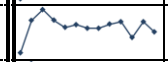
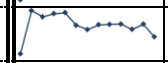
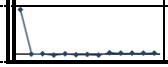
Divisional Benchmarking (2018/19 Q1)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Delayed recruitment of apprentices due to organisational change and subsequent restructure processes.	Support managers to recruit apprentices following staffing changes and work with recruitment team to market ongoing apprenticeship vacancies.	Mar 2019	Complete
Internal access to development through apprentice route has been slow to progress	A variety of further communications will be used to promote apprenticeships internally across the trust. Development of apprenticeship strategy to support departments to utilise apprenticeships for workforce planning gaps.	Mar 2019	Complete
Assistant Practitioner apprenticeship delayed again by provider resulting in 8 starts not taking place.	New provider procured for delivery of this with aim to start in March/April 2019	Apr 2019	In Progress (No Update)
Post conversion to apprenticeship has been less than expected.	Workforce planning closely linked to education needs in business planning round for 2019/2020 to identify more strategic approach to apprenticeships.	Oct 2019	In Progress (No Update)

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

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Organisational Health	Staff Sickness (Month Figure)	Well-Led	≤4%	G			Monthly	4.0%	3.9%	4.3%	3.6%		
	Staff Sickness (Rolling Annual Figure)	Well-Led	≤4%	A	40		Monthly (Month in Arrears)	4.2%	4.2%	4.2%	4.2%		
	Staff Stability	Well-Led	≥80%	G			Monthly	87.0%	87.2%	86.6%	86.6%		→
	Staff Vacancy Rates	Well-Led	≤10%	A	41		Monthly	16.6%	14.6%	16.6%	15.3%		↓
	Staff Vacancy Rates - Nursing & AHP	Well-Led	≤10%	A	42		Monthly	15.6%	15.1%	15.6%	14.3%		↓
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		0.49	Monthly	0.40	0.40	0.40	0.49		↑

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

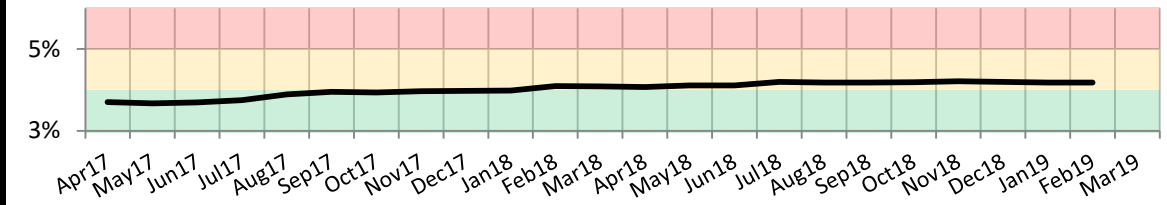
Remedial Action Plan - March 2019

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

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

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

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
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	Complete
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 (Update)
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	Mar 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions Identified	We are continuing with training in all areas, including bespoke sessions where required. We have also incorporated a sickness absence management overview into the managers induction. HR Business Partners continue to report absence metrics monthly at divisional board meetings.	May 2019

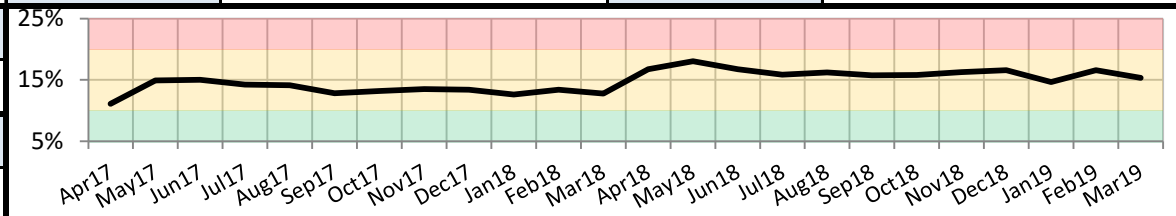
Remedial Action Plan - March 2019

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

Staff Vacancy Rates

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≤10%	Amber	n/a	16.6%	14.6%	16.6%	15.3%

Divisional Benchmarking (Mar 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. The South Division consultation has been concluded and recruitment to vacancies previously held by bank staff is underway. The Health Records service will be outsourced and in anticipation of this there were a number of vacancies being held. This consultation is imminent.	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)

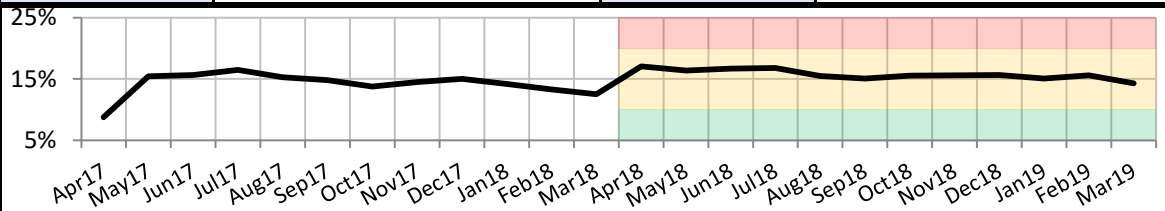
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Electronic Staff Reporting system development	We are currently working with the finance team to incorporate accurate establishment data into ESR. When this piece of work is complete, ESR will become the primary source of establishment data and vacancy reporting should be more accurate and up to date	May 2019

Remedial Action Plan - March 2019

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

Target	Rating	YTD	Dec-18	Jan-19	Feb-19	Mar-19
≤10%	Amber	n/a	15.6%	15.1%	15.6%	14.3%

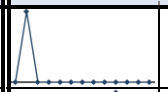
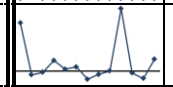
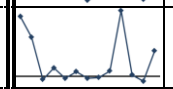
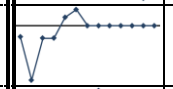
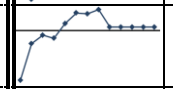
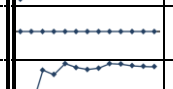
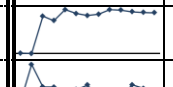
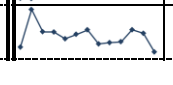
Divisional Benchmarking (Mar 19)	City Road	North	South
	n/a	n/a	n/a



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
Electronic Staff Reporting system development	We are currently working with the finance team to incorporate accurate establishment data into ESR. When this piece of work is complete, ESR will become the primary source of establishment data and vacancy reporting should be more accurate and up to date	May 2019

Objective 7	We will have a sustainable financial model	March 2019

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 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		4.08	Monthly	3.97	-0.12	-0.47	0.75		↑
	NHS Performance (In Month Var. £m)	Use of Resources	≥0	G		5.86	Monthly	3.97	0.09	-0.29	1.53		↑
	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	0.10	0.10	0.10	0.10		→
Liquidity	Liquidity (days)	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Cash Flow (In Month Variation)	Use of Resources	≥0	G		45.25	Monthly	48.20	46.40	45.70	45.25		↓
	Outstanding debtors (Total £m)	Use of Resources	≤ Plan	G		8.7	Monthly	9.9	11.3	10.9	8.7		↓

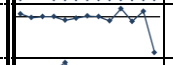
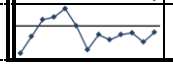
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Objective 7	We will have a sustainable financial model	March 2019

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

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

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

Strategic Issue	Metric Description	CQC Domain	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Dec 18	Jan 19	Feb 19	Mar 19	13 Month Trend	vs. Last
Contribution To ROI	I&E Margin (Current in Trust Metric : Overall Position)	Use of Resources	1	G		1	Monthly	1	1	1	1		→
	Research & Development Position (In Month Var. £m)	Use of Resources	≥0	R		-0.74	Monthly	0.15	-0.09	0.10	-0.67		↓
	Commercial Trading Unit Position (In Month Var. £m)	Use of Resources	≥0	R		-1.04	Monthly	-0.15	-0.12	-0.28	-0.11		↑

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