University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Trust Board – Public				**Public Trust Board paper F**	
Date of the meeting:	3 November 2022					
Title:	Performance and Accountability Framework					
Report presented by:	Becky Cassidy, Director of Corporate and Legal Affairs					
Report written by:	Becky Cassidy, Director of Corporate and Legal Affairs					
Action – this paper is for:	Decision/Approval	x	Assurance		Update	
Where this report has been discussed previously	The Performance and Accountability Framework has been reviewed and supported by the Audit Committee					

Acronyms used:

Purpose of the Report

This report presents the Trust Board with the reviewed Performance and Accountability Framework for approval.

Recommendation

The Trust Board is asked to:

- Approve the Performance and Accountability Framework following support from the Audit Committee.

Summary

The existing Framework was written in 2019 and has not been reviewed since. The attached framework reflects the current position but will require further review over the coming months to continue to improve the grip, challenge and oversight of performance and accountability across the organisation.

Main report detail

The Framework has been reviewed with the Director of Corporate and Legal Affairs, Chief Financial Officer, Chief Operating Officer and Director of Quality, Efficiency and Improvement. The Audit Committee have reviewed and supported the document and recommend to Trust Board for approval.

Two specific points to note:

- Cost Improvement and Productivity framework has been included in the revised version
- There is no reference to Strategy within the reviewed version as the Trust is currently reviewing its Trust Strategy. The Framework will be reviewed and updated once the Strategy has been approved.

Supporting documentation

Appendix 1 – Performance and Accountability Framework

University Hospitals of Leicester NHS
NHS Trust

PERFORMANCE AND ACCOUNTABILITY FRAMEWORK

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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1.0 Purpose

The Performance and Accountability Framework (hereafter referred to as “the Framework”) ensures the Trust has sufficient mechanisms in place to monitor and drive the delivery of its strategic and operational plans.

The Framework is one document which pulls together the Trust’s business as usual performance across all areas. It sets out the accountability arrangements of the Trust as a whole, as individuals and as directorates. In order to achieve its ambitions, the Trust must ensure consistency in its approach to managing and delivering its plans, and that sufficient escalation processes are in place and the Board is routinely sighted the mitigation of risks.

This Framework has been designed to align as closely as possible to the newly approved NHS Single Oversight Framework 2022/23. The NHS Single Oversight Framework 2022/23 supports Integrated Care Boards and NHS England to work together and develop proportionate and locally tailored approaches to oversight.

2.0 Roles and Responsibilities

2.1 Board of Directors

The Board of Directors has overall responsibility for the implementation of the performance and accountability framework. The Board is required to ensure that the Trust remains compliant within its legal requirements of its Provider License and has regard to the NHS Constitution. The Board formulates strategy, shapes culture and ensures accountability across the organisation. The Board holds the organisation to account for the delivery of the Strategy; by being accountable for the ensuring the organisation operates effectively and with openness and transparency and candour and by seeking assurance that systems of control are robust and reliable.

2.2 The Executive team

The Chief Executive Office (CEO) is the Trust’s ‘Accountable Officer’. This is a formal role conferred upon the organisations Chief Officer. The role of the Accountable Officer is a key element in governance terms with a line of accountability for the proper stewardship of public money and assets and for the organisations performance stretching up to parliament. The Chief Executive leads the Executive team and is accountable to the Trust Chair and Trust Board for meeting the objectives it sets, for day to day management and for ensuring that governance arrangements are effective. All members of the Executive team report directly to the CEO

The Deputy Chief Executive Officer (DCEO) is accountable for the development of the Trust’s strategy and delivery of Reconfiguration. The DCEO will deputise for the CEO wherever appropriate.

The Chief Operating Officer is accountable for performance across the Trust's seven Clinical Management Groups (CMGs).

The Chief Nurse and Medical Director are accountable for quality and safety.

The Chief Financial Officer is accountable for the delivery of the financial plan.

The Chief People Officer is accountable for the delivery of the People strategy.

The Chief Information Officer is accountable for the delivery of the Trust's IM&T strategy.

The Director of Estates and Facilities is accountable for the delivery of the Trust's estate and facilities management services.

The Director of Quality Transformation Efficiency Improvement is accountable for the delivery of the transformation and cost improvement programme.

The Director of Corporate and Legal Affairs monitors compliance with relevant legislation, advises the Trust Board on key governance issues; and provides support to the Trust Board and its committees.

2.3 Clinical Directors

Clinical Directors are accountable for the performance of their CMG and report directly to the Chief Operating Officer. They are supported in their role by a Head of Operations and a Head of Nursing/Midwifery

3.0 Performance Framework

The Trust's approach to performance management aims to provide integrated and robust monitoring and management process from speciality level through to Trust Board. It is designed to capture, report, monitor, communicate and predict performance for a range of national, local, operational targets and indicators. This in turns assists the Trust, CMG and Corporate Directorates in their understanding and management of their performance.

Performance is monitored across Clinical Management Group and corporate function – including access, quality & safety, finance, workforce and strategy.

For Clinical Management Groups, the framework is described below:

3.1 Clinical Management Group performance and accountability

The Trust has established 7 Clinical Management Groups including:

- CHUGGS (Cancer, Haematology, Urology, Gastroenterology and General Surgery)
- CSI (Clinical Support and Imaging)
- ESM (ED Specialist Medicine/Acute Medicine)

- ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep)
- MSS (Musculoskeletal and Specialist Surgery)
- RRCV (Renal, Respiratory, Cardiovascular)
- W&C (Women's and Children's)

Each CMG is led by a Clinical Director, Head of Operations and Head of Nursing.

Each CMG is then further divided into either specialities or Services. There is a clearly defined management structure within each CMG which consists of a Medical/Clinical Lead (referred to as Head of Service), General Manager and Matron,

3.1.1 CMG Board Accountability

Each CMG has a Management Board which meets on a monthly basis. CMG Management Boards consider at each meeting a performance pack which covers the domains:

- Quality
- Performance
- Finance
- Workforce
- Strategy

The purpose of this format is to ensure there is consistency in the reporting of data at both CMG and Corporate levels and that the clinical/strategic priorities of the CMGs align to those set by the Trust. Aligning the CMG Board format in this way also ensures that issues and actions discussed within each CMG are escalated, where necessary, to the monthly Performance Review Meetings (PRMs) with the Executive Directors.

3.1.2 Speciality Review Meetings

Regular performance review meetings are held by CMG management team with each speciality/service leadership team. These are chaired by the Head of Operations and involve the Clinical Director, Head of Finance, HR Business Partner, Head of Nursing and CMG Business Analyst.

The purpose of these meetings is to scrutinise speciality/service performance to ensure that any material issues are appropriately reflected in the reporting of CMG performance, allowing clear view and escalation of issues and priorities, thereby supporting Ward to Board escalation of critical issues and successes.

3.1.3 Performance Review Meetings

Monthly PRMs are held with CMG leadership teams. PRMs are chaired by the Chief Operating Officer and attendance includes the Chief Financial Officer, Chief Nurse, Medical Director, Chief People Officer and Director of Quality Transformation Efficiency Improvement.

The purpose of these meetings is to review, discuss and manage CMG performance, and gives both CMGs and Executives the ability to escalate issues to the Executive Board, Committees and Board as required.

Data presentation is designed to be fit for purpose, informative, and clear and simple to understand / interpret. Dashboards are used to indicate if a process is showing special cause or common cause variation. Icons are used to indicate whether the Trust is able to meet any stated target. The Trust's Data Quality Forum aims to ensure the validity and robustness of data.

For each PRM, a dedicated data pack is prepared, compiled centrally but completed by the individual CMG.

The structure of the performance reports used to evaluate performance is consistent, irrespective of whether the reported data relates to corporate, CMG or specialty areas.

The content of the reports is continually reviewed and enhanced and is readily adaptable so that, as other targets or indicators develop or emerge, they can be readily incorporated.

A standard agenda is used for each PRM (example attached as appendix 2)

3.2 Corporate functions performance management

The Executive Team are held to account for their individual portfolios and objectives by the Chief Executive.

The Chief Executive meets monthly with each Executive Director to discuss key issues. Performance against agreed objectives is reviewed formally by the Chief Executive mid year, and at the end of each financial year, culminating in a report to the Remuneration Committee by the Chief Executive on each individual Director's performance.

The Trust Chair similarly conducts and annual appraisal of the Chief Executive's performance against objectives, and reports on the outcome to the Remuneration Committee. The Trust Chair reports to NHSE/I annually on the Chief Executive's performance.

3.3 Financial Performance Management

Achievement of the financial target is an important annual objective for the Trust and developing responsibility for income and expenditure to CMGs and Corporate Directorates is an appropriate and fundamental component.

As part of the annual planning and budget setting process each CMG and Corporate Directorate is required to sign-off their annual plan and approved budget. Financial Accountability Framework can be found in Appendix 3. Cost Improvement Programme Accountability Framework can be found in Appendix 4.

4.0 Accountability and Committee Structure

4.1 Ensuring Accountability

There are two main aspects to the role of the Trust Board in ensuring accountability:

- Responsibility for the delivery of the strategy;
- seeking assurance that the systems of control are robust and reliable.

The fundamentals for the unitary Board in holding the organisation to account for performance include:

- drawing on Board 'intelligence', the Board monitors the performance of the organisation in an effective way and satisfies itself that appropriate action is taken to remedy problems as they arise,
- looking beyond written intelligence to develop an understanding of the daily reality for patients and staff, to make data more meaningful,
- seeking assurance where remedial action has been required to address performance concerns,
- offering appreciation and encouragement where performance is excellent,
- taking account of independent scrutiny and performance, including from regulators and overview and scrutiny committees,
- rigorous but constructive challenge from all Board members, Executive and Non-Executive as corporate Board members.
- Stakeholders and external environment:

Seeking assurance that the systems of control are robust and reliable has the following seven accountability elements:

4.1.1 Quality assurance and clinical governance

The Board has a key role in safeguarding quality, and therefore gives appropriate scrutiny to the three key facets of quality:

- clinical effectiveness
- patient safety
- patient experience

Effective scrutiny relies primarily on the provision of clear comprehensive

summary information to the Board and its Committees, particularly the Quality Committee, set out for everyone to see.

The Board has a statutory duty of quality. In support of this, all Board members understand:

- their ultimate accountability for quality,
- there is a clear organisational structure that clarifies responsibility for delivering quality performance from the Board to the point of care back to the Board,
- quality is a core part of main Board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions,
- quality performance is discussed in more detail regularly by a quality committee with a stable, regularly attending membership, hence the Trust Board has established the Quality Committee,
- the Board becomes a driving force for continuous quality improvement across the full range of services.

4.1.2 Financial stewardship

The exercise of effective financial stewardship requires that the Board assures itself that the organisation is operating effectively, efficiently, economically and with probity in the use of resources. The Board has a statutory duty to balance the books. It is also required to ensure that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained.

4.1.3 Risk Management

The role of the Board in risk management is twofold:

- firstly, within the Board itself an informed consideration of risk should underpin organisational strategy, decision-making and the allocation of resources,
- secondly, the Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver the annual plan/commissioning plan and comply with the registration requirements of the quality regulator, the Care Quality Commission. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks.

Risk management by the Board is underpinned by four interlocking systems of control:

- The Board Assurance Framework – this is a document that sets out strategic objectives, identified risks in relation to each strategic objective along with controls in place and assurances available on their operation.

- Organisational Risk Management - Strategic risks are reflected in the Board Assurance Framework. A more detailed operational risk register is in use within the organisation. The Board needs to be assured that an effective risk management approach is in operation within the organisation. This involves both the design of appropriate processes and ensuring that they are properly embedded into the operations and culture of the organisation.

- Audit - External and internal auditors play an important role in Board assurance on internal controls. There needs to be a clear line of sight from the Board Assurance Framework to the programme of internal audit.

- The Annual Governance Statement - This is signed by the Chief Executive as Accountable Officer and comprehensively sets out the overall organisational approach to internal control. It should be scrutinised by the Board to ensure that the assertions within it are supported by a robust body of evidence.

The approach to risk management needs to be systematic and rigorous. However, it is crucial that Boards do not allow too much effort to be expended on processes. What matters substantively is recognition of, and reaction to, real risks – not unthinking pursuance of bureaucratic processes.

4.1.4 Legality

The Board seeks assurance that the organisation is operating within the law and in accordance with its statutory duties.

4.1.5 Decision-Making

The Board seeks assurance that processes for operational decision-making are robust and are in accordance with agreed schemes of delegation.

4.1.6 Probity

The Board adheres to the Nolan seven principles of public life. This includes implementing a transparent and explicit approach to the declaration and handling of conflicts of interest. Good practice here includes the maintenance and publication of a register of interest for all Board members. Board meeting agendas include an opportunity to declare any conflict at the beginning.

Another key area in relation to probity relates to the effective oversight of top level remuneration. Hence, the Board has established a Remuneration Committee. Boards are expected to adhere to HM Treasury guidance and to document and explain all decision made.

4.1.7 Corporate Trustee

If the organisation holds NHS charitable funds as sole corporate trustee the Board members of that body are jointly responsible for the

management and control of those charitable funds, and are accountable to the Charity Commission. At UHL, the Board has established a Charitable Funds Committee.

4.2 Committee Framework

In order to enable accountability, Boards are required to establish Committees responsible for audit and remuneration. Current good practice also recommends a quality-focused Committee of the Board, and also a Committee which can provide the Board with assurance on financial and operational performance matters.

The Trust operates a well established committee structure to strengthen its focus on quality governance, finance and investments, people and culture, Risk, and performance matters. The structure has been designed to provide effective governance over, and challenge to, patient care and other business activities. The committees have delegated responsibilities from the Board which are described in their terms of reference.

All of the Board committees are chaired by a Non-Executive Director and have a mixed membership comprising both Non-Executive and Executive Directors. The exceptions to this are the Audit Committee and Remuneration Committee, which (in accordance with NHS guidance) comprise only Non-Executive Directors as its core membership. In line with good governance the Trust Chair is not a member of the Audit Committee.

4.2.1 The Audit Committee

This committee is established under the powers delegated by the Trust Board with approved terms of reference aligned with the NHS Audit Committee Handbook. It discharges its responsibilities for scrutinising the risks and controls which affect all aspects of the organisations business. The Audit Committee receives reports from each of its meetings from the External Auditor, Internal Auditor and Local Counter Fraud Specialist. This committee reports directly to the Trust Board.

4.2.2 The Finance and Investment Committee

This committee meets monthly and oversees the effective management of Trust finances across a range of measures. This committee reports directly to the Trust Board.

4.2.3 The Quality Committee

This committee meets monthly and seeks assurance that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients. This committee reports directly to the Trust Board.

4.2.4 The People and Culture Committee

This committee focus their assurance on workforce issues and regularly scrutinise the culture of the organisation. This committee reports directly to the Trust Board.

4.2.5 Operational Performance Committee

The committee seeks to enhance Trust Board oversight and assurance around all matters relating to the Trust's short term operational performance and two year transformation programme. This committee reports directly to the Trust Board

4.2.6 The Reconfiguration and Transformation Committee

The committee has an assurance role in the delivery of the programme to reconfigure services. This committee reports directly to the Trust Board

4.2.7 Executive Boards

The Executive team, with the Clinical Directors and appointed GPs, form part of the Executive Board which meets weekly. The focus for each Executive Board changes on a rolling cycle to cover; Quality, Finance and Investment, People and Culture, Strategy, Estates and IM&T. The Executive Boards escalate directly to the relevant Board Committees. This Board escalates directly to relevant sub committees of the Board.

4.2.8 Risk Committee

This committee ensures oversight of the strategic and operational risks in the organisation, for advising the Executive Team on the key risks and for gaining assurance that the risk management systems and processes are functioning. This committee escalates directly to the Executive Board.

Appendix 1

Quality

Measure	Domain	Frequency	Exec Lead
Never Events	Safe		MD
VTE risk assessment	Safe		MD
3rd & 4th degree Perineal Tears	Safe		CN
Clostridium Difficile	Safe		CN
MRSA bactereamias	Safe		CN
E. Coli	Safe		CN
MSSA bactereamias	Safe		CN
Covid-19 Hospital-onset, probable	Safe		CN
Covid-19 Hospital-onset, healthcare-acquired	Safe		CN
Falls per 1000 bed days	Safe		CN
Rate of moderate harm and above falls per 1000 bed days	Safe		CN
Hospital acquired pressure ulcers	Safe		CN
Single sex breaches	Caring		CN
Inpatient Friends and Family Test - % positive	Caring		CN
A&E Friends and Family Test - % positive	Caring		CN
Maternity Friends & Family Test - % positive	Caring		CN
Outpatient Friends & Family Test - % positive	Caring		CN
% of complaints responded to in agreed timeframe	Caring		CN
SHMI	Effective		MD
HSMR	Effective		MD
Crude Mortality rate	Effective		MD

Operational – Emergency Care

Measure	Domain	Frequency	Exec Lead
4 hour wait	Responsive		COO
Mean time to assessment	Responsive		COO
12 hour trolley wait	Responsive		COO
Number of 12 hour waits in department	Responsive		COO
Time clinically ready to proceed	Responsive		COO
Ambulance handover	Responsive		COO
Ambulance handover – >60 mins	Responsive		COO
Long stay patients – 21+ days	Responsive		COO

Operational – Elective Care

Measure	Domain	Exec Lead
Referral to treatment	Responsive	COO
Referral to treatment 52+ weeks	Responsive	COO
Referral to treatment 104+ weeks	Responsive	COO
6 week diagnostic test waiting time	Responsive	COO
% operations cancelled on day	Responsive	COO
% outpatient did not attend rate	Responsive	COO
% outpatient non face to face	Responsive	COO

Operational – Cancer Care

Measure	Domain	Exec Lead
2 week wait	Responsive	COO
62 day backlog	Responsive	COO
62 day	Responsive	COO

Finance

Measure	Domain	Exec Lead
Control level performance	Well led	CFO
Capital expenditure against plan	Well led	CFO
Cost Improvement	Well led	CFO
Cashflow	Well led	CFO

Workforce

Measure	Domain	Exec Lead
Staff survey % recommend as a place to work	Well led	CPO
Staff survey % recommend as place for treatment	Well led	CPO
Turnover rate	Well led	CPO
Sickness absence	Well led	CPO
Annual appraisals	Well led	CPO
Statutory and mandatory training compliance	Well led	CPO
Adult nursing vacancies	Well led	CPO
Paed nursing vacancies	Well led	CPO
Midwives vacancies	Well led	CPO
HCA & support worker vacancies	Well led	CPO
HCA & support worker vacancies – maternity	Well led	CPO

Appendix 2

Monthly CMG Progress Review Meeting

Standing Agenda

Meetings to run for 90 minutes

Via Microsoft Teams link is included in the diary invite

Timings	Agenda Item	Lead	Paper
5 minutes	Welcome	Chair	
5 minutes	Sharing Good News Stories	CMG	
30 minutes	Key Action/Discussion Points	CMG	
45 minutes	PRM Pack – Review and Discussion	CMG/All	
5 minutes	Any Other Business and Confirmation of Agreed Actions	Chair	

Appendix 3

Financial Management Framework

1 Achievement of the financial target is an important annual objective for the Trust and devolving responsibility for our income and expenditure to CMGs and Corporate Directorates is an appropriate and fundamental component. The Financial Management Accountability Framework seeks to formalise and more clearly define what is expected of CMGs and Directorates in terms of the sign off of their annual budgets and their in-year management. Importantly, it also details how the performance management regime will operate, noting how adverse performance from plan will be handled.

2 The Financial Management Accountability Framework covers how CMGs and Directorates provide information and assurance to the Chief Financial Officer, Executive Team, Finance and Investment Committee and Trust Board on their financial performance. It is important that financial delivery is considered alongside clinical and operational delivery and safety.

3 The purpose of the Financial Management Accountability Framework is to formalise and specify some of what already exists in practice at UHL and in addition to take and implement aspects of best practice from successful NHS Foundation Trusts and Trusts in other parts of the NHS. The document sets out quite succinctly what is expected of CMG Boards and of the relevant Executive Directors.

4 The UHL Financial Management Accountability Framework describes what is in operation in 2022/23. Further work is ongoing to enhance this and support delivery of ‘best in class’ financial management.

5 The Trust is working within an annual financial plan for Income and Expenditure as agreed with NHSE. The organisation discharges its financial commitment to CMGs and Corporate Directorates through the annual planning and budget setting process.

6 As part of the annual planning and budget setting process each CMG and Corporate Directorate will be required to sign-off their annual plan and approved budget, including their underlying budget. This sign-off process will require physical/electronic signatures of the Chief Executive, Chief Financial Officer and respective CMG board members and Corporate Directors.

7 Each month, the Trust is required to report to NHSE on both year to-date financial performance and cost improvement programme performance (CIP), together with forecast outturn for the financial year. The Trust remains committed to achieving the agreed Income and Expenditure position and therefore each CMG and Corporate Directorate is required to fully own and deliver its individual financial plan.

8 CMG are subject to regular Performance Review Meetings (PRMs). At each PRM, CMGs will be required to report their financial position and forecast along with operational performance, KPIs and workforce statistics. The reported financial information should include:

- In month, YTD and forecast position compared to plan with narrative on drivers of variances
- CIP delivery in month, YTD, and forecast
- Run rate graphs including forecast expenditure and workforce/wte forecasts, with comparison to plan
- Best, likely, and worst-case forecast scenarios (from month 3), including the drivers of variances to plan in each scenario and the actions being taken to mitigate worst case from happening and drive best case. Clarity should be provided on non-financial impacts and areas where any support in decision making or taking an action is needed. Clear owners should be identified for actions

9 Although Corporate Directorates do not currently have a formal PRM, a PRM finance pack is produced by the Finance Team and shared with each Directorate. If any adverse trends or issues emerge these will need to be escalated to the Chief Financial Officer. Following escalation, a PRM will be held with that Directorate if necessary.

10 Any CMG or Directorate that is reporting an adverse financial position to plan year to date and forecasting to deliver adverse to plan at year end will be required to present a route to delivery of the plan, including the expected financial and non-financial impact of actions. The actions will be considered at the PRM and those which can and should be enacted will be agreed, considering the clinical, operational, and financial impacts together.

11 Financial Performance should align with CIP delivery with the principle that if the plan is being delivered this implies that CIP is being delivered. Whilst CIP should be predicated on recurrent savings it is recognised that this can be delivered through non-recurrent means in-year. Equally, if the financial plan is not being delivered this would normally translate into under-delivery of CIP, however there may be occasions where the CIP target has been delivered but an unrelated cost pressure is driving an overspend. In line with the existing policy, any risks surrounding delivery of the CIP target will follow the current CIP escalation route in place.

12 Following the PRM consideration will be given by the Chief Financial Officer and the Chief Operating Officer on what, if any, further actions are needed by the CMG.

13 It should be noted that any material failure to deliver on the part of one CMG or Corporate Directorate may require other areas of the organisation to take additional action.

14 This framework remains under review and further updates will consider what additional controls and autonomies may be required to support delivery of plan in CMG and Corporate Directorates. It will consider incentives and opportunities open to areas that deliver better than plan in year as well as additional support and controls that may be needed in areas delivering worse than plan.

15 There may be situations where budgets are not adjusted for approved increases in expenditure and/or income. In such instances, performance will be measured against an agreed forecast.

Appendix 4

Cost Improvement Plans and Productivity Accountability Framework

1. The Trust has a comprehensive Efficiency Programme which constitutes both productivity improvements as well as a detailed annual cash-out plan. The programme is locally owned (by CMGs and Corporate Directorates) and centrally driven by the Transformation Team.

2. **Reporting:** Reports on the efficiency programme are provided monthly to the Executive Finance and Performance Board. These reports detail progress against plan, top 10 schemes by value, breakdown of performance by CMG and corporate team, risks to delivery, and delivery of workstream plans. The Efficiency Programme report aligns with the monthly Finance report so there is clear and consistent read across. Monthly reports are also presented to the Finance and Investment Committee for update and assurance.

3. **Accountability:** The accountability for the delivery of the Efficiency Programme sits with the Director of Transformation.

4. **Oversight:** Oversight is achieved through monthly presentation of the Efficiency Programme reports at the Executive Finance and Performance Board and the Finance and Investment Committee. Confirm and challenge is provided by CMG heads, Executive Directors and NEDs to ensure the programme is on track, sufficiently ambitious, not imperiling quality and, if needed, provide any recovery plans. External oversight is provided through regular review meetings with Regional colleagues.

5. **Monitoring:** The Director of Transformation holds monthly 'Transformation Progress Meetings' (TPMs) with every CMG and Corporate Team. These are designed to ensure that each team is on track for delivery and to offer tangible support to implement the efficiency schemes identified. The TPMs ensure local grip and control. They provide a forum to review national benchmarking data by clinical specialty so that quality and efficiency improvements can be identified. CIP trackers are reviewed live (using Power BI software) at each meeting. Significant areas of spend (for example Agency or locum usage) are reviewed with trajectories for improvement agreed. Finally, Quality Impact Assessments and Project Initiation Documents (QIAs and PIDs) are reviewed to ensure one is completed for each scheme and there is full compliance with quality governance requirements.

6. **Medium Term Financial Plan (MTFP):** The Transformation Team has worked with colleagues in Finance to develop a MTFP which includes significant efficiency improvements over the next 5-7 years.

7. **Repository of Evidence:** The Programme Management Office (PMO) within the Transformation Team maintains the repository of evidence for the Trust's

Financial Sustainability Roadmap. The PMO also manages the QIA / PID process, supporting evidence and related audits.

8. **QIAs / PIDs:** A QIA / PID is undertaken and logged for each live scheme on the CIP tracker. Within the past 18 months three external assessments of this process have been undertaken – by the Regional Medical Director, an Internal Audit by PwC and a review as part of the Trust's CQC Well-Led inspection. All have received very favourable / compliant feedback.