University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper I

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 27 SEPTEMBER 2012

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr I Reid, Non-Executive Director

DATE OF COMMITTEE MEETING: 29 August 2012.

PUBLIC RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

None.

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE PUBLIC TRUST BOARD:

UHL financial position and work in progress to develop a recovery plan.

DATE OF NEXT COMMITTEE MEETING: 26 September 2012

Mr I Reid – Non-Executive Director and Finance and Performance Committee Chair
21 September 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 29 AUGUST 2012 AT 9.15AM IN THE C J BOND ROOM, LEICESTER ROYAL INFIRMARY

Present:
Mr I Reid – Non-Executive Director (Committee Chair)
Mr J Birrell – Interim Chief Executive (up to and including Minute 117/12/2 [part])
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mr R Kilner – Non-Executive Director
Dr P Rabey – Acting Medical Director (in the absence of Dr K Harris, Medical Director)
Mr A Seddon – Director of Finance and Procurement
Mr G Smith – Patient Adviser (non-voting member)
Mrs J Wilson – Non-Executive Director

In Attendance:
Ms D Mitchell – Head of Transformation Programmes (for Minutes 117/12/4 and 117/12/5)
Dr S Jackson – Clinical Lead for Quality and Safety, Acute Care Division (for Minute 116/12)
Ms K Johnston – Medicine Matron, Acute Care Division (for Minute 116/12)
Mr C Shatford – Medicine CBU Manager, Acute Care Division (for Minute 116/12)
Mr J Shuter – Deputy Director of Finance and Procurement
Ms H Stokes – Senior Trust Administrator

ACTION

RESOL VED ITEMS

113/12 APOLOGIES

Apologies for absence were received from Dr K Harris, Medical Director and Dr A Tierney, Director of Strategy.

114/12 MINUTES

Resolved – that the Minutes of the Finance and Performance Committee held on 25 July 2012 be confirmed as a correct record.

115/12 MATTERS ARISING FROM THE MINUTES

The following items were noted in respect of the matters arising report at paper B:-

(a) Minute 98/12 – delivery of capital investment business cases would be reviewed annually by the Director of Finance and Procurement;
(b) Minute 100/12 – it was agreed to resolve continuing queries over the process for closing off locum posts once the substantive vacancy had been filled, outside the meeting, and — **COO/N /MD**
(c) Minute 105/12 – updates on the clinical coding transformation scheme would be provided on a quarterly basis, with the next such report due therefore at the October 2012 Finance and Performance Committee. It was confirmed that members of the coding team were now attending junior doctor induction sessions. — **COO/ CN**

Resolved – that the matters arising report and any associated actions above, be noted. — **Named EDs**

115/12/1 Reducing Readmissions Workstream (Minute 101/12)

The independent review of the readmissions position was not yet available, despite being

expected in July/August 2012. Views differed on the extent to which readmissions were failing to reduce, and the Acting Medical Director noted that approximately 75% of readmissions were not avoidable – it was key, therefore, for UHL to focus appropriately on reducing the remaining 25% which were avoidable. This data had only become available following an intensive manual audit. In response to a further Finance and Performance Committee query, the Chief Operating Officer/Chief Nurse advised that she was awaiting a response on whether additional transformation resource was available to support the reducing readmissions workstream. **COO/CN**

Resolved – that an update on whether additional transformational support was available for the reducing readmissions workstream, be provided to the September 2012 Finance and Performance Committee. **COO/CN**

115/12/2 Imaging Services Transformation and Overview (Minute 101/12/4)

The Clinical Support Division had been asked to review the issues identified at the July 2012 Finance and Performance Committee, with a view to presenting a written report to the Committee on 26 September 2012. Structural issues were being progressed through wider discussion by the Executive Team. The relationship between theatres and anaesthetics also required further work. In response to a query from the Finance and Performance Committee Chair, the Chief Operating Officer/Chief Nurse confirmed that the Clinical Support Divisional Director was aware of what needed to be covered in the September 2012 report. **DCER/DDCS**

Resolved – that (A) the Director of Communications and External Relations (as Executive sponsor) and the Divisional Director Clinical Support Services provide an update on Imaging Services transformation to the 26 September 2012 Finance and Performance Committee, and **DCER/DDCS**

(B) it be noted that wider structural issues were being progressed through the Executive Team. **EDs**

115/12/3 Future Use of Market Share Data (Minute 107/12/1)

Discussions on integrating other sources of management information into this report would be pursued with the Director of Communications and External Relations outside the meeting. It was noted that if taken at the Trust Board in future, this report would likely be discussed in the confidential section of that meeting, in light of commercial considerations. **ICE**

Resolved – that the future use and consideration of the market share data be discussed further with the Director of Communications and External Relations and progressed outside the meeting. **ICE**

116/12 CBU PERFORMANCE – MEDICINE

Further to Minute 101/12/3 of 25 July 2012, clinical and management representatives attended to present the Medicine CBU's performance position. As per the template provided for this meeting, paper C covered issues relating to:- quality and safety; year to date financial performance and forecast performance plus mitigating actions (noting a £1.2m overspend as at month 4 with a forecast £2.2m year-end overspend); the CBU recovery run-rate; Medicine CIPs for 2012-13; transformation schemes 2012-13 – 2014-15; PLICs; the CBU position against national and operational targets; capacity and capability issues (currently particularly challenging at service manager level), and forward service developments/'horizon scanning'.

In discussion on the information within paper C, the Finance and Performance Committee:-

(a) noted progress on the medicine reorganisation, including the creation of a 'virtual' ED CBU headed by Dr N Moore;
(b) noted the likely £37.5k impact of the transforming transcription services project within Medicine, on which further clinical engagement was needed;
(c) voiced concerns over the use of Fielding Johnson Ward and its suitability for non-ambulatory patients. The Medicine CBU Matron advised that plans were in development to improve the ward's environment – she noted, however, the predominant nature of Medicine patients as non-ambulatory (with ambulatory specialties such as Infectious Diseases inappropriate to move to Fielding Johnson). Discussions also continued with Orthopaedics regarding changes to the future use of that ward. Noting UHL work underway to review both winter planning and wider capacity, the Finance and Performance Committee Chair agreed to highlight the Committee's concerns over the use of additional capacity wards such as Fielding Johnson and Odames for specific cohorts of patients, to the GRMC for information; **FPC CHAIR**
(d) queried progress towards identifying the correct level of bed capacity required by Medicine, noting that the additional capacity currently opened was assisting with flowthrough from ED. The Finance and Performance Committee also sought assurance that a robust basis would be used for any decisions to close wards, particularly as winter approached. The Acting Medical Director queried what actions were being taken on base wards to improve the timeliness of discharge – in response the Medicine CBU Matron cited moves to morning ward rounds, increased use of discharge nurses, and earlier movement of patients to the discharge lounge. She also commented that same day working for tests and diagnostics would be desirable. Appropriate availability of Community beds was also an issue. In respect of diagnostics turnaround, the Committee was later advised by the Acting Medical Director that ambitious targets had been set by the Clinical Support Division (imaging capacity had also been increased at weekends, as had physiotherapy, pharmacy and OT support);
(e) noted the CBU's views that reducing the performance variations between Consultants in respect of AMU would be beneficial in moving towards closing beds, as would reducing readmissions;
(f) welcomed the CBU's on-target delivery of its CIP for the year to date. However, members queried how to deliver the significant non-pay reduction forecast for the remainder of 2012-13 – in response, the CBU clarified that this linked primarily to reducing the drug spend (particularly in respect of FP10s for which the budget was £7.8m). Further clarity on the likely timescale for delivering these savings was expected within the next 2 weeks, noting that an interim manager focusing on this issue had just started in post (which would partially address existing management capacity shortages within the Medicine CBU);
(g) queried how confident the CBU was of its ability to improve its current patient experience. In response, it was confirmed that Medicine's position was improving in terms of both its patient experience scores and its complaints performance. Patient Advisers were specifically represented at both Divisional and CBU Board level;
(h) queried the level of engagement in PLICS data from key specialties within the Medicine CBU, noting the very significant impact on the CBU's cost position of 2 particular specialties (geriatrics and neurology). In response to a further query from the Director of Finance and Procurement, the CBU Manager confirmed that he would be submitting appropriate 2012-13 counting and coding changes by the required deadline of 30 September 2012. The Clinical Lead for Quality and Safety, Acute Care Division confirmed that all junior doctors had been reminded of the need to record diagnoses correctly, thus ensuring appropriate coding allocations. A coding co-morbidities proforma had been implemented in Medicine for inclusion in the clerking documentation and on the ICE system, and
(i) advised that Medicine's forecast outturn position was not acceptable from a Trust

perspective, and queried whether the CBU had adopted an overly-cautious position when forecasting. The Medicine CBU representatives did not consider that they had been unduly cautious, and they noted that the month 3 forecast had been accurate. The impact of the key mitigating actions outlined in paper C had been taken into account when forecasting, although there was more to factor in re: FP10s.

Following the departure of the Medicine CBU representatives, the Finance and Performance Committee welcomed the improved performance of the CBU and also noted the key contribution made by the clinical representative (Clinical Lead for Quality and Safety, Acute Care Division). The Finance and Performance Committee Chair queried what action was being taken on a Trust-wide basis to improve clinical engagement, noting interest in this issue by the Workforce and Organisational Development Committee. Noting the need for UHL's goals and plan to be clear in order to engage clinicians, the Acting Medical Director considered that progress had been made recently, aided by advances on the job planning front. The Interim Chief Executive commented on the wider need for UHL staff at all levels to be clear on what was expected of them and their organisational structure, which he hoped would become clearer over the coming weeks.

<u>Resolved</u> – that (A) the performance presentation by the Medicine CBU be noted, and

(B) through these Minutes, the GRMC be made aware of Finance and Performance Committee concerns over the current use of Odames and Fielding Johnson wards at the LRI, noting related ongoing work on overall UHL bed capacity and winter planning. **FPC CHAIR**

117/12 2012-13

117/12/1 <u>Quality Finance and Performance Report – Month 4</u>

Paper D provided an overview of UHL's quality, patient experience, operational targets, HR and finance performance against national, regional and local indicators for the month ending 31 July 2012. In introducing paper D (and prior to discussion on its financial elements) lead Directors noted the following points by exception:-

(1) that the key quality issues were as detailed in the first section of the covering narrative for paper D;
(2) key patient experience developments, including:-
- the Trust's intention to learn appropriate lessons from a recent AUKUH report into the steps taken by those Trusts performing above average on the Net Promoter Score;
- UHL's continued commitment to reducing avoidable pressure ulcers down to 0 by December 2012;
- key work on reducing falls, which would be reported in more detail to the GRMC;
- UHL's good position in terms of the likely 2013-14 CQUIN on dementia care;

(3) progress on operational targets, including
- delivery of RTT targets, and recent discussions with Commissioners to provide additional assurance on these;
- the expected green ratings on both diagnostics and cancelled operations from the end of August 2012;
- green performance on the ED 4-hour waits target for both July and August 2012 to date;
- concerns over delayed discharges, which had been discussed with Commissioners at the 28 August 2012 contract meeting, and
- continuing UHL concerns over the performance of the new non-emergency patient transport contract.

In discussion on the quality/patient experience/operational targets/HR aspects of the month 4 report (and Divisional heatmap) members:-

(a) queried why issues relating to ward fridges had emerged seemingly only as a result of a recent CQC visit, rather than being appropriately reflected in Divisional risk registers. Although advising that ward sisters were aware of their authority to spend on such issues, the Chief Operating Officer/Chief Nurse and the Acting Medical Director acknowledged the need for a clear communication on this matter (events planned accordingly). The Finance and Performance Committee reiterated its concern over whether Divisional risk register entries were percolating upwards appropriately, and sought assurance that risk management arrangements would be strengthened accordingly;

(b) queried whether the good performance on fractured neck of femur was sustainable if activity levels were to increase;

(c) queried how to ensure greater Consultant input to ward review and notation at an appropriately early stage in the day, which the Acting Medical Director agreed to feed back to the Medical Director accordingly; **AMD**

(d) sought assurance on the level of clinical buy-in (from key specialties) to the 62-day cancer waits target. A new referral pathway had been agreed with GPs, and it was anticipated that all work would shortly return in-house. The August 2012 position looked promising, however, the exception notice had not yet been lifted which was frustrating. The Finance and Performance Committee Chairman queried the accounting treatment for the penalty, although noting UHL's intention to dispute it;

(e) queried again UHL's scope to penalise partners in respect of delayed transfers of care (DTOCs) performance, although noting the historic agreement not to do so. The 28 August 2012 contract meeting had not covered the issue of DTOCs, nor had DTOCs leads been present at that meeting;

(f) queried plans to address the significant variations in the Net Promoter Scores within UHL. The Chief Operating Officer/Chief Nurse outlined the measures in place (including reporting the lowest performing wards to the GRMC), although noting the key need for local ownership;

(g) sought assurance that the national and local IT system issues would be resolved in respect of Choose and Book, and

(h) again queried the figures within the ED front door audit appended to paper D (in respect of % of patients advised to go to ED by their GP), noting the seemingly very low number for July 2012.

The Director of Finance and Procurement then reported on UHL's financial position for month 4, noting the very disappointing performance which had resulted in a cumulative £3.8m deficit for the year to date (£3.1m adverse to plan). The non-pay position was significantly adrift, the reasons for which were being explored urgently (details of non-pay spend by category and by CBU/Division now tabled for information). Pay variances continued to be explained by the rise in activity – although contracted WTEs had reduced, the rise in premium payments for additional capacity was not offset by tariff. The Director of Finance and Procurement also noted the impact of the marginal rate on UHL (as per contract discussions with Commissioners on 28 August 2012 re: ED attendance levels), and of the fall in elective inpatient activity in month 4.

With regard to the individual Divisional positions, Planned Care was reporting a significant variation to plan particularly in respect of musculo-skeletal services, with non-pay a key issue.

The Finance and Performance Committee Chair noted his disappointment at the month 4 position, which he agreed to highlight verbally to the Trust Board on 30 August 2012. **FPC CHAIR**

<u>Resolved</u> – that (A) the month 4 quality and performance report (month ending 31 July 2012) be noted;

(B) queries on how to increase the level of Consultant input into ward reviews (at an appropriately early point in the day), be highlighted to the Medical Director, and; **AMD**

(C) Finance and Performance Committee disappointment at the July 2012 financial position (and year-end forecast as discussed in Minute 117/12/2 below) be highlighted to the 30 August 2012 public Trust Board. **FPC CHAIR**

117/12/2 <u>Financial Forecast</u>

In addition to paper D above, the Director of Finance and Procurement also tabled a 2012-13 forecast report (paper D1), noting the significant impact of the marginal rate which affected Planned Care in particular. At its meeting on 28 August 2012, the Executive Team had discussed whether to reinforce the existing centrally-driven recovery controls on Divisions/CBUs. In talking the Committee through tabled paper D1, the Director of Finance and Procurement advised that the "central" element of the 2012-13 CIP was not yet allocated, and he commented on the very challenging position facing UHL. A list of potential risks and opportunities to mitigate the current forecast deficit was detailed on page 3 of paper D1, noting that Divisions would produce detailed recovery plans (based on that list) over the coming week. Reducing the level of premium pay spend was crucial, and a review was therefore required of capacity issues. The potential quantum of any contract challenges was capped at 10% of the contract value.

2012-13 CIP delivery was £5.9m short as at month 4, and the Director of Finance and Procurement commented on the need for more robust challenge of plans going forward. The existing controls on discretionary spend would also be reinforced to all staff, and the review of non-pay spend (as noted in Minute 117/12/1 above) would also be crucial to understand whether performance in recent months constituted a trend or a blip.

In discussion on the financial forecast, the Finance and Performance Committee:-

(a) voiced its significant disappointment at the position, and requested that it be discussed further in the private session of the 30 August 2012 Trust Board (given that it was not yet fully developed). The position would of course also be covered in the public Trust Board session on 30 August 2012, at which the Trust would report that a financial recovery plan was being developed ahead of further public discussion in September 2012; **DFP**

(b) reiterated the need for urgent and appropriate action to remedy the current financial position and year-end forecast;

(c) reiterated its view that centrally-imposed and driven controls must be adopted, rather than at Divisional level;

(d) noted the need for the Trust Board to be cognisant of the need to balance any reduction in ward/bed capacity with the need to achieve key operational targets;

(e) requested a Divisional trajectory for reducing premium agency use (with timescales), for discussion at the September 2012 Finance and Performance Committee; **DFP/ DHR**

(f) noted the queries raised at the July 2012 Trust Board by Mr R Kilner Non-Executive Director, in respect of the management capacity and capability statements within the Provider Management Regime return, which he intended to voice again;

(g) noted the need for Executive Directors to provide assurance on the actions planned to address the current financial position;

(h) suggested exploring the scope for charitable funding of furniture for patient areas (subject to the need for assurance that such use was appropriate and in line with Leicester Hospitals Charity's objectives), and **DFP**

(i) agreed that the Finance and Performance Committee must have advance sight of the more detailed financial recovery plan ahead of its September 2012 meeting (and the late September 2012 Trust Board). Noting Executive Team discussions scheduled for 4 September 2012, it was agreed to use the 13 September 2012 Finance and Performance Committee premeet also to discuss the more detailed financial recovery plan, and to invite Mr R Kilner and Ms J Wilson Non-Executive Directors to attend that premeet accordingly. **DFP**

<u>Resolved</u> – that (A) the tabled financial forecast position be discussed further in the private session of the 30 August 2012 Trust Board, noting the Committee's significant disappointment at the position; **DFP**

(B) the financial position and forecast be highlighted verbally to the public 30 August 2012 Trust Board, noting the work in progress to develop a recovery plan for report to the September 2012 Trust Board; **FPC CHAIR**

(C) the 2012-13 recovery plan be further developed for discussion at the 13 September 2012 Finance and Performance Committee premeet and circulated in advance of that meeting (Ms J Wilson and Mr R Kilner Non-Executive Directors, to be invited to session accordingly), ahead of the late September 2012 Finance and Performance Committee and Trust Board meetings; **DFP**

(D) the potential use of charitable funds be explored for purchasing furniture for patient areas (subject to appropriate assurances as noted above), and **DFP**

(E) a Division-by-Division trajectory for reducing non-contracted WTEs be presented to the 26 September 2012 Finance and Performance Committee. **DFP/ DHR**

117/12/3 <u>Potential Impact of Financial Penalties on UHL</u>

<u>Resolved</u> – it be agreed that this item had been covered in Minutes 117/12/1 and 117/12/2 above.

117/12/4 <u>2012-13 CIPs and Transformation Programme – Progress</u>

Paper E from the Director of Finance and Procurement briefed the Committee on CIP performance for 2012-13 and on major transformation projects. The Head of Transformation Programmes attended for this discussion and that in Minute 117/12/5 below, noting that a shortened version of paper E would be available for future Finance and Performance Committee meetings. 2012- 13 CIP delivery year to date stood at 82%, therefore showing (disappointingly) no improvement since the previous month. The most significant gaps remained within the Planned Care and Clinical Support Divisions, although both of those

were now reporting increased confidence re: future delivery. With regard to specific schemes within UHL's transformation programme, the Finance and Performance Committee noted:-

(a) that since issuing papers E and F a refocused scope had been received for the outpatients scheme, which would be circulated to members for information. There was a need to augment the transformation resource currently dedicated to the outpatients scheme, which was being explored accordingly. Good work was in progress to reduce Did Not Attend rates through the use of SMS texting, with a likely full-year effect of £300k (potential £800k if rolled out more widely); **HoTP/ DFP**

(b) the need to progress IT integration issues re: the EPMA project, with the Chief Information Officer – this had been escalated a number of times with the system provider and now required Executive-level intervention. The amber-red rating for this scheme reflected the timescale of the original business case, and the Head of Transformation Programmes advised members that some significant benefits had been reaped from the project to date. However, the return on investment was likely to be less than originally anticipated;

(c) implementation of the outsourcing transcription services project had slipped to the first week of October 2012 following a mini-pilot on 10 September 2012. This would not affect the financial savings associated with the scheme but could impact on management of change requirements if slipped any further;

(d) (in response to a query) that not all of the individual transformation schemes were being managed through the Transformation Support Office. A number of Director portfolio changes were also being discussed at the 30 August 2012 UHL Remuneration Committee, which could impact on Executive leadership of the transformation programme, and

(e) the need to clarify the CIP target summary within paper E and reconcile this to the correct figure. **DFP**

<u>Resolved</u> – that (A) the update on the 2012-13 CIP delivery and transformation programme be noted;

(B) an updated scope for the outpatients transformation scheme be circulated for information, and **DFP/ HoTP**

(C) the target CIP figure for 2012-13 be clarified and included in future CIP update reports. **DFP**

117/12/5 <u>First Cut of Data Underpinning the Long Term Financial Model (LTFM)</u>

As previously reported, a draft top-down LTFM was in preparation for the end of September 2012, noting the requirement to submit a draft model to the Midlands and East SHA by 31 October 2012. As achievement of upper quartile productivity assumptions would not meet the current financial gap, the Head of Transformation Programmes advised that she had requested Divisions to assess the impact of aiming for upper decile productivity assumptions instead. She also noted the need to review the overall management resources dedicated to the transformation programme and LTFM workstreams within UHL. In discussion on paper F the Finance and Performance Committee:- **DFP**

(a) noted that gains from transforming outpatients were not included in the current financial modelling;

(b) noted (in response to a query) that certain UHL services were already achieving upper quartile productivity – a list of Trust specialties and their positions against the upper quartile and upper decile would be provided to the September 2012 Finance and Performance Committee accordingly, also reflecting the services' PLICS position, and **DFP/ HoTP**

(c) queried why the ENT project was not currently included in the assumptions – the Director of Finance and Procurement agreed to pursue this with the Planned Care Divisional Director (as the Divisional sponsor). **DFP**

<u>Resolved</u> – that (A) a list of UHL specialties be provided to the September 2012 Finance and Performance Committee, showing their current performance relative to upper quartile and upper decile levels, the impact on productivity/performance of achieving those levels, and the correlation to the specialties' current PLICS position; **DFP/ HoTP**

(B) the position re: the ENT transformation scheme be clarified with the Divisional Director, Planned Care outside the meeting, and **DFP**

(C) the first cut Integrated Business Plan and LTFM be presented to the 26 September 2012 Finance and Performance Committee. **DFP**

118/12 NON-MEDICAL EDUCATION AND TRAINING FUNDING LEVY (NMET)

Paper G outlined the existing NMET levy for UHL, including the Learning Beyond Registration allocation and the impact of rebasing MPET (multi-professional education and training) funding in 2013. Non-Executive Director members of the Finance and Performance Committee expressed some residual uncertainty on the various funding positions, and agreed to seek clarification from the Chief Operating Officer/Chief Nurse outside the meeting on any queries. **NEDs**

<u>Resolved</u> – that any queries/clarifications on the NMET briefing paper be raised with the Chief Operating Officer/Chief Nurse outside the meeting. **NEDs**

119/12 ITEMS FOR INFORMATION

119/12/1 <u>Cancelled Operations Workstream</u>

Paper H advised of progress in reducing hospital cancelled operations, as per the action plan developed in May 2012. The Chief Operating Officer/Chief Nurse confirmed that the figures also included cancellations in the week prior to the operation and she outlined the specific reasons for a very recent rise in that element. The Finance and Performance Committee noted its view that this was a transformation scheme involving lean working, and noted the 1 September 2012 deadline for delivery of the action plan (the Trust's Head of Operations was now leading progress on this workstream).

<u>Resolved</u> – that the report on reducing hospital cancelled operations be noted.

120/12 MINUTES FOR INFORMATION

<u>Resolved</u> – that (A) the 23 July 2012 GRMC Minutes be noted for information, and

(B) the following sets of action notes be received by the 26 September 2012 Finance and Performance Committee for information:- **STA**
(1) 15 August 2012 Confirm and Challenge, and
(2) 5 September 2012 QPMG.

121/12 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper J comprised a draft agenda for the 26 September 2012 Finance and Performance Committee. Noting the planned Divisional presentations for 2 hours, it was agreed to extend the duration of that meeting from 8.15am – 1pm; those Divisional presentations should also focus on remedial actions, with a revised template to be issued accordingly by the Finance team. The discussion on earned autonomy should be taken immediately after those Divisional presentations (subject to discussion with the Interim Chief Executive as to whether that might be a more appropriate item for Trust Board rather than Finance and Performance Committee). The Finance and Performance Committee Chair reiterated the need for the Divisional presentations to be available to Committee members in advance. **ICE**

Resolved – that (A) the 26 September 2012 Finance and Performance Committee agenda be approved, subject to the comments above (including the extended duration), and **STA**

(B) a view be sought from the Interim Chief Executive as to whether it was appropriate for the Finance and Performance Committee to discuss earned autonomy issues. **ICE**

122/12 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following items be highlighted verbally to the Trust Board on 30 August 2012:- **FPC CHAIR**
(1) financial position and forecast 2012-13, and the intention to develop an appropriate recovery plan for discussion at the 27 September 2012 public Trust Board, and
(2) (private session) more detailed discussion on the financial forecast and remedial plans to date.

123/12 ANY OTHER BUSINESS

123/12/1 Deputy Director of Finance and Procurement

Given that this was his last Finance and Performance Committee before leaving UHL, Committee members voiced their thanks to the Deputy Director of Finance and Procurement for his contribution to the Trust during his time in post, and wished him well for the future.

Resolved – that the position be noted.

112/12 DATE OF NEXT MEETING AND 2013 MEETING DATES

Resolved – that (A) the next Finance and Performance Committee be held on Wednesday 26 September 2012 from 8.15am – 1pm in rooms 2 & 3, Clinical Education Centre, Glenfield Hospital, and

(B) Finance and Performance Committee meeting dates for 2013 be circulated to members, as previously reviewed by the Finance and Performance Committee Chair (involving a December 2013 meeting on either 23 or 24 December 2013). **STA**

The meeting closed at 12.30pm

Helen Stokes – **Senior Trust Administrator**