University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 22 December 2014

COMMITTEE: Finance and Performance Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 26 November 2014

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

- **Confidential Minute 122/14 – report by the Chief Executive**

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

- **Minute 126/14/3 – update on the Emergency Floor OBC, and**
- **Minute 127/14/4 – operational performance (including RTT).**

DATE OF NEXT COMMITTEE MEETING: 18 December 2014

Ms J Wilson
16 December 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 26 NOVEMBER 2014 AT 8.30AM IN SEMINAR ROOMS A AND B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Acting Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (excluding Minutes 123/14 and 124/14)
Mr P Traynor – Director of Finance
Mr G Smith – Patient Adviser (non-voting member)

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Mr J Clarke – Chief Information Officer (for Minute 122/14)
Dr S Dauncey – Non-Executive Director (excluding Minutes 123/14 to 125/14)
Mr P Gowdridge – Head of Strategic Finance (for Minutes 122/14 and 126/14/3 to 126/14/4)
Ms J Fernihough – IBM Executive Partner (for Minute 122/14)
Dr S Jackson – Chief Medical Information Officer (for Minute 122/14)
Ms E MacLellan-Smith – Ernst Young (for Minute 128/14/2)
Ms D Mitchell – Interim Alliance Director (for Minute 126/14/2)
Mrs K Rayns – Trust Administrator
Mr P Richards – IBM Executive Partner (for Minute 122/14)
Mr I Scudamore – Clinical Director, Women's and Children's CMG (for Minute 126/14/1)
Mr K Singh – Trust Chairman
Mr M Traynor – Non-Executive Director
Mr D Yeomanson – General Manager, Women's and Children's CMG (for Minute 126/14/1)

RECOMMENDED ITEM **ACTION**

122/14 REPORT BY THE CHIEF EXECUTIVE

Recommended – that this Minute be classed as confidential and taken in private on the grounds of commercial interests.

RESOLVED ITEMS

123/14 APOLOGIES AND WELCOME

An apology for absence was received from Ms K Shields, Director of Strategy. The Acting Committee Chair welcomed Mr P Traynor, Director of Finance to his first meeting of the Finance and Performance Committee.

Members noted that the Finance and Performance Committee was due to be replaced by the Integrated Finance, Performance and Investment Committee (IFPIC) in January 2015. These meetings would be scheduled on the final Thursday of each month to commence at 9am (instead of 8.30am).

124/14 MINUTES

Resolved – that the Minutes of the 29 October 2014 Finance and Performance Committee meeting be submitted to the 18 December 2014 meeting.

125/14 MATTERS ARISING PROGRESS REPORT

The Acting Committee Chair confirmed that the matters arising report provided at paper A detailed the status of all outstanding matters arising. Members received updated information in respect of the following items:-

(a) Minute TBC (21) of 29 October 2014 – the Trust Chairman voiced his concerns regarding the pace of progress with the Empath 5-year Business Plan. An update on this item was due to be consider later in the agenda (Minute 126/14/4 below refers);

(b) Minute 103/14/5(c) of 24 September 2014 – the update on landlord elements of University occupied UHL premises had been deferred to the 18 December 2014 Finance and Performance Committee meeting, to allow for appropriate prior consideration by the Executive Performance Board (on 16 December 2014);

(c) Minute 104/14/3(b) of 24 September 2014 – an update on the focused workstream with the Renal Respiratory and Cardiac CCG was due to be provided later in the agenda (Minute 127/14/3 below refers). However, this was not expected to include any proposals for the development of a single technical solution, which might link with the development of the Electronic Patient Record;

(d) Minute 91/14/2(c) of 27 August 2014 – Colonel (Retired) I Crowe, Non-Executive Director queried the timescale for resolution of the issues relating to revised patient restraint guidance and appropriate intervention by security staff. It was agreed that the Trust Administrator would seek an update from the Chief Nurse on this matter for circulation outside the Committee, and **TA**

(e) Minute 91/14/3 of 27 August 2014 – proposals for the development of continuous improvement in the FM contract had been deferred to the 18 December 2014 Finance and Performance Committee meeting, to allow for appropriate prior consideration by the Executive Performance Board (on 16 December 2014).

<u>Resolved</u> – that the matters arising report and any associated actions above, be noted. **NAMED LEADS**

126/14 STRATEGIC MATTERS

126/14/1 <u>CMG Presentation – Women's and Children's Services</u>

Mr I Scudamore, Clinical Director and Mr D Yeomanson, General Manager attended the meeting from the Women's and Children's CMG to present an overview of current financial and operational performance (as detailed in paper C). Introductions took place. The presentation was taken as read and the CMG team was invited to comment on the top 3 current issues that were causing the most concern. In response, the CMG team reported verbally on the following key issues:-

(a) RTT performance – non-admitted performance in clinical genetics for October 2014 stood at 76%, reflecting a considerable increase in activity over the last 5 years and a reduction in the Consultant body (following 2 retirements and a replacement Consultant relocating to Scotland). Recruitment in this specialist area had proved challenging, but a further advertisement was due to be placed (in the hope of attracting 2 available potential candidates) and registrars were being trained locally with a view to succession planning.

Theatre capacity in Gynaecology had previously been supported through utilisation of other CMGs' cancelled sessions, but this opportunity had reduced as the CMGs improved their utilisation rates. In addition, some Gynaecology activity (60 to 70 cases) had been lost as a result of theatre refurbishment works. To mitigate this, additional ambulatory Gynaecology cases would be delivered in an OPD setting and

work was taking place to improve day case utilisation. Approximately 20 cases had been transferred to the private sector that week;

(b) East Midlands Congenital Heart Service – the Trust's response to the NHS England Congenital Cardiac Services Review would require children's cardiac services to be co-located with other children's services and each centre would be required to undertake a total of 500 procedures per year (125 each for 4 Consultants). The timescale for the required changes was not yet clear but it was expected to be between 18 months and 5 years. In the interim period, it was intended to strengthen Children's services provided from Glenfield Hospital, uncouple them from the adult services and develop appropriate networking engagement with other centres to increase activity levels, and

(c) Future configuration of Maternity Services – subject to public consultation, UHL's strategic 5 year plan focused upon provision of obstetric-led maternity services from a single site. Level 3 ITU provision was expected to cease being provided on the LGH site within the next 12 months and arrangements would be required to manage a small number of low risk patients (eg 10 to 12 patients per year out of 4,300 deliveries) who might need level 3 care as a result of an unexpected deterioration in their condition. During the interim period, arrangements were being made to provide additional level 2 intensive care and HDU support for Maternity Services on the LGH site until 2017-18 with outreach into the delivery suite. Discussion took place regarding the process for sighting the Trust Board to this issue and it was agreed that the vehicle for this would be the Better Care Together Strategic Outline Case.

In discussion on the issues raised, Finance and Performance Committee members:-

(1) considered the workforce issues associated with embedding HDUs and ITUs within Maternity Services, given that the career path for Midwives was now direct entry (without prior nurse training). To mitigate this, a focus was being maintained in respect of skill mix and additional conversion courses for trained nurses were being offered through DeMontfort University;
(2) confirmed that the proposal to build up networking opportunities with other paediatric congenital heart centres was felt to be the most realistic scenario for building UHL's activity levels to achieve the national standard;
(3) queried whether there were any particular contributory factors affecting medical staffing recruitment, noting in response that the fill rate for training vacancies was good but it was proving challenging to recruit Consultants. Historically, the split site service, disjointed shift patterns and lack of training continuity had adversely affected recruitment and retention of staff. Feedback had also been provided that the service requirements were not always aligned with individual training needs, and
(4) noted that the business cases for development of a single Children's Hospital and a single Women's Hospital could now progress to Outline Business Cases (OBCs) due to the BCT programme setting out the Strategic Outline Case (SOC) for these changes.

The Acting Chair summarised by congratulating the CMG on their consistent financial and operational performance and robust approach to CIP delivery. She sought and received assurance regarding the process for converting 2015-16 CIP schemes from red to green RAG ratings, noting that the milestone to complete this work by the end of November 2014 was unlikely to be met, but work continued with EY to ensure that all the schemes were deliverable and this work would be completed by mid-December 2014. As in previous years, the CMG had set itself a target of 120% CIP delivery, to create a contingency to mitigate any slippage on individual schemes. In respect of RTT delivery, it was confirmed that the most challenged specialties were receiving additional support to maximise capacity and additional weekend lists would be continued.

Resolved – that the presentation and discussion on financial and operational

performance of the Women's and Children's CMG be received and noted.

126/14/2 Alliance Contract – High Level Programme for Transformation of Clinical Services

The Interim Director of the Alliance attended the meeting to present paper C, providing a summary of the high level programme for transforming identified UHL clinical services into the community setting. Appendix 1 provided an overview of the Better Care Together Planned Care Pathway Transformation workstream.

Particular discussion took place regarding the arrangements for transferring pain services into the community setting with effect from the fourth quarter of the year (January to March 2015) as this was recognised as the proof of concept case study. A recent change in clinical leadership had shifted the balance of clinical engagement in the scheme and the present clinical lead had highlighted some issues relating to clinical job planning. UHL had also raised concerns surrounding the expected loss of income and the duration of built in financial support to manage fixed cost pressures.

Other planned service changes would include ocular plastics, local anaesthetic hernia, and Barrett's Oesophagus (endoscopy) activity. Assurance was provided that the relevant business cases were being prepared for consideration by UHL's Revenue and Investment Committee and that the Trust would be supporting the principles of "left shift" into the community setting in accordance with the principles of Better Care Together Programme which aimed to provide the right services in the right place for patients, subject to the technical execution of the Alliance agreement that no organisation would suffer financial detriment as a result of the changes.

The Acting Chair requested that a further progress report on the transformation of UHL's clinical services to the Alliance be provided in January 2015. Finally, the Interim Alliance Director noted the need to clarify UHL's membership of the Alliance Management Board and the Alliance Leadership Board. **DS** **COO/ DF**

Resolved – that (A) the update and discussion on transformation of clinical services to the Alliance be received and noted;

(B) a further update be provided to the 29 January 2015 meeting, and **DS**

(C) UHL's membership of the Alliance Management Board and the Alliance Leadership Board be confirmed (outside the meeting) **COO/ DF**

126/14/3 Update on the Emergency Floor Outline Business Case (OBC)

The Chief Executive introduced paper E, particularly noting the pragmatic approach adopted towards activity assumptions and the letter of Commissioner support. The OBC was now scheduled for review by the regional TDA capital group in December 2014 and the national TDA capital investment group on 4 March 2015. Subject to TDA approval, the Full Business Case (FBC) would continue to be developed in parallel and it was expected that the main scheme would be ready to commence in April 2015.

In discussion on the report, the Finance and Performance Committee:-

(a) noted the potential impact of the 2015 general election (given that the purdah period would commence on 18 March 2015);
(b) sought and received additional information regarding the arrangements for re-commissioning Urgent Care provision on the LRI site and integrate this with the out of hours service. The contract was due to be re-tendered with a commencement date of April 2016 and UHL had already expressed a desire to be involved in the procurement process (as host of this service);
(c) confirmed that the proposed activity assumptions (provided on page 4 of paper E)

reflected a worst case scenario and that the sizing of capacity reflected a robust financial business case;

(d) queried the impact of marginal rate emergency tariff (MRET) upon the proposals, noting in response the Chief Operating Officer's view that the Trust should seek to re-set the 2008-09 MRET baseline once the Emergency Floor was opened and the assessment units were co-located in the new facilities, and

(e) requested that the activity scenarios be worked through in more depth as part of the work on the FBC. **DF**

Resolved – that (A) the proposed emergency activity assumptions be worked through in more depth, and **DF**

(B) the Emergency Floor FBC be presented to the Finance and Performance Committee in December 2014 or January 2015. **CE**

126/14/4 Progress Report on the Development of the Empath Business Case

The Director of Finance and the Head of Strategic Finance reported verbally, providing feedback from a recent meeting of the Empath Shareholders Group and commenting generally on the level of understanding (both within and outside of the host Trusts) in respect of the Empath model and the associated governance arrangements.

Mr N Calow, the Empath Finance Director was preparing a briefing paper on this subject and opportunities were being explored to separate the different components of the Empath service and establish a proper arms length body. Colonel (Retired) I Crowe, Non-Executive Director noted that Internal Audit had flagged 2 risks surrounding Empath governance arrangements. It was agreed that an update on this workstream would be presented to the Integrated Finance, Performance and Investment Committee in January 2015, alongside the Full Business Case.

Resolved – that the Empath FBC and a briefing paper on the Empath governance structure be presented to the 29 January 2015 meeting of the Integrated Finance, Performance and Investment Committee. **DF**

127/14 PERFORMANCE

127/14/1 Month 7 Quality and Performance Report

Paper F provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 31 October 2014. The Chief Operating Officer reported on the following operational aspects of the report:-

(a) Emergency care 4 hour waits – a detailed update would be provided to the Trust Board on 27 November 2014 and this was expected to focus on patient inflow, outflow, attendance levels, delayed discharges, internal effectiveness, advice on ways of reducing clinical variability and the LLR response to the report produced by Dr I Sturgess;

(b) RTT 18 weeks (Minute 127/14/2 below refers);

(c) Cancer performance continued to be variable – the Executive Performance Board had considered this issue on 25 November 2015 and noted that small teams of pathway validation resources were shared between RTT and the cancer centre. Regular meetings were being held with the 5 most challenged tumour site teams;

(d) Cancelled operations performance had improved significantly and was now compliant with the target of no more than 0.8% of on the day cancellations. Only 2 of these cancellations had breached the target to rebook within 28 days, and

(e) Choose and Book slot availability stood at 20% – although compliant performance had not been achieved previously, a great deal of work was taking place in this area and it was expected that compliance with the 4% target would be achieved in the near future.

In respect of diagnostics performance, Dr S Dauncey, Non-Executive Director and Quality Assurance Committee (QAC) chair highlighted an issue affecting mammography pathways which was due to be considered at that afternoon's QAC meeting. The Chief Operating Officer advised that UHL had recently appointed a Director of Performance and Information who would be commencing in post in January 2015.

Resolved – that the month 7 Quality and Performance report (paper F) and the subsequent discussion be received and noted.

127/14/2 Progress Report on RTT Improvement Plan

The Chief Operating Officer referred members to the RTT exception report, as provided on pages 13 to 16 of the Quality and Performance report (paper F). He advised that the November 2014 target to achieve 95% RTT admitted compliance had not been met and that the earliest that compliance could be expected now was January 2015. Some robust improvements had been made within all the challenged specialties but the early pace of embedding the changes had not been as fast as required. Within the non-admitted target, Orthopaedics waiting lists were causing the most concern.

The Acting Chair queried whether any additional support would be required to improve RTT performance within the Orthopaedics speciality and it was agreed to invite the service to attend the Integrated Finance, Performance and Investment Committee meeting in January or February 2015 to explore any additional areas of support that might be required. Members noted that the Trust Board walkabout on 27 November 2014 would include some of the Orthopaedics services based at Glenfield Hospital and that additional weekend operating lists were being held in order to address an increase in referrals which was also being experienced at a national level. **COO**

The Chief Executive noted the need to brief Trust Board members on the revised RTT trajectory ahead of the Board to Board meeting with the NTDA on 7 January 2015 and he suggested that a detailed review of the Trust's trajectory towards RTT compliance be undertaken at the 18 December 2014 Finance and Performance Committee meeting. **COO**

Resolved – that (A) the exception report and discussion on RTT performance be received and noted,

(B) representatives from the Orthopaedics service be invited to attend the Integrated Finance, Performance and Investment Committee meeting in January or February 2015 to explore any additional areas of support required to improve RTT performance, and **COO**

(C) a detailed review of UHL's trajectory towards achieving a compliant RTT position be undertaken at the 18 December 2014 Finance and Performance Committee meeting. **COO**

127/14/3 Clinical Letters Performance

The Chief Operating Officer reported verbally on improvements in clinical letters performance within the Renal, Respiratory and Cardiac CMG following a focused piece of work within that CMG over the last 6 weeks. The backlog of letters awaiting typing had reduced from approximately 1,400 to 400 and all of the vacant administrative and clerical positions had been recruited to. Arrangements were being made with the IM&T

department regarding the arrangements for further embedding Dictate IT and the associated CMG entry on the risk register was due to be re-scored accordingly.

This rapid improvement had provided the evidence required for proof of concept and arrangements were now being made to roll-out this robust approach to the remaining CMGs, recognising the importance of timely discharge and clinic correspondence. A further update on progress would be provided to the 18 December 2014 meeting. **COO**
Subject to the outcome of this workstream, proposals to implement a single technical solution for the Trust had been put on hold.

Resolved – that the improved clinical letters performance in the RRC CMG be noted and an update on proposals to roll-out the same approach within the remaining CMGs be provided on 18 December 2014. **COO**

127/14/4 Update on the Ambulance Turnaround Action Plan

Paper G provided a short position statement on the contractual elements of ambulance turnaround times and the process for gathering robust data to support accurate performance reporting.

Since paper G had been circulated, Commissioners had agreed to change UHL's data capture mechanism to the more widely used RFID tagging. This system was generally accepted to be more accurate and this was expected to be in place by the fourth quarter of 2014-15. In the meantime, UHL would continue to work with EMAS to improve ambulance handover processes. An update on the impact of the new data capture mechanism would be provided in February 2015. The Trust Chairman commented that **COO**
he would be meeting with the EMAS Chairman in the near future and that this issue was likely to feature in their discussions.

Resolved – that an update on ambulance turnaround times and the impact of the new data capture mechanism be provided to the Integrated Finance, Performance and Investment Committee on 26 February 2015. **COO**

128/14 FINANCE

128/14/1 2014-15 Financial Position to Month 7

The Director of Finance introduced papers H and H1 providing an update on UHL's performance against the key financial duties surrounding delivery of the planned deficit, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 27 November Trust Board and the 25 November Executive Performance Board (respectively). He particularly drew members' attention to the following key risks:-

(a) data warehouse errors which had led to the month 7 income position being estimated. Some immediate IBM resources had been agreed to address the problem which had arisen from some experienced UHL staff leaving and not being replaced. Assurance was provided that additional monitoring and scrutiny arrangements had been implemented. Since the reports had been circulated, the confirmed income position had improved by £600,000;
(b) the contractual position with Commissioners and the process for handling activity query notices. A memorandum of understanding had been signed off to agree a collaborative framework of principles to handle specific areas of dispute, although this had already been superseded by subsequent discussions, and
(c) the ability of CMGs to deliver their control totals whilst handling winter pressures. With effect from January 2015, weekly meetings would be held with each CMG to monitor their performance.

In response to Non-Executive Directors' questions on the financial report, the Director of Finance advised that:-

(i) the cash flow forecast was robust for 2014-15 and an update on the longer-term cash flow position would be included in future iterations of the financial performance reports; **DF**
(ii) premium pay expenditure trends were increasing and the most noticeable increase in nursing agency use within Emergency and Specialist Medicine. For 2015-16, one of the 4 cross-cutting CIP schemes would specifically focus on workforce, and
(iii) the Musculoskeletal and Specialist Surgery CMG was being held to account for its revised year end control total and a significant portion of the data warehouse additional income had been attributed to this CMG. A detailed review of the first half year performance was being undertaken and the CMG was expected to deliver a break-even position for the second half of the financial year (which would be a positive improvement on the earlier forecast position).

Resolved – that the briefings on UHL's Month 7 financial performance (papers H and H1) and the subsequent discussion be noted.

128/14/2 Cost Improvement Programmes for 2014-15 and 2015-16

Ms E MacLellan-Smith, EY attended the meeting to present paper I, providing the monthly update on CIP performance for 2014-15 and plans for 2015-16. Members noted that the total forecast CIP value for 2014-15 stood at £48.16m and that the value of green RAG-rated schemes had now exceeded the £45m target for the first time (£45.14m). Work was continuing to convert the remaining £3m red and amber schemes to green, but in the event of any slippage, arrangements would be made to bring forward some of the early 2015-16 schemes to make up the difference. The main risks to full delivery of the required savings for 2014-15 relating to management of operational pressures during the winter period and recruitment of nursing staff in Emergency and Specialist Medicine to reduce agency nursing expenditure.

For the 2015-16 programme, the Trust was not likely to meet the end of November 2014 milestone to have 60% of its plans (against the £41m target) RAG rated green or amber, but this was expected to be achieved during the early part of December 2014. Wave 2 of the service reviews in loss-making specialties was underway – this included dermatology, cardiology and general surgery. A more joined-up approach was being developed to reduce the risk of double-counting CIP benefits within wider business case development and the Better Care Together Programme.

In respect of the 4 high impact cross-cutting CIP themes for 2015-16, the Chief Operating Officer had been confirmed as the SRO for (1) beds, (2) theatres and (3) outpatients and the Director of Finance had been confirmed as the SRO for (4) workforce. Substantive appointments had been made for 2 of the 7 PMO support roles for the CMGs and interviews for the remaining 5 posts would be held in December 2014. Appropriate EY and UHL training and development programmes would be provided for all these postholders.

Colonel (Retired) I Crowe, Non-Executive Director noted that no progress had been reported in respect of the Research and Development Directorate's CIP target for 2015-16 and he queried whether there were any issues that the Committee should be aware of. In response, it was noted that the Directorate had not appreciated the scale of the target or the milestones required. It was agreed that an update on this issue would be incorporated into the next iteration of the CIP report. **COO**

The Director of Finance reported verbally on the new PMO assurance processes, noting that weekly meetings would be held on a Monday afternoon starting in January 2015. He also endorsed the strategic approach to 2015-16 CIP planning, noting that December

was a key month for assessing the progress of CIP plans for the next financial year.

Resolved – that (A) the CIP update (paper I) and the subsequent discussion be noted, and

(B) an update on the R&D Directorate's progress with 2015-16 CIP planning be included in the December 2014 CIP update. **COO**

128/14/3 Patient Level Information and Costing System (PLICS), Service Line Reporting (SLR) and Reference Costs Update

Paper J provided the quarterly update on the continued development of PLICS and SLR and an update on the Trust's 2013-14 Reference Cost submission. Appendix 1 set out the SLR position broken down by CMG and service and appendix 2 provided a comparison of the index scores with other peer group Trusts. In view of time constraints at this meeting, and the limited opportunity for the Director of Finance to comment on the accuracy of this data or the embedded position, it was agreed to defer a substantive discussion on this item to the next meeting. **DF**

The Committee noted a need for Non-Executive Directors and the wider Trust Board membership to receive some form of financial awareness training in order to fully interpret and appreciate the impact of the Reference Cost scores. In summary, the Director of Finance noted the purpose of the reference costs information and confirmed that UHL's draft position for 2013-14 had worsened to 101 (from 97 in the previous 2 years). **DF**

Resolved – that (A) a substantive discussion on the PLICS/SLR and Reference Cost update be deferred to the 18 December 2014 meeting, and **DF**

(B) the Director of Finance be requested to explore the scope to provide financial awareness training for all Trust Board members. **DF**

129/14 SCRUTINY AND INFORMATION

129/14/1 Clinical Management Group (CMG) Performance Management Meetings

Colonel (Retired) I Crowe, Non-Executive Director commented on the lack of some CMGs' responses to the identified actions arising from these meetings.

Resolved – that the action notes arising from the October 2014 Performance Management meetings (paper K) be received and noted.

129/14/2 Executive Performance Board

Resolved – that the notes of the 28 October 2014 Executive Performance Board meeting (paper L) be received and noted.

129/14/3 Quality Assurance Committee (QAC)

Resolved – that the 29 October 2014 QAC Minutes (paper M) be received and noted.

129/14/4 Revenue Investment Committee

Resolved – that the 17 November 2014 Revenue Investment Committee notes (paper N) be received and noted.

129/14/5 Capital Monitoring and Investment Committee

Resolved – that the 17 November Capital Monitoring and Investment Committee notes (paper O) be received and noted.

130/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper P provided a draft agenda for the 18 December 2014 meeting and it was agreed that the agenda would be revised following discussion at today's meeting and re-circulated accordingly.

Resolved – that the items for consideration at the Finance and Performance Committee meeting on 18 December 2014 be revised and re-circulated. **TA**

131/14 ANY OTHER BUSINESS

Resolved – that no other items of business were noted.

132/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 27 November 2014:- **Acting Chair**

- **Confidential Minute 122/14 – Report by the Chief Executive;**
- **Minute 126/14/3 – update on the Emergency Floor OBC, and**
- **Minute 127/14/1 – operational performance (including RTT performance).**

133/14 DATE OF NEXT MEETING

The Trust Administrator was requested to change the venue for the 18 December 2014 Finance and Performance Committee meeting to the Leicester Royal Infirmary. **TA**

Resolved – that the next Finance and Performance Committee be held on Thursday 18 December 2014 from 8.30am – 11.30am in the Board Room, Victoria Building Leicester Royal Infirmary (please note change of venue).

The meeting closed at 11:45am

Kate Rayns, Acting Senior Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Acting Chair from 29.10.14)	8	7	87%	P Hollinshead	3	3	100%
R Kilner (Chair up to 24.9.14)	6	6	100%	S Sheppard	4	4	100%
J Adler	8	7	87%	G Smith *	8	8	100%
I Crowe	8	7	87%	P Traynor (from 26.11.14)	1	1	100%
R Mitchell	8	8	100%				

* non-voting members