Borders NHS Board

Meeting Date: 1 April 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

RESOURCES & PERFORMANCE COMMITTEE MINUTES 21.01.2021

Purpose of Report:

The purpose of this report is to share the approved minutes of the Resources & Performance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Resources & Performance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Resources and Performance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Compliant.
Consultation	Not Applicable.
Glossary	R&PC – Resources & Performance Committee

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 21 January 2021 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr M Dickson, Non Executive
Ms S Lam, Non Executive
Mr B Brackenridge, Non Executive
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Mrs A Wilson, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mrs J Smyth, Director of Strategic Change & Performance
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Mrs N Berry, Director of Nursing, Midwifery & Operations
Dr T Patterson, Director of Public Health
Mr A Carter, Director of Workforce
Mrs V McPherson, Partnership Representative

In Attendance:
Miss I Bishop, Board Secretary
Mrs S Horan, Deputy Director of Nursing, Midwifery & AHPs
Mr G Clinkscale, Associate Director of Acute Services
Dr A Cotton, Associate Medical Director
Dr J Bennison, Associate Medical Director
Ms S Laurie, Communications Officer

1. Apologies and Announcements

Apologies had been received from Mr John McLaren, Non Executive.

The Chair advised that Mr Bill Brackenridge would be departing the meeting at 9.45am.

The Chair confirmed the meeting was quorate.

The Chair reminded the Committee that a series of questions and answers on the papers had been provided and their acceptance would be sought at each item on the agenda along with any further questions or clarifications.

2. Declarations of Interest

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

Ms Sonya Lam declared that her partner was a specialist advisor for the Scottish Government. She further declared in regard to the Respiratory Service item on the agenda, that she had known the recently appointed respiratory consultant in a work and social capacity for 20 plus years.

Mr Tris Taylor declared that in regard to the Non Domestic Energy Efficiency Framework item on the agenda, he worked for Keltbray, a Group that includes a provider of renewable energy infrastructure.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declarations made by Ms Sonya Lam and Mr Tris Taylor as contained within the Board Q&A document.

3. Minutes of Previous Meeting

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The minutes of the previous meeting of the Resources and Performance Committee held on 5 November 2020 were amended at page 7, paragraph 2, last sentence to be replaced with "Regardless of ownership, it was essential that the organisation had the data required to control Board performance and expenditure." and with that amendment the minutes were approved.

4. Matters Arising

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

4.1 **Action 7:** Mr Ralph Roberts updated the Committee in regard to the delay with the Forensic Medical Examination Suite, mainly due to the identified location being used for the pandemic. He commented that NHS Borders was likely to be the last Health Board to have a physical unit in place. He advised that progress would be made as soon as it was feasible.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the action tracker.

5. Delayed Discharges

Mr Ralph Roberts commented that a partnership approach was key to reducing delayed discharges and where operational support was afforded progress was clearly made. An internal audit had taken place and the recommendations from that would need to be executed. Whilst progress was being made it was clear that numbers fluctuated on a daily basis and the partnership needed to remain focused on reducing delays throughout the complete pathway.

Mr Rob McCulloch-Graham drew the attention of the Committee to the findings of the internal report and commented that the major theme was in regard to systems and processes. There had obviously been non-compliance with policies that had been introduced and when an operational focus was put in place compliance improved and the number of delayed discharges reduced accordingly. There were managerial indicators in place and he provided the example that when social work input was available to the mental health service delayed discharges reduced and when that input was withdrawn delayed discharges increased. Subsequently a social worker had now been employed to support the mental health service.

Mr McCulloch-Graham further explained that there were issues in regard to guardianships and discussions took place with the local Sheriff Court to progress those swiftly. Investment had been put into nursing homes as the data had showed that the majority of delays were people waiting for high end nursing and subsequently 7 beds had be opened in Queens House, with an additional 5 beds purchased. There had clearly been an issue with delayed discharges in Community Hospitals and work was underway to mirror the traction provided in the Borders General Hospital and Mental Health services to ensure Community Hospitals complied with policies and processes and that work had already yielded a reduction from 25 to 12 over the previous week.

Mr Malcolm Dickson enquired if the problem areas were being targeted. Mr McCulloch-Graham confirmed that they were and highlighted that a new system and action plan had been put in place 4 months previously. An operational focus was being applied to Community Hospitals and capacity was now available in the care sector. The area of difficulty remained the provision of nursing care homes, however those numbers were relatively small.

Dr Lynn McCallum welcomed the review of weekend working and highlighted the main impact would be on the Borders General Hospital as the infrastructure was unlikely to be available in the Community Hospitals. She reminded the Committee that delayed discharges were medically fit patients and if the necessary social care support and pharmacy support was in place at the weekends there was no reason that those discharges could not be pre planned and executed.

Mrs Nicky Berry advised that she and Mrs Jen Holland co-chaired the Leadership Group across health and social care and were already in discussions regarding the whole system 7 day discharge process.

Ms Sonya Lam enquired how people could be prevented from deteriorating when they were admitted to hospital. Mr McCulloch-Graham commented that it was important to keep a patients length of stay as short as possible as the more the patient remained in hospital the less mobile they became and the less likely they were to return to their home with many being placed in residential care and losing their independence. Whilst progress had been seen with a reduction in length of stay, that was now increasing potentially due to the current pandemic.

Mrs Alison Wilson commented that she hoped the previous culture of individuals allowing patients to stay in hospital unnecessarily had now changed and she echoed the discussion on criteria lead discharge as the key element to reducing delays. In regard to pharmacy services she commented that the department had tried on several occasions to support a 7 day service, however it was clear that a 6 day service was all that was required from the pharmacy department, with the majority of complex patients planned well in advance of discharge.

Mr Bill Brackenridge commented that the focus on operational grip required to be sustained and in regard to partner commitment he enquired if more was required. Mr McCulloch-Graham assured the Board that delayed discharges remained a priority for all partners.

Mr Roberts echoed that partnership commitment was in place and work was being taken forward in a positive and partnership way to build a more sustainable solution in regard to delayed discharges and the whole health and care system for the Scottish Borders.

Mr Tris Taylor commented that from his perspective there were a couple of points to clarify. There appeared to be challenge about Board or Committee over-reach in terms of asking for operational oversight information and he suggested quantification data would be an important lever to enable operational grip and subsequent performance management.

There was obviously a judgement to be made of the relative costs and benefits of deeper reporting and recording and he welcomed the clarification that delayed discharges were a high priority for the partnership. He was keen to understand if the costs were nominal in terms of quantification for workforce and aggregates as it amounted to £10m of the health board budget and he was keen to understand what was in place in terms of costs for Scottish Borders Council (SBC).

In terms of accountability Mr Taylor enquired if there was a system of accountability across the partnership to allow Executives to share the pain across the partner organisations effectively.

Mr Taylor further enquired if the management actions from the internal audit were on track.

Mr McCulloch-Graham commented that the £10m was an estimate. If all delayed discharges were eradicated it would not equate to a £10m saving, such significant savings were only realised when

beds were closed. Costs to SBC equated to poor delivery on delayed discharges with more extensive care packages or higher end care being required.

In terms of accountability on finances, Mr McCulloch-Graham commented that each of the partners held each other to account through their respective Executive Teams. A joint financial plan had been commissioned some 2 years previously and a timetable had been drawn together, however due to the pandemic both organisations had struggled to achieve it. The management restructure of the Health & Social Care Partnership had enabled the appointment of the Chief Financial Officer (CFO) to the Integration Joint Board (IJB). Between that CFO post and the respective partner organisations' Directors of Finance, accountability would be achieved across all the partners. Mr Andrew Bone explained the whole system accountability process.

Mr McCulloch-Graham advised that with regard to the internal audit report, the NHS Borders Audit Committee would ensure the management actions were addressed.

Further discussion focused on: home first provision; reviewing care once in place; culture change; delayed discharges being an issue across NHS Scotland; complexity of guardianship legislation and subsequent challenges; over prescription of care locally and how that impacted on the costs of delayed discharges; shifting the balance of care from acute to the community to reduce the bed base, reduce costs and enable patients to be in the right setting at each element of their patient journey; joint trajectory for delayed discharges for 2021/22; discharge programme evaluation; and strategic change programme in relation to community hospital and care home capacity and financial underpinning.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the report.

Dr Janet Bennison, Associate Medical Director, joined the meeting.

Mr Bill Brackenridge, Non Executive, departed the meeting.

Mr Rob McCulloch-Graham, Chief Officer Health & Social Care, departed the meeting.

6. Financial Planning Process & Timescales 2021/22

Mr Andrew Bone provided an overview of the content of the report and highlighted several elements including: timescales; financial planning framework moving from a 3 year planning framework to a 1 year financial plan aligned to the remobilisation plan; the forecast delivery of £3.5m of savings in this financial year would not be achieved and savings would be carried forward; planning for COVID-19 costs for the next financial year and the moral obligations for pay and price inflation; cost pressures process both internally and at a national and regional level; impact of COVID-19 on next year's profile of service delivery; and joint financial planning with the Scottish Borders Council and the Integration Joint Board.

Mrs Fiona Sandford enquired about benchmarking against other Health Boards. Mr Bone commented that he had benchmarked COVID-19 costs specifically and NHS Borders was a little higher than the average across NHS Scotland. When compared to comparable systems it was not as divergent as expected. In terms of proportion of budget moving into the next financial year, NHS Borders had the largest deficit of 3%.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the changes to the financial planning framework for 2021/22, in particular the requirement to prepare a single year financial plan aligned to the Board's Remobilisation Plan.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the timescales for preparation of the financial plan.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the risks identified in the paper and that further work to fully assess the risks attendant on the financial plan will be undertaken in line with the financial planning timescales described in the paper.

7. Non Domestic Energy Efficiency Framework

Mr Andrew Bone commented that the item had generated some feedback on the Q&A and he provided an overview of the complexities involved in the framework. He further explained the full process and the 3 exit points of the contract.

Mr Tris Taylor commented on the contracting process, potential difficulties with sub-contractors and management of risks associated with the project.

Cllr David Parker commented that Scottish Borders Council had made significant gains in energy efficiency and had undertaken a self-investment approach as they had been in a better position as a public sector organisation to raise capital and borrow money. He was supportive of the approach being suggested given the Board would be supported nationally. He further commented that Mr Bone had reassured him in regard to the 3 points of exit from the contract and he suggested the Board begin the journey.

Mr Bone acknowledged Mr Taylor's concerns and accepted that the project would be down to how good the contracting arrangements were and having the Scottish Futures Trust and Scottish Government owning the programme would provide much needed acumen to the programme.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** approved the recommendations as outlined in the report (section 4.4) which were:

- Agree that NHS Borders participate in the 'prepare' and 'procure' phases for the development of an EnPC for the BGH site.
- Establishment of an NHS Borders project team
- Agree that the Director of Finance may direct resources of up to £50,000 in the first instance towards any costs incurred in the initial phase of contract development.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the risk in relation to the board's liability for expenses incurred by contractors should the board decide not to proceed to final stage procurement, and the mitigation against this risk (section 4.3.8).

8. Respiratory Service

Mr Gareth Clinkscale provided an overview of the content of the paper highlighting background, contextual information and the review of the service. In regard to the review of the service he commented that whilst it had been completed it had not followed the usual process of a full business case and options appraisal. The deviation from the usual process had been due to managing the COVID-19 response with business case activity not being deemed a priority. The acute leadership team had made the decision to seek approval of the £150k consultant post.

The Chair commented that the Board was assured that due process had been followed in terms of the proposal and request for £150k for a substantive post.

Dr Lynn McCallum explained the rationale for seeking a substantive post given the failure to recruit over the previous 3 years to a fixed term position. She further commented on the risks of not being able to provide a sustainable respiratory service in the Borders General Hospital and the likelihood that individuals would be attracted to work with the respiratory physician as he was a highly respected individual in the field of respiratory medicine.

Mrs Lucy O'Leary sought assurance of the extent to which respiratory was seen as part of a holistic frailty service and how that was involved in other long term conditions. Mr Clinkscale commented that respiratory was part of the full pathway across both secondary and primary care.

Dr McCallum commented that the organisation had a small clinical team and there had been discussions with primary care in regard to what a community pathway would look like. The intention was for the secondary care resource to deliver respiratory care differently and that would play into the frail elderly service as it was known that people did better in their own home environments.

Mrs Alison Wilson commented that she was supportive of the respiratory service and was involved in pulmonary rehab and had been saddened that it had not been sustained as it have saved on admissions. He concern was in the circumventing of the process and what message that gave to other services. However, she recognised the need for the appointment and would be keen that any appointee had dedicated time to look at how the efficiencies generated were invested back into the service.

Ms Sonya Lam enquired what the risks to the service were and how those were mitigated, if there were other services in a similar position and how it fitted with the medical workforce strategy. Mr Clinkscale confirmed there were no other services being delivered through a locum or unaccredited consultants.

Dr McCallum commented that in regard to the medical workforce strategy sustaining small services was more complex in a smaller organisation. It required flexibility across the whole system.

Mrs Sarah Horan commented that in regard to nursing and Allied Health Professionals, the appointment would provide a period of stability in the respiratory service.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES & PERFORMANCE COMMITTEE** approved the recruitment of 1.0wte additional Respiratory & General Medicine Consultant at a cost of £150k following review of the service and in response to concerns around service sustainability that may risk delivery over the next 12 months.

The **RESOURCES & PERFORMANCE COMMITTEE** asked that the Clinical Governance Committee explore the post-pandemic fuller pathway assessment.

9. Windows 10 Device Options

Mr Tris Taylor, Non Executive departed the meeting.

Mrs Jackie Stephen, Head of IM&T joined the meeting.

Mr Andrew Bone provided an overview of the content of the paper which focused on governance for such a high level of expenditure.

The Chair commented that it was part of the Road to Digital programme of work.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES & PERFORMANCE COMMITTEE** approved the spend commitment to the replacement of IM&T devices to a total cost of approximately £1.03m as detailed in the attached IM&T SBAR report.

10. Any Other Business

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there was none.

11. Date and Time of next meeting

The Chair confirmed that the next meeting of the Resources & Performance Committee would take place on Thursday, 4 March 2021 at 9.00am via MS Teams.

The meeting concluded at 11.06am.

Signature: ……
Chair

RESOURCES & PERFORMANCE COMMITTEE: 21 JANUARY 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Sonya Lam:** I declare my partner is a specialist advisor for the Scottish Government.	**Iris Bishop:** Thank you Sonya I will formally note this in the minutes for this meeting.
2	Declarations of Interest	**Sonya Lam:** I declare that I have known the recently appointed respiratory consultant in a work and social capacity for 20+ years.	**Iris Bishop:** Thank you Sonya I will formally note this in the minutes for this meeting.
3	Declarations of Interest	**Tris Taylor:** With regard to the Non Domestic Energy Efficiency Framework - I work for Keltbray, a Group that includes a provider of renewable energy infrastructure.	**Iris Bishop:** Thank you Tris I will formally note this in the minutes for this meeting.
		MINUTES OF PREVIOUS MEETINGS	
4	Minutes of Previous Meetings	**Tris Taylor:** I'm sure it's correct to paraphrase what I said as 'It didn't really matter who owned delayed discharges what was required was the data to control performance and expenditure' but if it's acceptable to change to 'regardless of ownership, it was essential that this organisation have the data required to control Board performance and expenditure' that fits closer with what I imagine I might have said… happy to defer to others.	**Iris Bishop:** Thank you Tris I will make this amendment to the minutes.
		MATTERS ARISING	
5	Matters Arising		
		FINANCIAL PLANNING PROCESS & TIMESCALES 2021/22	
6	Financial Planning Process & Timescales 2021/22	**Karen Hamilton:** *3.4 Included within the plan was a requirement for delivery of c.£15m of recurring savings over this timeline, of which a*	**Andrew Bone:** I think an overarching assessment would say high risk.

	Appendix-2021-1	*substantial element had not yet been mandated through the Boards financial turnaround programme and remains a risk* What level of Risk?	Firstly because although some scoping work was undertaken this has not yet been worked up into detailed plans, notwithstanding any impact Covid may have had on the viability of these opportunities; secondly, because there is still uncertainty about implementation timescales, including those schemes where there is a more detailed delivery plan. I would anticipate that we will be able to move perhaps 15-20% of this into a lower risk bracket by mid-2021. Anything beyond this level will undoubtedly require significant focus across the organisation.
7	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *3.5 'It is anticipated that the Board will be fully funded for all relevant costs in relation to Covid19 in the current financial year.'* How secure is this expectation?	**Andrew Bone:** No formal discussions at this stage, it is purely a planning assumption, however based on previous interactions with SG finance I would be reasonably satisfied that it is their intention to deliver this position. The challenge will be the overall affordability across NHS Scotland, and any areas where NHS Borders plans appear to benchmark poorly against peers. My main concern would not be the agreement of the resource requirements identified through financial planning, but the risk that actual costs deviate from this as we progress into financial year 21/22. **Ralph Roberts**: Board Chief Executives have also been given this assurance, all be it verbal and general at this stage. As Accountable officer I believe we are carrying more formal risk at this

			stage of the financial year than would normally be the case, but in the context of the current situation and the assurances we have been given, I believe this is an acceptable risk to carry.
8	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *3.6 NHS Borders remains at Stage Four on the Scottish Government's Performance* Is it not 'Level' 4?	**Andrew Bone:** The Scottish Government framework describes it as "stage" however the terminology is used interchangeably.
9	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *4.1.3 Directors of Finance continue to work with Scottish Government colleagues to develop the key assumptions underpinning financial planning for 2021/22. At this stage there remains a significant level of uncertainty in relation to availability of resources, including any brokerage requirements.* Level of concern here?	**Andrew Bone:** The risks are significant at this point largely because we haven't yet had a budget settlement or had time to 'crunch the numbers'. I would hope that by mid to late February we will have a much greater understanding of the scale of any support requirements and also the Scottish Government position in relation to same. My own assessment is that we are highly likely to see an increased level of gap emerge from our financial plan as a result of the difficulties in mobilising a revised turnaround programme while we continue to deal with pandemic response and service recovery and remobilisation. **Ralph Roberts:** Again note the level of risk as described by Andrew Bone. BCE's have been given assurance that SG is sighted on the level of risk and the governance implications of this and is willing to have further discussions to agree how to address this. Recognising the level of uncertainty the SG also have at this stage I agree we need to accept the level of risk identified and work closely with the

			SG to manage this.
10	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *4.3.2 Expenditure on Covid19 related activities is estimated at c.£14m (inclusive of winter, flu and covid vaccination programmes)* Just a comment there are a lot of uncertainties here?	**Andrew Bone:** Absolutely. The £14m is the estimated spend in 2020/21 however I'm not yet in a position to estimate costs for 2021/22 – this will be heavily influenced by the phasing and success of the vaccination programme.
11	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *4.4.3 'Discussions via finance networks' have indicated that Boards should prepare draft financial plans on the basis that Covid19 related expenditure will be fully funded aligned to the planning assumptions outlined for the Remobilisation plans.* Who are they and how much influence do they have?	**Andrew Bone:** There are a number of these networks and all have significant representation of both NHS Directors of Finance and Scottish Government finance. The primary purpose of all of these groups is to foster communication and to provide professional opinion and advice on NHS expenditure and technical accounting matters, rather than to directly influence strategy or Scot Gov policy. The DoF network is a fortnightly teleconference with ScotGov finance team and this does provide a direct forum for HB DoFs to raise issues with SG senior finance team.
12	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *4.5* ***Financial Turnaround (Savings)*** Are we able quantify 'savings' in relation to non delivery of services over 20/21 – presumably 'if we haven't done stuff we haven't spent money on it!	**Andrew Bone:** We estimate that the cost of delivering non-Covid services will be reduced by c.£6m in year, although it is not possible to directly link all of this to reduced activity. Despite this, the cost per case of individual services is likely to be significantly higher. This is because the fixed costs and overheads remain in place, even when activity is lower – e.g. we employ broadly the same surgical workforce regardless of whether we are delivering a full elective programme.

			So unfortunately there will be some areas where costs have been incurred despite a reduced level of activity.
13	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Karen Hamilton:** *4.6.2 It is likely therefore that this position will be significantly altered and will require early discussion with SG colleagues.* When will this start?	**Andrew Bone:** I would envisage early discussion with SG team as soon as I have draft figures available. I would anticipate this to be early to mid-February. **Ralph Roberts:** SG have also indicated early discussions with those Boards on the SG performance escalation framework and I would expect those to happen by mid march.
14	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Lucy O'Leary:** *4.3.2 Expenditure on Covid19 related activities is estimated at c.£14m (inclusive of winter, flu and covid vaccination programmes) in the current financial year.* Is this net of any reduction in variable costs due to reduced activity on non-Covid business? Are there estimates of these cost reductions and where do they appear within financial statements/ forward plans?	**Andrew Bone:** There is only one offset related to reduction to core services, which is a reflection of where acute beds have been repurposed as Covid19 capacity. The impact of this is £1.5m. Separately we are reporting a projected underspend of c.£3m on core operational expenditure, within which there is c.£6m underspend predicted on clinical board expenditure, with offsetting costs relating to pressures noted within our financial plan including elements of the board's recurring deficit.
15	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Malcolm Dickson:** Paras 4.1.5-4.1.6. (page 4 or 33) Presumably this Scot. Gov. decision to publish its budget one month before the UK budget carries the risk that the UK budget may not meet the requirements of the Scottish budget? I appreciate that this is a risk we can do little to mitigate against but I guess we have to be aware of the possibility	**Andrew Bone:** That would appear to be the case. The Cabinet Secretary for Finance (Kate Forbes) has indicated that the budget preparation is intended to provide increased certainty to Scottish business and public sector. I would envisage that the budget settlement outlined on 28th January will provide clarity on the level of risk around any proposed changes

		that we may need to revise our planning accordingly in or after March.	to resources.
16	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Fiona Sandford:** I share Malcolm's concern that the disconnect between SG budget and Westminster's is likely to cause more uncertainties 4.3.1 If much of non-Covid activity is paused, will this not result in significant savings (short term, of course)	**Ralph Roberts:** agreed re uncertainty – see AB comment above. This was acknowledged at recent BCE meeting with SG. Agreed in relation to short term savings – see comments above.
17	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Fiona Sandford:** *4.6.2 'significantly altered'* – can you indicate an order of magnitude?	**Andrew Bone:** I will give an indication of the likely range as verbal briefing at R&PC.
18	Financial Planning Process & Timescales 2021/22 Appendix-2021-1	**Sonya Lam:** Noted	**-**
		NON DOMESTIC ENERGY EFFICIENCY FRAMEWORK	
19	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Karen Hamilton:** *3.4.3 A strategic assessment was prepared and submitted to Scottish Government Capital Investment Group in 2018 with the expectation that a programme for campus review would be initiated in 2019/20. Establishment of this programme has been delayed and continues to be paused due to the ongoing challenges presented by the Covid19 pandemic. It is expected that this work will be commissioned in 2021/22 as part of a full refresh of the board's PAMS.* *'Expected to be commissioned 2021/22'*/ What happens if it isn't? What about items already paused due to Covid?	**Andrew Bone:** There is no formal timeline within which the BGH campus work needs to be conducted. SG are not pushing for this, the risk lies with NHS Borders in terms of seeking support for our strategy and any actual financing requirements. As outlined in the paper, financing is likely to be limited in the short to medium term. The consequence of a delay will be mainly in terms of stakeholder perceptions at a local level. We will prepare an outline timetable for this process through the capital investment group and provide update to a future RPC (likely to be post-March). The capital update to RPC in March will include

			revised timescales for implementation of all current commitments.
20	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Karen Hamilton:** *4.2.6 The guaranteed savings relate to the whole EnPC, so a bundling of energy efficiency measures.* *In Scottish Government's 'Programme for Government' announced in September* Don't think I understand this sentence?	**Andrew Bone:** The 'bundling' means that rather than demonstrating savings on each individual action – e.g. replacement of cladding, or steam pipes – the contract would collate a range of measures, some of which might be short term, and some requiring longer term investment for payback in later periods. The performance contract would take all of these measures together and look at the expected efficiency gain in totality across the lifetime of the contract. This would then be compared to existing performance to identify expected savings.
21	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Karen Hamilton:** *4.3.6 2020, it was stated that £95 million would be made available over the next parliament,* What if there is a change in Government?	**Andrew Bone:** Always possible, and not a risk that we can mitigate locally. The model is not reliant on this funding however; this presents a potential source of capital funding which would be directed towards projects in the scope of the NDEE. It would change the nature of the financing but not the basis of the contracts themselves. Accessing this resource will in any case be highly competitive and I would not expect our case to be built with reliance on this source.
22	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Karen Hamilton:** *4.4.1 Agreement that the Director of Finance may direct resources of up to £50,000* Could we have a brief outline of expected use of these funds?	**Andrew Bone:** This would be a contingency fund only. It would be used to cover expenses incurred in delivering project support – so might include backfill of key NHS staff to allow time to be released to the project.

			I am proposing this arrangement because – if supported – I would want to progress within minimum timelines in order to deliver benefits from the contract at earliest available opportunity.
23	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Malcolm Dickson:** I am minded to approve these proposals. My experience of leading the Police contingent in the privatisation of Prisoner Escort and Court Custody Management across Scotland reminds me that private concerns will usually invest much more time and effort into the procurement process than public services are able to, and so I'd simply suggest that our project team when set up, as I'm sure it will anyway, learns as much as it can, as early as it can, from the experience of others who have trod this path before (eg NHS Lothian)	**Andrew Bone:** We would certainly be looking to build expertise by working with colleagues in national procurement and Scottish Futures Trust; health facilities, etc, as well as private sector counterparts. A key success factor in final contract delivery would be our ability to manage the arrangements once in place so having expertise within our own NHS team will be business critical.
24	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Fiona Sandford:** Happy to support this – just one query? 3.3 NHS Borders Estate is in a generally satisfactory condition cf other boards – Really? In whose opinion?	**Andrew Bone:** The assessment I am referring to is based on the 2017/18 survey and I would expect that there will be a different position reflected in the next published report (this was deferred during Covid and I'm not aware of publication date at this point). The criteria are set nationally by Health Facilities Scotland (HFS). Assessment is undertaken locally, so there may be some element of interpretative difference between HB submissions, however we do have a level of expertise in this area and have supplemented this with advisors from HFS when required.
25	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** The background is set out very well but we need a better attempt to quantify the numbers involved in such an agreement being executed. For example: what do we	**Andrew Bone:** The first phase of the procurement process requires bidders to identify the potential savings they could deliver to the board, prior to any further engagement and

		estimate would be the cash values and length of such a contract to both NHSB and a potential partner (whole-life and per year - upper and lower range limits would be fine)?	workup of the detailed business case and contract. No detailed modelling has yet been undertaken. I am clear that we would not seek to progress the procurement without having a full business case which demonstrated these benefits – this would be developed jointly with the preferred bidder in advance of progressing to contract award, and within the procurement framework described in the paper. I am reluctant to make any assessment in advance of this, however as an indication the NDEE framework describes potential for annual savings to be in the region of 12% against in scope expenditure. I would expect any contract award to be for a minimum of 8 and more likely 15 year term.
26	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** 4.3.9 Risk Assessment - this is thin, particularly on the Commercial side. It does not adequately state or consider the risks of actually being a signatory to such a contract. As we have seen this year, well-laid Board plans for estates are always subject to change in light of clinical pressures. Contracts for infrastructure/energy/renewables projects can never be drawn to anticipate every eventuality and there will be a mechanism for making and settling claims in the event the Board is unable to meet its obligations - for example, to allow demolition, construction or fit-out works by a certain date. On the other side, the best-laid plans for energy construction can often be de-railed and, while there will be a mechanism for making and settling claims in the event	**Andrew Bone:** I recognise that there is a need to fully develop the risk assessment of this project and we would expect to undertake this work through the project group in advance of progressing to tender. I would agree that we need to have a very clear understanding of the commercial risks arising from such a contract, and if we agree to progress I would be seeking support of national procurement and central legal office in addition to our internal project team and external project support. I would also expect to seek advice and input from other NHS Scotland boards who have progressed EnPC contracts under the previous arrangements.

		the provider is unable to meet its obligations, what are the financial and reputational risks of the Board having to arrange emergency or short-term energy top-up contracts to prevent disruption to its usual business?	
27	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** Any providing partner will have an overriding interest in ensuring their contract delivers on or above its expected margin and will have distinguished professional contract administrators and quantity surveyors on hand to negotiate should there be any deviation from expected performance, on either side. Such negotiations, in the worst case scenario, might put the Board into time consuming mediation - or worse - with an opposite number at least as big, and possibly much bigger, than itself. I would prefer to see a fuller statement of the financial risks of variance from agreed performance standards by both parties; and a realistic statement of the risks of ambiguities in whatever agreement is made between the Board and a provider.	**Andrew Bone:** See comments above. Development of the risk assessment will be progressed through the project team if we agree to proceed.
28	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** I'd also like to ask what experience we currently have - for example, in tough negotiations with heavyweight commercial construction/heavy industry/infrastructure contract holders like SSE and E.On - that we can bring to bear on being a partner in such an agreement when things don't go to plan; and what exists within the Health & Social Care Directorate at SG. This ask is in the context of significant infrastructure contract overrun on the new hospital campus in Edinburgh.	**Andrew Bone:** Within NHS Borders, our commercial and procurement capability is limited to areas of normal business operations, including provision of services and minor works with a scale usually below £250k and typically on a single or maximum three year basis. The majority of large scale projects and contract awards are negotiated through NHS National services procurement or through external advisors and support. For the NDEE framework the Project Support Unit within Scottish Futures

			Trust has been specifically established to provide project input and support, with further input from national procurement advisors and Scottish Government. I would anticipate however that we would consider any further commercial advice/support we require once we have a clearer understanding of scale of the potential opportunity. I do not envisage that this contract will be of a similar scale to those which have reported nationally in relation to overrun and/or commercial issues.
29	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** I note Scottish Government will underwrite certain risks concerning the financing model, but this is very far from underwriting the risks associated with this type of partnership agreement running into regular or serious problems.	**Andrew Bone:** That is fair, and I would want us to be fully sighted on the specific financial and legal risks that may arise from entering into this arrangement prior to sign-off. I do believe that we need to progress the initial phase in order to scope further both the benefits and risks of this project before we can provide the clarity required.
30	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Tris Taylor:** In short - are we really ready to dedicate some Finance and Procurement time to potentially adversarial negotiations with a vastly more experienced partner on a reasonably regular basis? Do we have, or are we ready to hire, a heavyweight contract administrator capable of going toe to toe with such a partner, and maintaining control of the paperwork required? And if not, is it right that we dedicate an initial £50K to spec out such a contract?	**Andrew Bone:** I would not underplay the potential risks around such an arrangement, but equally I would be keen to explore as far as we can before we dismiss it – this model is not one we have developed in isolation, it is a nationally developed public sector framework applicable across Scottish government and its functions. I think this probably warrants further discussion in the meeting.

31	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Sonya Lam:** For clarification, NHS Borders would need a project team for what could be a 15 year period and pay HFS/SFT up to £50k for additional support.	**Andrew Bone:** No, sorry – apologies for any confusion. We would require a project team only for the initial procurement phase (likely to be less than 12 months). It is likely that there may be some level of contract management resource required thereafter however we would evaluate this as a cost against the project before expressing any net benefits. This will be described in the final business case.
32	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Sonya Lam:** If this is a long term project, is £50k sufficient with costs that will rise over so many years?	**Andrew Bone:** See comment above.
33	Non Domestic Energy Efficiency Framework Appendix-2021-2	**Sonya Lam:** Would/can other collaborations be considered with for example academia for evaluation, input from students with an academic interest in energy/business?	**Andrew Bone:** I would be open to exploring such models, although at the centre of this will be the need to undertake commercial rigour on contract management.
		RESPIRATORY SERVICE	
34	Respiratory Service Appendix-2021-3	[redacted] General Comment – papers really benefit from numbered paragraphs !	**Executive Team:** Agree and will look to ensure this is consistently done in future for all papers
35	Respiratory Service Appendix-2021-3	[redacted] ***Assessment*** *The Acute Services Quadrumvirate recognises that the review undertaken has not engaged all relevant parties or professions (for example Primary Care, AHPs or Nursing beyond the Lead Nurse for Acute Services).* This statement is worrying – are we making assumptions about their views? I note that 'short term' Covid demands are relevant here but we are making a long term decision?	**Lynn McCallum:** For clarity there was an afternoon consultation that involved multiple professionals working within the respiratory service – the final report took all views into account and discussed the staffing ratios of all professions within the service. I have sent the full report separately for review.
36	Respiratory Service Appendix-2021-3	**Karen Hamilton:** *The Quadrumvirate also consider a very high risk that the single consultant appointed may leave post if there is not*	**Lynn McCallum:** Categorically not. This is a service that has been struggling for a very prolonged period of time with exceptional

		tangible evidence of an investment in the service and increase in capacity to meet current activity levels. Are we being held to ransom? Seems like it! Please convince me otherwise!	challenges in recruitment. We have been working with a locum consultant who does not have a CCT in Respiratory Medicine. This carries considerable risk but he has been the only senior doctor that we have been able to attract to the service. The very experienced and highly respected consultant that has recently joined the team, has identified a number of key areas of concern that need addressed urgently. It is recognised that additional consultant time will be required to deliver these changes. Without this additional resource, the consultant does not feel that he can safely run the service, therefore potentially compromising his own registration.
37	Respiratory Service Appendix-2021-3	**Karen Hamilton:** *The equivalent of one 12 PA consultant post activity in Borders for £450k investment.* Why were NHS Lothian so intransigent?	**Gareth Clinkscale:** NHS Lothian had little requirement for these posts and so were not supportive of providing funding towards them.
38	Respiratory Service Appendix-2021-3	**Lucy O'Leary:** Concerned that this proposal has been produced without engagement with other clinicians (nursing, AHPs etc).	**Lynn McCallum:** Please see above and the full respiratory report that has been circulated to the Committee privately as it contains person identifiable information.
39	Respiratory Service Appendix-2021-3	**Lucy O'Leary:** *The review describes a requirement for investment in medical staffing to address risk in service provision, move the service closer to benchmarked District General Hospital staffing levels/service offering and begin to develop a Respiratory clinical model comparable to other Health Board Respiratory services.* How will proposed staffing compare to the benchmarked staffing model? How will it compare with other Health	**Lynn McCallum:** Please see the full respiratory report for benchmarking against other DGHs in the region. The recently appointed respiratory consultant has met with our Clinical Oversight Group (GPs and secondary care) to discuss community pathways. These are well established in other health boards and help to prevent admission to hospital.

		Boards? (I would like to see the associated evidence here) What is the modelled impact of this proposal on service demand in terms of increased prevention, shifting from acute to community activity, etc?	
40	Respiratory Service Appendix-2021-3	**Lucy O'Leary:** *When COVID-19 activity and the associated demands on the Acute Services operational team reduce, a broader piece of work will be undertaken with all key stakeholders (Acute & Community) to develop a service that provides an optimum, efficient service for patients.* Does this proposal risk putting the cart before the horse? How does this fit with the plan to develop the respiratory service to respond to future demand associated with "long Covid"?	**Lynn McCallum:** Given the fact that 30% of acute admissions are respiratory related and that all Respiratory Consultants are dual accredited with General Internal Medicine, I do not think that there is any risk to this appointment in terms of activity. This is without taking Long Covid into account or considering returning sleep activity from Lothian.
41	Respiratory Service Appendix-2021-3	**Malcolm Dickson:** *Page 4 /52. "When COVID-19 activity and the associated demands on the Acute Services operational team reduce, a broader piece of work will be undertaken with all key stakeholders (Acute & Community) to develop a service that provides an optimum, efficient service for patients. Such developments have reduced secondary care bed days in other healthcare settings."* Isn't there a small chance that such a review, if undertaken without bias, might come to a different conclusion from that of the current, understandably limited review, conducted by someone who presumably has a vested interest? Might it therefore be advisable to seek to use Internal Audit for such a future review, and should the additional consultant be contracted in the first instance for a relatively	**Lynn McCallum:** See above re service review. I do not think that a short term appointment will attract applicants. As it is, we have struggled enormously to attract anyone to substantive contracts although the current consultant (who is highly respected in respiratory circles) will be an attraction to the unit!

		short term?	
42	Respiratory Service Appendix-2021-3	**Fiona Sandford:** While this may be the right course of action, and I'm happy to accept the advice of clinical colleagues, this smacks a bit of being held to ransom… assurances that we are not would be welcomed! Given that we failed to appoint before, how confident are we of appointing this time?	**Lynn McCallum:** See above.
43	Respiratory Service Appendix-2021-3	**Sonya Lam:** I support the request to increase medical staffing. It may however, have been useful for the Committee to view this paper in the context of the review undertaken, to understand the staged approach and in particular the 18 recommendations.	**Lynn McCallum:** The full respiratory report has been circulated to the Committee privately as it contains person identifiable information.
44	Respiratory Service Appendix-2021-3	**Sonya Lam:** I note that the review has been undertaken without the engagement of all relevant parties or professions e.g. primary care, AHPs. The recruitment of another consultant will undoubtedly impact on the activity required of other member of the MDT. How will this potential increase in activity for other professions be managed?	**Lynn McCallum:** See above.
45	Respiratory Service Appendix-2021-3	**Sonya Lam:** The paper alludes to a perceived risk to patient safety if the newly appointed consultant were to leave. Prior to the appointment what were the patient safety issues and what mitigating actions were in place? What did our data tell us?	**Lynn McCallum:** There is considerable risk associated with this individual leaving. These include work load, holiday cover and reputational damage.
46	Respiratory Service Appendix-2021-3	**Sonya Lam:** What are the further workforce changes within the wider multi-disciplinary team expected within the next 12 months?	**Gareth Clinkscale:** One other key member of the MDT has unavoidable planned leave forthcoming. This post cannot be replaced without a significant training period and this will inevitably impact on workload of the wider team.

47	Respiratory Service Appendix-2021-3	**Sonya Lam:** What is the likelihood of recruiting another consultant if recruitment has previously been challenging?	**Lynn McCallum:** The recently appointed consultant will in himself, be a draw for younger respiratory consultants. I think we are more likely to recruit in this context.
48	Respiratory Service Appendix-2021-3	**Sonya Lam:** What is the impact on the person who has undertaken the long term locum and what support is required?	**Lynn McCallum:** He is now in a far more supported situation than previously. We propose to support him to complete a CESR application (recognition of respiratory training to consultant level).
		DELAYED DISCHARGES	
49	Delayed Discharges Appendix-2021-4	**Lucy O'Leary:** Paragraph numbering would be extremely helpful for this (as for all papers)	**Executive Team:** Agree and will look to ensure this is consistently done in future for all papers
50	Delayed Discharges Appendix-2021-4	**Lucy O'Leary:** *P 7-10. 1 Totals for 2020/21 have been projected for 12 months based on the 8 month average for Apr-Nov 2020* Do these FY projections take into account the effects of Covid and/or underlying seasonal demand? If no, is this assessment of DDs robust enough to use for future planning? If yes, what are the factors that have led to a reduction in projected levels of standard DDs for 20/21 compared to the two previous years?	**Rob McCulloch-Graham:** It is recognised that the projected figures do not take in seasonal changes but it was felt that it was important to create as valid a comparison as possible. We will need to keep this under review once we have the full year's figures, acknowledging the 20/21 financial year has been exceptional. **Ralph Roberts:** This is a valid point and one that we are aware of. We need to be careful about conclusions drawn and ensure we continue to monitor and assess impact. There is no doubt that an element of the reduction in DD OBDs in 20/21 will be related to the very significant drop in DD during Wave 1 in the pandemic, as a result of a more proactive approach to discharging patients from hospitals in the initial stage of the pandemic.

			However despite this it is reasonable to conclude there has been a year on year reduction.
51	Delayed Discharges Appendix-2021-4	**Lucy O'Leary:** *Page 11: The 2021 evaluation process will consider the cost of providing services against the opportunity cost if the service was withdrawn (i.e. cost of keeping people in hospital), as well as further analysis of the assumed benefits delivered by the projects – reduced occupied bed days, reduction in homecare packages etc. This will not be available until February at the earliest.* It may also be beneficial to carry out a similar cost benefit analysis of the actions that will more directly address the reasons for delayed discharges – provision of specialist and general nursing home care, enhanced home care, trusted assessment etc.	**Rob McCulloch-Graham/Ralph Roberts:** Agree and this will be included within the commissioning exercises within the next financial year for the IJB. The approach to evaluation of the Discharge programme has been shared with and supported by the IJB and this will continue to be developed with their input.
52	Delayed Discharges Appendix-2021-4	**Lucy O'Leary:** This seems to me to be the heart of the matter. If we have evidence which actions create the biggest benefit to the whole system (not just DDs in relation to acute bed occupancy, although that's likely to be the biggest source of cost and clinical impact) we have an improved basis on which to base decisions on targeting resources (joint investment/ staff/ clinical and public engagement etc). There's a huge range of projects and changes described on pp14-15 – which ones are most effective in making things better?	**Rob McCulloch-Graham/Ralph Roberts:** In developing the Discharge programme evaluation it has been acknowledged that it is difficult to disaggregate the individual impact of different elements of the programme as they are all interrelated within patient flow. This is being built in, as far as possible to the evaluation approach being developed and already shared with the IJB. A number of the services which have been implemented over the last three years, were common practice in other partnerships, are recommended as "good practice" and are expected within the range of services a H&SC partnership should offer. .

			For example there was no “re-ablement” function” in the Borders in 2017, Home First was then introduced. The question that is required now is not the validity of some of these services and whether they are required, but how well they are functioning, which does include the need to develop the way in which we measure impact and efficiency.
53	Delayed Discharges Appendix-2021-4	**Tris Taylor:** I appreciate the additional level of quantitative detail in this report. It provides a slightly higher degree of assurance information than the paper brought to the last meeting. However, while this additional quantitative detail is an improved *statement* of the overall problem, indicators that support measurement and control of performance and remedial actions to *break down and address* that problem continue to be omitted. Specific examples? Well, of the indicators presented (volume of delayed patients, business unit of delay site, cost of delay, delay location, reason for delay, stratification of reasons for complex delays), the only new indicator since the last paper is cost. This is welcome, as is the stratification - but the suite of indicators excludes many, previously set out to the Chair and Chief Exec in email (and hopefully directed onward), that seem to me to be important for adequate controls and improvement. I’m not asking for those indicators especially, but the worry is that there are just not enough indicators to inform performance management and improvement.	**Rob McCulloch-Graham/Ralph Roberts:** The paper provides quantitative comparison over time for the following factors • number of patients delayed • where the delays are occurring • the reasons for those delays • and the financial impact of the delays This is identified in the Internal report (Appendix) and has been accepted by management as an area for improvement. Pleased that the development of the information accepted and note the further comments *(NB previous feedback has been shared).* While there are clearly further indicators that can be developed, as identified by Internal audit and acknowledged in the paper the Information systems related to DD are continuing to be brought together and at the current time we are not in a position to make significant progress with the level of detailed indicators suggested. However this will be built on going forward.

54	Delayed Discharges Appendix-2021-4	**Tris Taylor:** There are two distinct areas of omission: 1) *Evidence that the overall programme of projects intended to deliver expected benefits to discharges is well controlled:* there is no data on the baseline and actual dates, expected and actual benefits, expected and actual return on investment, lessons identified and learned;	**Rob McCulloch-Graham/Ralph Roberts:** The internal audit report comments on the level of control to ensure compliance with policy and this has been accepted by management We are currently preparing an evaluation report for the IJB in February. There was a similar report provide last February and the updated report is in line with the timeline agreed by the IJB.
55	Delayed Discharges Appendix-2021-4	**Tris Taylor:** 2) *Evidence that business-as-usual discharge performance, independent of any related transformation programme activity, is well controlled*: supplied indicators do not quantify the complexity and interdependence of the tasks involved to a standard which would provide an adequate control structure; indeed, as noted by internal auditors, there has been significant non-compliance with policies.	**Rob McCulloch-Graham/Ralph Roberts:** The initiatives, structures, policies and programme were similarly identified within the national evaluation on delayed discharge. They are now expected components of Discharge Programmes. The brief given to the internal auditors was to examine the level of compliance which it is acknowledged is an issue and actions are identified in the action plan included as an appendix. However, it is important the R&PC recognises that we do not currently detailed performance and recording systems in place to allow the level of reporting, scrutiny and assurance implied. Developing this would take significant time and investment of human & IT resource, including clinical staff. Particularly at the current time a judgement needs to be made of the cost benefit associated with this level of recording and reporting.

56	Delayed Discharges Appendix-2021-4	**Tris Taylor:** Further to 2), no information is given on the position of the Management Actions in response to the internal audit - despite 10 out of the 11 having completion dates on or before 31 December 2020.	**Rob McCulloch-Graham/Ralph Roberts:** **A**ccepted. We continue to monitor progress on the action plan through the DD steering group identified within the action plan and agreed by the partnership. The audit committee of the NHS Borders will receive on-going reports on progress against the recommendations and the actions from Internal Audit which were accepted and agreed by the Audit Committee. It would be helpful for the R&PC to confirm that it is in agreement with this action plan being monitored through the audit committee.
57	Delayed Discharges Appendix-2021-4	**Tris Taylor:** So, this report shows a little more detail on some of the underlying reasons for delay - but it does not give assurance that those reasons have been, or will be, adequately addressed.	**Rob McCulloch-Graham/Ralph Roberts:** It would be helpful to be clear about the level of assurance (Strategic V Operational) that the R&PC / Board require on this issue. It would be normal for a Board Committee to gain Strategic assurance around the Strategic Direction and also in relation to high level outcomes. At this level the information provided shows: • How the partnership has responded to the issue of delays over the last three years • A comparison with practice within other partnerships in Scotland • The number of patients delayed comparatively over time • Where the delays are occurring • The reasons for those delays

			• The financial impact of the delays • How well or otherwise service are complying with policy • How services have further adapted to –address difficulties and non-compliance • How we seek to further evaluate and further progress the programme This should provide a level of assurance that progress is being made, all be it that the need for further progress is acknowledged and the potential and timescale for this will be developed further through our Remobilisation plan, as the overall discharge programme is evaluated and as the Strategic Implementation plan is progressed. On individual issues it is also reasonable for the Board / Governance committee's to seek assurance that the processes and arrangements in place to address areas of concern are robust enough. You would expect this to be done on an occasional "deep dive" basis. It is acknowledged that in this instance this is more challenging because of the complex interaction between elements of the H&SC system and the various programmes of work to support improvement (as referenced above in relation to the Discharge programme evaluation). This makes direct links between individual actions and performance data difficult to identify. It is believed the R&PC should take further assurance from the positive work underway at

			the managerial steering group that has; • Set escalation triggers • Agreed escalation routes • Further refined data collection • Re-allocated resource within managerial delegation limits • Re set arrangements for discharge between hospitals, and from hospital to care • Reacted to government policy guidance on delays and testing regimes • Undertaken individual case work as required • Addressed issues of non-compliance directly at service level but also across services and with the public, through new communications • Examined the changing nature of delays. An example of the impact of this has been the significant reduction in MH delays as a result of actions taken within the overall redesign of services and the shift to community support alongside operational action to increase clinical leadership and the SW capacity in MH to focus on the decisions required to support discharge of patients with complex needs. This should provide some further assurance that that staff are engaged and focussed on continued improvement. We would also hope that the Committee members do note progress in the provision of information even acknowledging further opportunities for improvement.

			While acknowledging the importance of continuing to develop reporting and even more importantly the service rigour in implementing timely and effective decision making around discharge processes, we do need to be cautious in concluding that the provision of increasingly detailed quantitative information will provide perfect understanding of the complex interactions that ultimately determine the effectiveness of the whole system. We also need to accept that to develop the whole system information system to support this, is a long term programme that we do not currently have the clinical service, Information or IT resource to invest in. However we are committed to continuing to make progress on this and in using information to drive improvement within individual discharge projects and accept the underlying challenge to improve the way in which we do this.
58	Delayed Discharges Appendix-2021-4	**Tris Taylor:** Finally, while this report repeats and extends a strategic narrative around discharges, the request at hand has not been for strategic narrative (I believe the Board consensus to be that the overall strategic direction on discharge has been justified); what is missing is quantitative information that will a) help describe why the strategic direction has not delivered as expected, and b) validate current and future actions.	**Rob McCulloch-Graham/Ralph Roberts:** Please see answers above.
59	Delayed Discharges Appendix-2021-4	**Sonya Lam:** The effort behind this report is appreciated.	**Rob McCulloch-Graham/Ralph Roberts:** Agree it is important this is seen as a whole system issue; Jen Holland as Operational lead

		I acknowledge that this has been raised as an issue from the Board but I am concerned we are looking at this in isolation and not as part of a whole-system approach. Should we be looking at delays in care across the system?	in Social care is jointly chairing the managerial DD steering group with Nicky Berry. The development of the DD trajectory and evaluation of the Discharge programme will be led by the IJB on behalf of the whole system. Noted we also need to understand other delays in the system, not just related to discharge from hospital.
60	Delayed Discharges Appendix-2021-4	**Sonya Lam:** If we had no delayed discharges, what degree of impact would this have on flow and other performance indicators such as the 4 hour target?	**Rob McCulloch-Graham/Ralph Roberts:** This hasn't been quantified or modelled but clearly would have a benefit, both in relation to availability of beds for admitting but also length of stay, subject to the other influencing factors on this such as the level of patient acuity.
61	Delayed Discharges Appendix-2021-4	**Sonya Lam:** It would appear that there are a greater proportion of delays and OBDs in community hospitals and the main reasons for delay are waiting for residential and nursing home placements. ○ The projects within the existing discharge programme have no direct impact on delayed discharge. I welcome the evaluation of these services in terms of cost benefit. ○ There is reference to residential and nursing home capacity in the SIP action plan, as 60 bed-care unit. What does this mean, what will be the impact and what are the timescales? ○ I welcome a deeper understanding of the impact of delay on deterioration of function and independence and an understanding of the decision making for residential or nursing	**Rob McCulloch-Graham/Ralph Roberts:** Noted and agreed. Noted and agreed. There is a commitment from SBC to develop additional Care unit capacity. Work is currently underway to develop more detail on this proposal, currently focussed on Hawick. More joint work on this is required. This should be the focus of IJB development Noted.

		care i.e. at what point in their journey.	There exists a body of clinical evidence which can relate the length of stay in hospital, which reduces mobility and results in significant muscle reduction. In a similar fashion, caring for people out with their own homes, removes significant levels of self-determination and independence. All of these factors lead to an increased level of needs for individuals returning to their homes. In some cases to such an extent that residential care becomes the only option. These are major drivers within the strategies for Health and Social Care .
		WINDOWS 10 DEVICE OPTIONS	
62	Windows 10 Devices Appendix-2021-5	**Sonya Lam:** I agree with the urgency but question why this paper comes to the Committee now and not earlier?	**Andrew Bone/June Smyth:** A move to Windows has been part of our overall Road to Digital Programme (the programme of work to upgrade our infrastructure) which was approved by the Board in May 2017. The paper could only be developed once the full analysis of the estate was completed and we understood the detailed plan to move to Windows 10. This work was scheduled to be completed much earlier in 2020 but the team were all re-directed to COVID-19 related activities until recently. That analysis completed in the last two weeks and the paper is now presented to purchase the required equipment.
63	Windows 10 Devices	**Sonya Lam:** If Windows & support has ended (14/01/2021) and devices	**Andrew Bone/June Smyth:** At the time the paper was written it was unclear whether or not

	Appendix-2021-5	will not receive critical security patches and are exposed to threats, how long will this situation take to resolve. What are the risks and what are the mitigating actions in the interim?	and for how long Microsoft would offer extended support for Windows 7 and how much that would cost. Delays in last year's programme meant that we would need to purchase extended support so we could continue to have access to security patches. A new national pricing agreement is now in pace and we will be able to access patches as before to ensure continuity. We have also explored how we could accelerate deployment of the equipment requested in the paper and continue to do so as it will also reduce the complexity and local burden in supporting a mixed environment as well as maintaining security aspects. This is not the only security measure in place, although it is a key mitigation. Our aim has been to move as quickly as possible, exploring all options at the best value costs. We are comfortable that our risk position now is the same as it has been for the last 12 months in relation to desktop operating systems and we have plans in place to undertake the upgrade over the coming months. Progress may still be limited by redirecting resources to urgent COVID-19 activities should this continue to be required and increased home working.