Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 3 September 2020 at 9.05am 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
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs N Berry, Director of Nursing, Midwifery & Acute Services
Dr L McCallum, Medical Director

In Attendance: Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Strategic Change & Performance
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Mr A Carter, Director of Workforce
Dr A Cotton, Associate Medical Director
Mrs C Oliver, Communications Manager
Mrs J Stephen, Head of IM&T
Ms D Burt, Programme Manager
Mr K Lakie, Senior Finance Manager

1. Apologies and Announcements

Apologies had been received from Mrs Alison Wilson, Non Executive, Cllr David Parker, Non Executive, Dr Tim Patterson, Director of Public Health, Mr Gareth Clinkscale, Associate Director of Acute Services, and Dr Janet Bennison, Associate Medical Director.

The Chair confirmed the meeting was quorate.

The Chair welcomed a range of attendees to the meeting.

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.

Mr Malcolm Dickson declared that his sister in law worked for the Northumbria Healthcare Foundation Trust.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declaration made by Mr Malcolm Dickson 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 final meeting of the Finance and Resources Committee held on 19 March 2020 were approved.

The minutes of the final meeting of the Strategy and Performance Committee held on 6 February 2020 were approved.

4. Matters Arising

4.1 **Action 1:** Mr Tris Taylor sought assurance in regard to engagement with the third sector and how any changes would be made as a result of that engagement. Mr Rob McCulloch-Graham advised that a Third Sector Interface Group led through Scottish Borders Council had been utilised as the mechanism to engage with the third sector directly on the winter plan. He suggested sharing the Third Sector Interface Group terms of reference with Mr Taylor.

Mr Taylor sought further assurance in regard to the effectiveness of the mechanism used, changes made and suggested providing that data to the Board. The Chair commented that the Winter Plan was a feature of the next Board meeting agenda and suggested such an analysis should be picked up at that point as part of that discussion.

Mrs Nicky Berry commented that learning from previous years in regard to winter planning was always deemed as essential in preparation for the following year. A Winter Planning Board had been formulated and membership included GPs. She welcomed the avenue that had been opened up for engagement with the Third Sector.

Mrs June Smyth advised that the next iteration of the Remobilisation Plan would include the winter plan which would no longer be formulated as a stand alone plan.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 1, given the winter plan was to become part of the remobilisation plan.

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

5. Resources & Performance Committee Terms of Reference

Mr Tris Taylor suggested the final paragraph at item 1.8 be moved to section 1.10.

Mr Taylor suggested the final paragraph at item 1.10 should be reviewed and articulated into 2 elements. Miss Bishop agreed to look further at sections 1.8 and 1.10 with the Code of Corporate Governance Steering Group.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Terms of Reference and the items to be further explored (sections 1.8 and 1.10).

6. Resources & Performance Committee Business Plan 2020/21

Miss Iris Bishop introduced the business plan and advised that it would remain as a live document, would evolve further and flex where appropriate, to ensure the Committee could meet its requirements to provide assurance to Borders NHS Board on the matters delegated to it.

Mr Malcolm Dickson enquired if receiving the workforce plan once a year was adequate. Mr Andy Carter commented that a more frequent sharing of the workforce plan could be accommodated.

Mr Tris Taylor suggested that data collection and visualisation reporting along with progress against delivery of the strategy be added to the business plan. Mrs June Smyth suggested she meet with Mr Taylor outwith the meeting to ensure any data analysis would meet the needs of the Committee. Mr Andrew Bone further suggested that financial information also be incorporated into that data collection and analysis.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to receive the Workforce Plan on a six monthly basis.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to include data collection and analysis within its Business Plan.

7. Financial Turnaround Programme – Progress Report

Mrs June Smyth provided an update on financial turnaround and highlighted several key elements including: savings requirements; COVID-19 impact; assumptions as a result of COVID-19; deliverability of savings; and anticipated delivery of savings in 2021/22.

Mrs Fiona Sandford suggested a clearer articulation between brokerage and COVID-19 spend. Mr Andrew Bone commented that the organisation was expected to net off COVID-19 expenditure, however he would ensure the alignment was more explicit.

Further discussion focused on: fortnightly contact with Scottish Government on COVID-19 expenditure and impact on financial plans; monthly submission of the local mobilisation plan performance tracker; high level benchmarking of all Health Boards savings plans had been undertaken and all appeared to be showing a deterioration in savings plan; the Programme Management Office (PMO) resource had been diverted to support COVID-19 activity; the PMO were enablers to support services to deliver savings and make change happen; and some services had achieved underspends, however whether they were due to reduced activity levels and would be recurring or non-recurring required clarification.

Mrs Smyth advised of 2 errors within the paper, page 3, second bullet to read “£780k” and not “£900k” and the third bullet to read “part year effect” and not “full year effect”.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the report with the amendments reported.

8. Laboratory Information Management System (LIMS) National Outline Business Case

Mrs Jackie Stephen introduced the LIMS item and explained that it was a critical component for a diagnostic service. The current system was 26 years old and required renewal. It had been agreed with colleagues in the East Region to work towards a single system. A consortium was formed and 10 Health Boards were participating. The aim had been to ensure a consistent position across Scotland that fitted with the national laboratory programme and achieved sustainable diagnostic services across Scotland. Deloittes had been commissioned to work through the outline business case and several meetings had taken place using MS Teams. Mrs Stephen explained that in terms of Borders, the consortium approach was the best outcome and it was anticipated that costs would be further reduced. She clarified that the next stage in the process was to run a procurement process to reach a preferred option with the intention of then commissioning a framework contract.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** approved NHS Borders continued participation and commitment to the national Outline Business Case for a LIMS as a committed partner in the procurement and development of the Final Business case and recommend to NHS Borders Board that they ratify this position.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the potential level of financial commitment that may be required to replace the current LIMS and ask that NHS Borders factor that into future financial plans.

9. Edinburgh Cancer Centre Initial Agreement

Mr Kirk Lakie advised the Committee of the intention to replace the cancer facilities currently located on the NHS Lothian Western General site. He commented that in regard to the Initial Agreement it would contain a number of principles to include in the outline business case such as equality and equity of access across the region and the development of local satellite units. It was intended that the Initial Agreement would be submitted to the Scottish Government for review and feedback shortly and then resubmitted for agreement in October.

Mr Tris Taylor suggested the language in the paper appeared cautious. Mr Lakie advised that the language reflected the position of partners being keen to look at the provision of care that could be provided in a new facility in the future as opposed to a direct like for like replacement.

Mrs Sonya Lam echoed the sentiments that the replacement facility should not drive the new model but should be reflective of what cancer services should be delivered for people.

Mr Ralph Roberts commented that the report referenced NHS Dumfries & Galloway who currently sent their cancer patients to the east region, however, if they moved to sending patients to the west region it would have an impact on the final costs of the new facility.

Mr Bill Brackenridge enquired how the Health Board would influence the provision of the new facility to ensure it was person centred. Mr Roberts explained the process from Initial Agreement to Outline Business Case to achieving a final agreement and advised that the Board would only be able to influence the project to a certain extent.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the content of the Edinburgh Cancer Centre Initial Agreement and plan to submit it to Scottish Government CIG on 9th September.

10. Complex Care Unit – Learning Disabilities

Mr Simon Burt explained the proposal to provide a local complex care unit subject to permission from the Scottish Government. The unit would enable the repatriation of clients from expensive placements elsewhere in the UK back to the Scottish Borders as well as providing a resource to meet the increasing demand locally for those transitioning from young people to adults who had high level needs. A third sector provider Cornerstone were willing to develop the model in the Borders as it was within their strategic plan and they had access to capital funding, however they required access to land. A portion of land on the NHS Borders estate had been identified as suitable and legal advice was being sought from the Scottish Government in regard to the possibility of using that land.

Mr Andrew Bone commented that all of the NHS estate land was crown owned and there were processes and mechanisms to be followed in regard to the disposal of land and buildings and the gifting or leasing of land. It was a complex issue and advice was being sought from the Scottish Government and Central Legal Office as to how to take the matter forward.

Mr Malcolm Dickson enquired why the proposal was only for an 8-bedded unit when we might forseeably have more resident Borderers than that in need of a bed from time to time, and when occasions arose when we might have less, the operating company could make a vacancy available to another health authority. Mr Simon Burt advised that he would follow up on the query.

The Chair commented that the general view from the Committee appeared to be to support the proposal in principle and pursue the further work to develop an agreement.

Further discussion focused on: consequences of provider failure; failure clause would be built into legal agreements; and opening up assets to local communities.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** approved the project in principle and approved pursuing further work in the development of a local Learning Disabilities Complex Care Unit, subject to advice and permission from the Scottish Government.

The **RESOURCES AND PERFORMANCE COMMITTEE** requested an update on the project early in 2021, along with an answer to the query raised by Mr Dickson.

11. Finance Report for the Period to the end of July 2020

Mr Andrew Bone advised that the table at the beginning of the Executive Summary presented the high level drivers of current financial performance. He further advised that the organisation was £4.96m overspent of which £4m related to the COVID-19 response and a stringent monitoring mechanism for COVID-19 expenditure had been established.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the 2020/21 Finance Performance Report for the period to 31st July 2020.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that NHS Borders' ability to deliver the agreed Efficiency Plan had been impacted as a direct result of service dealing with the pandemic and the subsequent remobilisation.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the results of the initial Quarter One Review and year end outturn forecast based on end of June 2020 financial position will be detailed in a separate report.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that following review of the Quarter One submission NHS Borders may be required to amend the year end brokerage funding requested from Scottish Government to achieve a break even outturn.

12. COVID-19 Local Mobilisation Plan – Finance Report

Mr Andrew Bone provided an overview of the content of the report and advised that it covered COVID-19 costs specifically and had been confined to report on the year to date position. A national mechanism had been established for Health Boards to report on COVID-19 expenditure on a monthly basis. The report described the same £4m referred to in the Finance report with more detail in terms of how it had been incurred and what the driving costs were. He also advised that whilst the report covered expenditure it also set out the financial impact of COVID-19 on other activities.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the contents of the report.

13. Quarter One Review and Financial Forecast

Mr Andrew Bone provided an overview of the content of the report and highlighted: the Draft Quarter 1 Review had been prepared to Scottish Government timelines; it predated the Turnaround review and the paper presented the pessimistic view; section 3 provided background to the quarter 1 review; the annual operational plan was the baseline for performance; and section 4 provided an overview of the forecast, described the underlying position and savings forecast; and uncertainty of planning assumptions.

Mr Bone advised that allocations were expected in September, however there remained a risk that retrospective cover for costs endured earlier might not be included.

Mr Ralph Roberts commented that he was uncomfortable as the Accountable Officer with the risk associated with the level of projected overspend, however he recognised and acknowledged the

reasons for the position. Discussions were taking place with the Scottish Government in regard to levels of assurance on the initial remobilisation plan and greater clarity was expected over the following weeks.

Further discussion focused on: costs of new services from scratch with new staff or inclusive of deployed staff; and addressing shortfalls in funding through the level of remobilisation to be put in place.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the forecast position of £22.7m deficit as presented in the draft Quarter One Review.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that this position excluded the brokerage figure of £7.9m anticipated in the board's financial plan; and that the net movement from plan is therefore £14.8m.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the net additional costs associated with Covid-19 response and remobilisation are forecast at £14.0m.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the revisions to the projected savings delivery as described in the paper.

The **RESOURCES AND PERFORMANCE COMMITTEE** acknowledged the level of uncertainty in relation to planning assumptions arising from the current operating environment.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed the actions that would be taken to finalise the forecast, as described in section 9 of the report.

14. Performance Briefing July 2020 – during COVID-19 Pandemic Outbreak

Mrs June Smyth provided a brief overview of the content of the report.

Mr Tris Taylor commented that 'Unfortunately' was a weasel word as it amounted to the Board being asked to accept 'luck' as an explanation for failure to achieve a target - which was not sufficient for any governance process. He sought assurance on "the analysis of why not?" "Why had our ambition so drastically decreased - from eradication of delayed discharges altogether, to a 30% reduction?" He put it to colleagues that certainly in the 3 years he had been a Board member the Board had collectively failed in its duty to scrutinise delayed discharge performance, because it had not taken any action on the associated assurance information systems. The only developments he thought he could remember were the employment of the terms 'standard' and 'complex' to describe types of cases; and the trajectory line on the chart. He suggested the Board should have systematically, iteratively developed its delayed discharge reporting such that it was able to better understand the reasons for delays, the costs associated with delay reduction plans, the value achieved, the gap in performance against expectations, the reasons for that gap, and the associated opportunity cost. For such a big issue the numbers of patients involved were small, and he suggested the Board should receive better-stratified data over time. He suggested little data processing would be involved and where there was a problem the Board must apply analysis, and that analysis must develop and keep developing until the problem was solved. He hoped the Board could apply that in every case where an indicator was subject to the same interrogation over and over again - as signified by Fiona's 'age old question about why so many standard delays'.

Mrs Smyth agreed that the conversation took place at each presentation of the report as the position with delayed discharges continued to decline. She reminded the Committee of the direction from the Board for the Integration Joint Board (IJB) to take ownership of the issue and she advised that data was available for the IJB.

Mrs Nicky Berry welcomed Mr Taylors commented and assured the Committee that work had been taken forward on addressing delayed discharges in the Borders General Hospital (BGH) through implementing a "moving on policy" which was being revisited and would be implemented across the Community Hospitals. An improvement facilitator was assisting Community Hospitals with the implementation.

The Chair suggested further information on addressing delayed discharges be provided to the next meeting.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Performance Briefing for July 2020.

The **RESOURCES AND PERFORMANCE COMMITTEE** sought an update on Delayed Discharges at the next meeting.

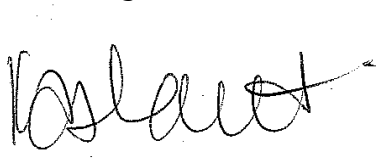
15. Any Other Business

There was none.

16. Date and Time of next meeting

The Chair confirmed that the next meeting of the Resources & Performance Committee would take place on Thursday 5 November 2020 at 9am via MS Teams.

The meeting concluded at 11.03am.



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Chair

RESOURCES AND PERFORMANCE COMMITTEE: 3 SEPTEMBER 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Malcolm Dickson:** I will make my usual declaration of interest when there is any mention of external providers and/or external customers in the Board Papers (Finance Report). My sister-in-law is an Executive Director (Executive Director of Nursing, Midwifery and Allied Health Professionals, and Executive Director for Surgery and Community Services) on the Board of Northumbria Healthcare Foundation Trust. If anyone wants to ask a specific question about external providers or customers I will leave the room for the duration of that specific discussion.	**Iris Bishop:** Thank you Malcolm I will make a note of your declaration in the minutes.
		MINUTES OF PREVIOUS MEETINGS	
2	Minutes of Previous Meetings	**Karen Hamilton:** Note that minutes are from both previous meetings now merged in to R&PC. F&P 19th March – item 12 Inaugural meeting today not 7th May? S&P 6th Feb – Item 12 next meeting 7th May ??	**Iris Bishop:** Yes Karen as the R&PC is a newly formed Committee and the F&RC and S&PC are its predecessors it is correct that the last minutes of those meetings should be approved at this meeting. With regard to "Date of next meeting", the minutes are technically correct as at the time of the meetings the next round of meetings for S&PC and F&RC as the newly formed R&PC would have been on 7 May 2020. However, COVID-19 occurred and we stood down all the Board Sub Committees, hence the inaugural meeting being today.
3	Minutes of Previous	**Sonya Lam:**	**Iris Bishop:** My apologies Sonya for

	Meetings	Item 3: Ms not Mrs	getting this wrong again. I have now amended this error.
		MATTERS ARISING	
4	Matters Arising	**Karen Hamilton:** One action for Rob re Winter Plan review. How to take forward?	**Rob McCulloch-Graham:** Third sector interface members engaged, GP engaged.

		RESOURCES & PERFORMANCE COMMITTEE TERMS OF REFERENCE	
5	Resources & Performance Committee Terms of Reference	**Malcolm Dickson:** Good, comprehensive and understandable. Typo at 3rd bullet? H&SCI should presumably be H&SCP At 1.10, I suggest adding: " , and better decision making across the healthcare system." Otherwise it could imply that performance monitoring and reporting exists solely for the needs of Board members.	**Iris Bishop:** Thanks Malcolm yes H&SCI should really be H&SCP, I will make the amendment. I am happy to take your suggestion for point 1.10 to the next Code of Corporate Governance Steering Group (CoCGSG) meeting where we review the various elements of the Code including the Terms of Reference of the Board Sub Committees and recommend any changes to the Audit Committee prior to formal submission to Borders NHS Board for approval. The CoCGSG is next due to meet in October.
6	Resources & Performance Committee Terms of Reference	**Karen Hamilton:** Noted no comment.	**Iris Bishop:** Thank you.
7	Resources & Performance Committee Terms of Reference	**Sonya Lam:** Item 5: 1.1.3. In terms of reviewing the Committee's work, is there a measurement framework that provides an indication of what good looks like. For example, how will we know if we have ensured alignment across the whole system planning and commissioning?	**Iris Bishop:** Thank you Sonya, the intention was that the self assessment document would act as a measurement framework to ensure the Committee was achieving what it set out to do. The self assessment document is currently in draft form and requires further work.

		RESOURCES & PERFORMANCE COMMITTEE BUSINESS PLAN 2020/2021	
8	Resources & Performance Committee Business Plan 2020/2021	**Malcolm Dickson:** The business plan is also good but I wonder if just an annual look at the workforce plan and projection is sufficient given that this is the resource that consumes the majority of the budget? I suggest twice a year at least, eg to monitor progress against:- a target workforce profile; projected staff cuts as part of efficiency savings; projected leavers and recruitment etc.	**Andy Carter:** The pandemic has changed the landscape around workforce planning; the pace of service change has been rapid, with the need to establish services which were previously not established (Test & Protect). NHS Borders has decent workforce data. It can be used to track progress against the business plan and there can be regular checking between plans.
9	Resources & Performance Committee Business Plan 2020/2021	**Karen Hamilton:** Clarity of Actions under September 3rd 2020? Consider timings for Financial Strategy progress....	**Iris Bishop:** Thank you Karen, the Financial Strategy is scheduled to be received by the Committee in January, May and November each year. The business plan has been fluid for 2020 due to the impact of COVID-19, therefore the financial strategy has been pushed back to the next meeting on 5 November.
10	Resources & Performance Committee Business Plan 2020/2021	**Sonya Lam:** Item 6: Is the annual self-assessment of the Committee's work in one of the existing business plan lines or should it be a separate activity?	**Iris Bishop:** Thank you Sonya, the self assessment should appear as a separate activity in the business plan. I will amend accordingly.

		FINANCIAL TURNAROUND PROGRAMME - PROGRESS REPORT	
11	Financial Turnaround Programme - Progress Report	**Malcolm Dickson:** Typo page 3/30: in the second set of bullets, 3rd bullet, I presume the first of the two FYEs is meant to be PYE?	**June Smyth:** Thank you for pointing this out Malcolm. Apologies, the first FYE should read PYE.
12	Financial Turnaround Programme - Progress Report	**Karen Hamilton:** Concern that Turnaround has been on hold for last 6 months or so? Have Covid activities and demands been influenced (restrained?) by Turnaround? Noted that PMO effectively 'closed'. The future for significant savings looks bleak - when will we restart this activity? Appreciate there is a presentation to go with this item which hopefully will show impact of Covid on Turnaround in a readily digestible table format. How do we sit with other Boards in comparison?	**June Smyth:** The PMO is still very much open, however due to the pandemic all turnaround activities were paused to enable PMO resource to be shifted to COVID-19 response functions such as setting up the Test and Protect team and drive through testing facility. PMO resource continues to support response functions such as planning the enhanced flu campaign and project managing the reshaping urgent care programme. All PMO resources are currently committed to COVID-19 related activities. We are intending to engage with services from 1 April 2021 to plan how to deliver 2021/22 schemes. We do not believe that there is capacity in services to engage before this time. COVID activities and demands are scrutinised through the Recovery Group. All spend requests must be support by data and evidence to be approved. PMO resources are prioritised through this meeting also. In terms of comparisons with other Boards that should become clearer through

			September once discussions with SG around COVID-19 are held with the Directors of Finance.
13	Financial Turnaround Programme - Progress Report	**Fiona Sandford:** How realistic is it that the 900K savings moved to 2021/22 will be achievable? Are we kicking the can down the road?	**June Smyth:** Firstly apologies Fiona that there is a typo and the £900K savings should read £780K savings. Based on the assumptions outlined we believe that £780K is achievable. The projected savings for some schemes have been reduced from what was initially identified to reflect new ways of operating. Once resource can be shifted back to turnaround activities as well as a campaign to identify new schemes is initiated we will review all schemes that have been delayed/not delivered to date to identify elements that can be progressed to deliver savings.
14	Financial Turnaround Programme - Progress Report	**Sonya Lam:** Page 3. Will input from service leads and business units lead to a different conclusion? How realistic is it to achieve savings in Q4 in the context of remobilisation and winter pressures?	**June Smyth:** We believe they will come to the same conclusion. PMO and finance colleagues have a close relationship with the services and therefore the revised plan represents to the best of our knowledge what is achievable. We will be undertaking further scrutiny around those schemes which we have classed as at risk for 2021/22. We have examples of these in the presentation which will provide more detail. The savings that are to be delivered for Q4

			relate to schemes that are either already well advanced, there is a contract that has ceased, or will require minimal service change to deliver.

		LABORATORY INFORMATION MANAGEMENT SYSTEM (LIMS) NATIONAL OUTLINE BUSINESS CASE	
15	Laboratory Information Management System (LIMS) National Outline Business Case	**Malcolm Dickson:** The risk implications on the covering paper all point to the need for this new LIMS, ie there appear to be no risks in joining a partnership with other boards or in using a largely untested new procurement system. In the Deloitte paper, 8 risks have been identified. In the same Deloitte paper at 1.3.4 demand optimisation is recommended to address a problem which I'm sure is accurate (from what I've picked up from executive colleagues) but it doesn't seem to me to explain how LIMS will help solve the problem. These minor points aside, I'm happy that we continue to explore the possibility of this collaborative project.	**Jackie Stephen:** Accept the risks are as in the business case and could have been pulled through. This isn't a new procurement process, and the consortium has a very experienced rep from digital national procurement on the Board to advise the group. They will provide expert advice throughout. LIMS contribution to demand optimisation will be through better access to data and through flagging tests already undertaken etc through configuration. It will help labs better see where workload is. It will also help with effective use of resources through additional functionality.
16	Laboratory Information Management System (LIMS) National Outline Business Case	**Karen Hamilton:** Does this relate in any way to improved Covid testing in the future? We are asked to Approve, noted the risk implications – do we really have a choice? ? Noted figures are worst case scenarios – how soon might we see more accurate estimates?	**Jackie Stephen:** There probably isn't a direct link to improved testing though it may allow us to process and mage workload better and better links to other systems. My view (and labs colleagues) is that we need a new LIMS desperately and it is a significant risk to us so no there isn't much choice in whether to purchase just how, when and what. This provides the best opportunity for us to be consistent with the rest of Scotland and drive value. The final cost will be provided at Full

			business case stage following the procurement process and a preferred option / supplier being identified. This is before any actual commitment to sign a contract and is likely to take 12 months.
17	Laboratory Information Management System (LIMS) National Outline Business Case	**Fiona Sandford:** LIMS: happy to support the proposal	**Jackie Stephen:** Thank you
18	Laboratory Information Management System (LIMS) National Outline Business Case	**Sonya Lam:** Item 8: Approve ongoing participation. Although the OBC states at this stage that LIMs is not anticipated to enable significant monetary benefit, it will be important for NHSB (and other Boards) to understand what the efficiencies will be in the FBC.	**Jackie Stephen:** Agree absolutely and this is work we will undertake as part of the FBC. Once we understand the preferred solution it should be easier to see how we can change ways f working but some may relate to the national labs programme and how labs function in Scotland. We intend to have one regional instance in the east region which does offer opportunities for us.

		EDINBURGH CANCER CENTRE INITIAL AGREEMENT	
19	Edinburgh Cancer Centre Initial Agreement	**Malcolm Dickson:** Risk implications - there must be some similar risks to those identified for the LIMS project, eg large building projects seldom come in anywhere close to budget, or are we at risk by being the smallest partner and therefore likely to have the least influential voice? Nevertheless, I am happy that we continue to participate in consideration of this project.	**Kirk Lakie:** At this stage of the process we are keen to establish a number of key principles and ensure we have a clear commitment within the Initial Agreement to mitigate or address as we move through the process of developing a business case for regional cancer services. These being : • Equity of access • Sustainable workforce models • Affordability and Value We will use the well established regional planning framework (RCAG, SCAN etc) to ensure our views are taken into account as we move through the development process.
20	Edinburgh Cancer Centre Initial Agreement	**Karen Hamilton:** Noted this is an issue on the far horizon for us at present. Content that our concerns are covered in final para of the Exec Summary	
21	Edinburgh Cancer Centre Initial Agreement	**Fiona Sandford:** What indicators will we use to determine whether or not we are satisfied that there will be improved care closer to home?	**Kirk Lakie:** NHS Borders have indicated that the strategic intention outlined in the paper of ensuring “care closer to home” needs to be further developed to the point where we can determine what the future shape of service will be, and crucially, where we need to invest to facilitate that vision.

			I don't think it's clear or indeed inevitable at this stage that all of the required investment, capital or otherwise, will be in Edinburgh. It's certainly possible that delivering the models of care that will emerge will require investment in West Lothian, NHS Borders and NHS Fife. We are challenging the underlying " like for like replacement " assumptions which are apparent in the IA at present.
22	Edinburgh Cancer Centre Initial Agreement	**Sonya Lam:** Noted. My understanding is that this initial agreement and plan is predicated on a transformed cancer service model. From the workshop held in April 2019, is NHS Borders clear about the benefits realisation of this transformed clinical model to Borders and how does the model align with our own cancer services that that are not included in this IA? Are our clinical leads and other relevant stakeholders fully engaged and in agreement with the transformed clinical model? What is our ROI of £1.2-1.37m annually?	**Kirk Lakie:** I would agree that at present the ECC IA has an almost singular focus on services delivered from the Western General site and there is a need to step back and review from a Cancer Services perspective, taking into account elements delivered in satellite units in West Lothian, Fife and the Borders. There is commitment within the IA to ensure that this work will be undertaken following agreement over the next 12-18 months. The Regional Planning Group have committed to supporting senior posts in both NHS Borders and Fife (B7) to ensure this is done. It's also clear that significant additional attention will need to be given to establishing an understanding of opportunities and benefits that an investment of this scale will bring to the

		If we invested this amount annually into local cancer services what would the benefits be?	region, and how affordability and value will be guaranteed. I don't think that this is clear at this stage.

		COMPLEX CARE UNIT – LEARNING DISABILITIES	
23	Complex Care Unit – Learning Disabilities	**Malcolm Dickson:** I believe this is an eminently worthwhile development. It must be horrendous for families of patients on external placements to have to travel long distances to visit, and this will give a local service to some of our most needy patients. However, I have some questions. I'm not sure whether the intention is to enter into a contract with the company concerned to provide this service, or will we simply be landlords plus pay for each of the patients admitted from amongst our patients? If a contract, it would surely have to be time-limited (renewable provided we're happy with the cost and performance of the service) and subject to care standards that we impose? I believe we currently have 12 placements elsewhere (at least that's what the annual cost implies), with an estimated new demand of two to three patients per year, not necessarily matched by vacancies, so why are we only seeking an eight-bedded unit? Why not twelve or even fourteen and the unit could take in placements from elsewhere if there are vacancies and no known Borders patients likely to need a place?	**Simon Burt:** Thank you for your helpful comments. The arrangement between the Health and SC partnership will be to provide the land and not to block purchase beds. However when we come to detail of the lease if land we will want to ensure that we have the option of using some or all of the beds to meet local need and to allow the Provider to contract a bed out when demand is not there locally. In regards to quality of service provision then I agree we will need to look at placing safeguards in place. We would need to look at an alternative provider coming in to deliver care if the current provider was de registered by the Care Inspectorate for example or consistently provided a poor level of care. In regards to numbers there is a balance here with deliverability against demand. We do have in excess of 8 placements external to the Borders but all wouldn't necessarily be suitable to move in together due to different types of need, compatibility etc. The Providers draft plans are flexible and could include up to 10 placements within the proposed development and potentially a few more. As you rightly mention, the Provider

			has the ability to allow other external placements in if local demand is insufficient, safeguarding investment and ensuring financial viability and keeping placement costs down. I will also be attending the committee to present the paper.
24	Complex Care Unit – Learning Disabilities	**Karen Hamilton:** In principle I support this concept of at least future individuals having the choic to remain on Borders for long term care. (repatriating clients may have different issues). There is clearly a cost saving as well as a potential quality of life benefit for some. Noted the legalities and principles of gifting land – Is November realistic to present a formal proposal?	**Simon Burt:** I'm hopeful that November is realistic however this will be partly dependent upon SG ability to respond quickly. There will also need to be contractual negotiations between the provider and NHS Borders/NHS Scotland as well so again we will be dependent upon how quickly the respective legal teams can reach agreement for consideration. **Andrew Bone:** Following discussion with SG colleagues we have now received agreement in principle to explore this option further and take a detailed proposal back to SG for approval once legal and financial workup is completed. This work will be dependent upon CLO advice and further negotiations with the proposed provider. A project timeline will be agreed and any changes to the timescales outlined will be updated to the board in September.
25	Complex Care Unit – Learning Disabilities	**Fiona Sandford:** Complex Care Unit: should we not be more ambitious on size (echoing Malcolm)	**Simon Burt:**

26	Complex Care Unit – Learning Disabilities	**Sonya Lam:** Approve pursuing further work. Do we have an estates strategy?	**Andrew Bone:** There is an extant Property & Asset Management strategy however it is recognised that we need to do further work to clarify the long term future and priorities for our Estate. This will include the development of the Borders Health Campus project, which covers BGH site, as well as a Primary Care Premises strategy. This work is intended to be taken forward over the next 12-18 months. In terms of the land holdings being considered for the Complex Care unit, an initial assessment has confirmed that the board do not have any strategic intention to develop services on this location. Assuming the proposal is supported, we would expect to further articulate this in the final case.

		FINANCE REPORT FOR THE PERIOD TO THE END OF JULY 2020	
27	Finance Report for the period to the end of July 2020	**Malcolm Dickson:** Is the bottom line that the out-turn for this four month period, if we assumed that we are refunded the C19 costs and provided with one third of the anticipated £7.8m brokerage, would be as follows? April – July budget deficit £4.96m C19 expenditure £3.94m 4 month proportion of £7.8m brokerage £2.6m A – (B + C) = £1.58m to the good? At 4.3, I would hope that addressing the deteriorating performance against access standards will be less of a priority than clearing the backlog, albeit I appreciate that the two are linked.	**Andrew Bone:** Whilst each of the elements of this calculation are correct, I would not anticipate that the board will receive brokerage such that it would result in underspend. SG will consider the board's year end forecast before determining the extent to which brokerage will be allocated. In terms of C19 expenditure, whilst SG have approved *in principle* our expenditure reported to end June, we do not have the same level of assurance over prospective plans for the remainder of 2020/21 – this will be considered through Q1 review discussions.
28	Finance Report for the period to the end of July 2020	**Karen Hamilton:** Recommendations noted. The risks articulated on P10 give concern particularly around the uncertainty on financial recompense for Covid spend. Do we have any hints of timescales for more information? What impact will there be on recovery in the absence of this?	**Andrew Bone:** I will provide verbal update under the Q1 review paper. We do anticipate that there will be greater clarity on funding as we progress through the Q1 forecast process. SG have confirmed that allocations will be made in September, however scope/scale still to be determined. Initial dialogue with SG – 7th Sept Final Q1 submission 18th Sept Update to NHSB Board 24th Sept
29	Finance Report for the period to the end of July 2020	**Fiona Sandford:** Do we have any indication how our financials benchmark with other Boards?	**Andrew Bone:** The detailed benchmarking is being undertaken by 2 separate groups – regional peer review on NHS non-delegated

			costs and a national review of H&SC plans. No published out puts at present but information shared with DoFs network indicates NHS Borders are fairly comparable overall – Covid related expenditure appears to be c.9% of annual spend; range for territorial health boards is between 8 – 13%.

		COVID-19 LOCAL MOBILISATION PLAN – FINANCE REPORT	
30	COVID-19 Local Mobilisation Plan – Finance Report	**Malcolm Dickson:** 5.1.6 I noted the slight discrepancy helpfully explained here, but does this mean that we are not claiming C19 pharmacy costs from SG? 6.3 I think we are all very appreciative of the role that our Director of Nursing and others have played in Care Home liaison and medical supervision, and the hopefully lasting advantages that this has brought in terms of mutual trust and understanding. And I appreciate that it is as necessary now, especially in the Hawick area, as at the height of the pandemic. But, has there been any indication from SG how long these additional responsibilities in relation to Care Home supervision might last, or are they likely to become permanent? If the latter I'd hope that concerted effort could be put into seeking new permanent funding to support this work.	**Andrew Bone:** 5.1.6 – no, we are flagging all covid related expenditure to SG and would be seeking reimbursement, however for our internal reporting it is not possible to disaggregate prescribing spend and therefore the financial impact of Covid cannot be reported directly. The figures provided (as with all HBs) are based on agreed national planning assumptions. We will seek funding reimbursement if we are able to demonstrate an overall financial overspend on prescribing, but if other factors (i.e. reduced activity) offset these costs, then it is likely that this will not be directly funded. **Nicky Berry:**
31	COVID-19 Local	**Karen Hamilton:**	**Andrew Bone:** I will discuss this point as

	Mobilisation Plan – Finance Report	Taking the opportunity to acknowledge the challenge of remobilisation in every area – not least the Finance environment. How far can we view the costs to date as an accurate forecast of the costs over the year bearing in mind the degree of activity, workforce etc ? The 3 risk headings outlined are very broad and referred to as further described in the Qtr 1 Review paper. In that paper (P 11) can we assume that all risks described are directly related to Covid. Could you clarify?	part of the Q1 review paper, but briefly: The costs for the year to date are reflective of the Covid response phase. We have mechanisms in place to track these using the same processes that we apply to all other areas of expenditure (delegated approvers, cost centre monitoring, etc.). Projecting forward from this position is more difficult because we have to overlay the impact of remobilisation plans, winter planning, and a potential 2nd wave. The assumptions for remobilisation are based on stages for increasing activity throughout the remainder of the year, but will be contingent on our ability to implement the proposed plans – in some cases this includes workforce requirements which may not be fully available. The 3 risk headings are deliberately broad and should be considered as thematic. Within these we can describe a number of subsidiary risks however these are dynamic and in some cases a function of the planning timescales – in effect, they will be resolved as we develop greater clarity over the resources required/available to deliver the plans. The strategic risk register has been updated to include an annex to the existing Finance risk around delivery of statutory targets – this annex describes in detail the additional financial risk arising from Covid19 pandemic and actions

			employed to manage this risk. For Q1 review the risks articulated could be considered as exclusively related to covid-19 given that this sets the context for all of the financial challenges described, however some of these risks are indirect –e.g. non-delivery of savings plans is described within the risks identified in the board's AOP. The increased risk to savings arises largely as a result of the capacity challenge faced by PMO and service management due to Covid19 response. I would advise that the Q1 risks should be seen as predominantly Covid-19 related, but supplementary to the risks already articulated in the Board's financial plan, which pre-dates Covid19.
32	COVID-19 Local Mobilisation Plan – Finance Report	**Fiona Sandford:** Do we have any indication how our financials benchmark with other Boards?	**Andrew Bone:** See 29, above.

		QUARTER ONE REVIEW AND FINANCIAL FORECAST	
33	Quarter One Review and Financial Forecast	**Malcolm Dickson:** I'm always looking for a bottom line and it seems that, at present (and things can and will change), we can anticipate an end of year deficit of around £800k? 4.7.2 This refers to the non-recurrent savings target of £7.1m but does not predict that the £7.1m will be achieved. Can we assume that it will?	**Andrew Bone:** I think this point probably requires discussion at the meeting. This interpretation could be inferred from the information provided (i.e. that if we receive brokerage in line with Fin Plan AND are fully funded for Covid and remobilisation). I don't think we can assume that all of this will be funded in full at this stage, however. Equally, I would expect to argue that we require further brokerage to offset our non-delivery of savings and this would – in theory – close the gap on the £800k. 4.7.2 – at Q1 we are anticipating that the £7.1m will be delivered in full. This includes some elements which require further work to finalise during the next 6 months, however I would assess these as low/medium risk.
34	Quarter One Review and Financial Forecast	**Karen Hamilton:** We are asked to acknowledge a level of uncertainty (Section 5). Do we have any indication of the financial impact of these areas of uncertainty? Worst case scenario?	**Andrew Bone:** The scenario presented in the forecast is a combination of the most-likely and worst case scenarios. We have been prudent around funding assumptions, and optimistic about recruitment (which translates into pessimistic around costs) against remobilisation plans. These assumptions continue to be refined through dialogue both internally and with SG. A reasonable assessment of current trend (£5m overspend after 4 months) would indicate that we are on trajectory for an

		Any discussion generally with SG regarding brokerage – continuation, variation? Happy to pick this up verbally at the meeting.	outturn position of £15m. Accepting that Remobilisation and Winter will both increase this pressure, the forecast is indicating that costs would increase by c.£1m per month for the remainder of the current year. The main counter to this would be the extent to which we (a) can recruit and (b) choose to rescale our plans to meet the level of funding made available. Examples of sensitivity within the forecast: • There is £1.4m of costs within the forecast which relates to the increased bed requirements to manage a potential 2nd wave. If this does not manifest then it is likely these costs will not be incurred. • £1m is included for Winter plans however the plan remains in development – based on current cost modelling this may be underestimated by c.£0.5m. • Recurring savings delivery is reported as £0.9m in the forecast. The Turnaround assessment describes potential delivery of £1.6m in 2020/21. The Q1 forecast was prepared in advance of this review. If we deliver at £1.6m then the forecast will improve by £0.7m. Brokerage – we can discuss at the meeting.

		PERFORMANCE BRIEFING JULY 2020 – DURING COVID-19 PANDEMIC OUTBREAK	
35	Performance Briefing July 2020 – during COVID-19 Pandemic Outbreak	**Malcolm Dickson:** I appreciate the reasoning behind these shortened reports and am grateful for the effort that is put into them. Page 4, outpatient consultations. Is the 52% projection for appointments delivered virtually intended to be permanent or only until we have seen off C19 and the backlogs it has caused? If not permanent I suggest that we should consider seeking a permanent target, set by the relevant clinical boards and adjusted in light of experience if necessary. Will all or most of the huge, lost outpatient activity (29,387 appointments) need to be recovered? Presumably some people will just have got better on their own accord or with medication, some may have died, some will no longer be relevant (eg some follow-up appointments for successful procedures or treatments). I guess the difficulty is that some sort of contact will need to be made to establish who still needs a consultation, and the likelihood is that this will be most?	**June Smyth:** 52% is intended to be permanent. Clinicians were asked to predict, based on their experience of conducting virtual consultations during COVID-19, considering percentages for both new patients and review patients. There may be a slight variance based on using these modalities moving forward. We plan to use national benchmarking data for comparisons. Waiting list validation has been conducted by all specialty teams for patients on new waiting lists to support clinical prioritisation but also identify those patients who may not need to be seen. Contacting patients is dependent on patient condition. Telephone appointments are being used to assess patients.
36	Performance Briefing July 2020 – during COVID-19 Pandemic Outbreak	**Karen Hamilton:** DD's. I note the relative improvement in Table on page 2 and the strategies to keep these numbers down. Is the 'Choices' principle being applied to those waiting for specific care homes? Are those DD's waiting reviewed and/or reassessed regularly to ensure destinations are still appropriate?	**Rob McCulloch-Graham:** Info from daily tracker - Yes it is we have two examples yesterday, of patients having a temporary move. However there are also two examples where one move only has been determined by the MDT. Yes they are by both MDT and Social Work.

		Waiting times (P4) – presumably if the target is 52% out patients 'seen' (this includes phone contact?) virtually then 48% will be face to face but planned return is described as 40%? The lost in and out patient activity figures are alarming but understandable. What impact do we think this has on staff morale??	**June Smyth:** The target is 52% of outpatients seen virtually (including phone contact) and 48% seen face to face but we are only able to recover 40% of this 48% within our available resource. Staff are understandably frustrated that we can't offer more capacity but services (clinical and operational leads) have been directly involved in designing the remobilised services and are well aware of the constraints in which we need to operate to safely deliver services whilst living with COVID-19. More capacity may be possible as we move through the coming months but that would be subject to additional resources which may not be available (space, money and staff). We are currently working through this with services to more fully understand this.
37	Performance Briefing July 2020 – during COVID-19 Pandemic Outbreak	**Fiona Sandford:** Age old question on why so many standard case delayed discharges	**Rob McCulloch-Graham:** No one reason; lack of high end dementia care, risk averse behaviour in some cases of discharge, Guardianship issues, lack of capacity within home care, difficulty in using moving policy. Processes in place and operational however the system performs better under pressure.
38	Performance Briefing July 2020 – during COVID-19	**Sonya Lam:** Item 14: Noted. Delayed discharges: What has changed in approach between March and now? What assurance is there in	**Rob McCulloch-Graham:** No one reason; lack of high end dementia care, risk averse behaviour in some cases of discharge,

	Pandemic Outbreak	terms of reduction?	Guardianship issues, lack of capacity within home care, difficulty in using moving policy. Processes in place and operational however the system performs better under pressure.
		Cancer: if referrals significantly dropped by 70% what action are we taking to increase referral rates?	**Kirk Lakie:** Referral number for urgent suspicion of cancer were tracked very closely and while they dipped significantly at the point of lock down, in general excluding screening activities referral numbers have recovered strongly. Comparative analysis undertaken suggests at this point in the year referral numbers are at or close to 2019 levels. We have kept, and will continue to keep this under review.
		Acknowledge a smaller suite of measures reported but can we have an update for the 4 hour target and how are we addressing our performance?	**June Smyth:** *See chart below Q&A table for an overview of EAS performance to July2020 Week Ending 30th August Position: 6 Wk Ave 67 Prev Week 116 Last Week 66 ↓ -43%

*Emergency Access Performance Data