Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 5 November 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
Mrs A Wilson, Non Executive
Mr J McLaren, 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 V McPherson, Partnership Representative

In Attendance: Miss I Bishop, Board Secretary
Mr G Clinkscale, Associate Director of Acute Services
Dr A Cotton, Associate Medical Director
Mrs C Oliver, Communications Manager
Mr C Myers, General Manager, Primary & Community Services

1. Apologies and Announcements

Apologies had been received from Cllr David Parker, Non Executive, Dr Tim Patterson, Director of Public Health, Mrs Nicky Berry, Director of Nursing, Midwifery & Acute Services, Mr A Carter, Director of Workforce and Dr Janet Bennison, Associate Medical Director.

The Chair welcomed Mr Chris Myers, General Manager Primary & Community Services to the meeting.

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.

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

Ms Sonya Lam declared that her partner was a specialist advisor for the Scottish Government

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declarations made by Mr Malcolm Dickson and Ms Sonya Lam 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 3 September 2020 were amended at page 5, minute 10, to include an additional paragraph 3, 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." and at the end of the third recommendation to include "along with an answer to the query raised by Mr Dickson." and at page 7, minute 14, paragraph 2, line 14 remove "very" and with those amendments the minutes were approved.

4. Matters Arising

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

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

5. Finance Strategy

Mr Andrew Bone provided a presentation to the Committee on financial strategy which was intended to build on the awareness of issues for the Committee and show his initial observations on developing a financial strategy and actions and processes to consider for implementation. During the presentation he highlighted several key elements including: financial and operational challenges; performance escalation; the current operating environment; strategic fit; workforce planning; remobilisation, recovery, redesign framework and strategic framework for COVID-19 response; and expenditure.

Mr Malcolm Dickson enquired if the aspiration was to support 3 year planning with a 3 year budget. Mr Bone confirmed that work would be taken forward to align to the Board's strategies in order to provide sustainability over 5, 10 and 15 years. If the strategy was right it should be easier to make a decision to align to that instead of continually updating the strategy.

Mrs Fiona Sandford enquired if the costs were above inflation and Mr Bone confirmed that costs were inclusive of inflation.

Mr Ralph Roberts commented that his understanding was that the aspiration of Scottish Government was to move to a 3 year plan that linked service planning, workforce planning and financial planning. However he cautioned that the Scottish Government budget cycle was linked to the UK's budget and did not usually get beyond a 1 year cycle. However, he surmised that it should not preclude the organisation from making a long term strategy based on agreed long term assumptions.

Mr Dickson enquired in the wider context of how much could be delivered by the Board and whether the Board should be engaging with Scottish Borders Council to adopt some common ground in how both organisations face a financials treaty for the future. Mr Bone commented that the Board would be working with partners and getting into those types of conversations. The

challenge was to find the opportunities where joint work would yield results and deliver a change that both organisations were signed up to.

Mr Tris Taylor commented that he was pleased to see organisational acceptance that Finance work could be strategic. He was very much in favour of the work continuing and developing across the function and the organisation and enquired what the reception had been like from Finance and other colleagues to date. Mr Gareth Clinkscale commented that operational leadership teams had welcomed Andrew's approach as the framework made sense from an operational perspective.

Mrs June Smyth commented that the Executive Team had discussed the approach, a change in language and retention of the lessons learnt from turnaround. During the initial phase of COVID-19 the organisation had one single purpose and had pulled in the same direction. Through the lessons learnt discussion it was stressed that when returning to financial turnaround there was a need to keep that in mind. There was a general feeling that in bringing the programme back on stream the organisation should consider how it would drive it or position it, to better secure from staff the purpose of the programme, so in effect keeping the best of what it had learned and put in place under turnaround but within a longer term strategic context just as Mr Bone had outlined. Mr Bone commented that in terms of performance and data the intention was to improve and build on what had been helpful during the turnaround process.

Mr Taylor further commented that it was important that the Board focus on the cultural aspects of its responsibilities. He suggested what had been described by Mr Bone as the approach and intention to drive some behaviours organisationally, as well as putting rigour in the processes of performance management and data visualisation, were explicitly centred on providing actionable insights for whoever was receiving it and that was part of setting the organisations culture.

Further discussion focused on: acknowledgement of interdependencies; plan to bring all GP staff such as practice nurses, receptionists, etc under Health Board employment; next phase of the GP contract due from next April; and charitable schemes.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Presentation.

6. Finance Report for the period to end of September 2020

Mr Andrew Bone reported that the Board was £6.7m overspent at the end of month 6. Aside from that he had now received confirmation of allocations around COVID-19, which were not included in that position. He further highlighted that the reporting of COVID-19 figures to the Scottish Government included all of the costs associated with COVID-19, such as the repurposed use of some areas as designated COVID-19 beds. All costs were reported however some were reported differently as they were included in the Scottish Government submission. He assured the Committee that a reconciliation had been undertaken to ensure consistency overall.

Mr Malcolm Dickson referred to the Committee Q&A and commented that his questions had been answered both during the presentation and by the Finance Report. Both he and Audit Scotland had referred to old language and he had welcomed some consensus on the way ahead. He further enquired if there was available resource to do the forward planning that Mr Bone was anticipating. Mr Bone commented that the Audit Scotland report had suggested a restart of turnaround as soon as possible and irrespective of what happened with strategy, the core of that was that savings needed to be identified and pursued. The recommendation by Audit Scotland had been accepted and the conversation on what that model would look like would happen over the following weeks with an expectation that a response to that recommendation would be provided to the Audit Committee.

Ms Sonya Lam enquired about staff vacancy versus patient activity, given the majority of the underspend had been in medical agency staffing and she had not seen that reflected in other staff groups. Mr Bone advised that a full analysis had not yet been undertaken, however, in terms of medical agency there were 2-3 posts at that level which were posts associated with the COVID-19 response and specific posts had been implemented for specific issues. There was a reduction in agency spend in other areas which probably reflected the pre COVID-19 work done on turnaround. Mr Gareth Clinkscale confirmed that a medical locum had been engaged to support the COVID-19 response as well as some critical gaps in planned care that were associated with sickness absence and not COVID-19.

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 30th September 2020.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that NHS Borders' ability to deliver the agreed Efficiency Plan has been impacted as a direct result of service dealing with the pandemic and the subsequent remobilisation. Detailed information will be provided in a further report to this Committee.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the Board has now received additional allocations in relation to the COVID response and remobilisation plans. The reported position at month 6 does not include this funding, pending agreement of allocation. This approach is in line with SG advised reporting of year to date performance. Funding will be released to budgets at Month 7.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that following receipt of this allocation, the board will review its year end forecast and that this may result in a revised brokerage request against the board's requirement to achieve a breakeven outturn. A separate review on the year end out turn will be presented to the Board.

7. COVID-19 Local Mobilisation Plan – Finance Update

Mr Andrew Bone provided a brief overview of the content of the paper and focused the attention of the Committee to table 7 on page 12 of the report which brought together all of the elements into a single chart to visually see how the organisation sat financially against the forecast.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the reported position in relation to expenditure incurred to date.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the increased clarity available in relation to allocations, and the comparison of these allocations against the expenditure forecast.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the overall impact on the board's year end forecast and the further work required to update the forecast and deliver financial balance in 2020/21.

8. Capital Plan Update

Mr Andrew Bone provided an overview of the content of the paper which was the first capital update report of the year.

In regard to the Committee Q&A he referred to Mr Dickson's question on the adult changing facility and explained that it had not been possible to progress that work whilst the organisation was dealing with the COVID-19 pandemic. He assured the Committee that work would be progressed as soon as it was safe and practical to do so.

Mr Bone commented that in regard to medical equipment, there had been no substantial replacement of medical equipment undertaken due to COVID-19. He anticipated being able to reinstate that rolling programme early and advised that should there be a shortfall in other programmes he would re-evaluate the phasing into the following year.

Mr Tris Taylor sought notice of the deadline for completion of the Forensic Medical Examination Suite. Mr Ralph Roberts advised that he was not in a position to be able to confirm a definite date, as there was more work to be taken forward on potential alternative options to the original plan. He suggested the Committee agree that it wished a completion date to be identified for the Forensic Medical Examination Suite, so that it could be entered onto the Committee's action tracker.

Mr Malcolm Dickson commented that he was fully supportive of the way adjustments had been made and accepted Mr Bone's comments in regard to Endowment funded schemes. However, he suggested there was a danger if endowment projects continued to be considered under the existing criteria for prioritisation, as with other projects, as they may never reach the prioritisation level required to expedite them. He gave the example of the adult changing facility which had been continually delayed under that prioritisation process. He suggested endowment funded schemes should be considered separately if the labour costs were included in the endowment funding.

Mrs June Smyth highlighted to the Committee that in regard to the LD Complex Care Unit as supported by the Committee on 3 September, she, Andrew Bone and Simon Burt had discussed and agreed that some uncommitted funding would be used to progress the proposal in terms of assessing the technical feasibility of the site and some associated legal support.

The Chair commented that there was further work to be done in regard to transparency of endowment unit costs and she suggested the Endowment Committee progress that work.

Ms Sonya Lam enquired if there were any areas of risk the Committee should be aware of where capital projects were not proceeding. Mr Bone commented that a new process would be established to steer the development of the Property and Asset Management Strategy (PAMS) and capital programme itself and through that process he expected to develop a programme risk register. In terms of specific risks associated with projects already in place there were programme risks and they were broadly in areas of service risk, financial risk and reputational risk.

Mr Bone further commented that he had created a new Capital Investment Group to develop a forward plan and the premises strategy, Borders General Hospital campus, oversight of backlog maintenance, road to digital programme and environmental sustainability would all be taken through that group.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the issues described in the report.

The **RESOURCES AND PERFORMANCE COMMITTEE** approved the updated expenditure plan for 2020/21 (section 5.2).

The **RESOURCES AND PERFORMANCE COMMITTEE** endorsed the revised approach to the development of the board's Property & Asset Management Strategy (section 5.3).

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed that it wished a completion date to be identified for the Forensic Medical Examination Suite.

9. Delayed Discharges Update

Mr Rob McCulloch-Graham provided an overview of the content of the paper and specifically drew the attention of the Committee to paragraphs 2.1 and 2.2.

Dr Lynn McCallum sought a timeline on implementation of the Trusted Assessor especially given the impact of beds being occupied by those who did not need them. She commented that whilst work was being taken forward around senior decision making going into the weekends, in effect on the ground the experience was that new packages of care or moves to care homes could not be facilitated. There appeared to be work required on the connectivity of staff on the ground to ensure discharges could take place on the weekends. Whilst a process might be in place, in effect it was not happening on the weekends. She emphasised that a consultant might agree a patient could be discharged but it was more than just the sign off by the consultant that was required, Social Work and Allied Health Professions needed to facilitate the discharges and be able to work across all 7 days in order to do that. She commented that the issue was far larger than that, that was represented in the report before the Committee.

The Chair commented that the report provided the situation at the moment and did not give the granularity that the Committee had been looking for in terms of reasons for why delayed discharges were in the position that they were. Progress appeared to be being made in the Borders General Hospital and Huntlyburn however it was the Community Hospitals where the blockages were worse and the Committee had hoped to understand the reasons for that and the impact it had on the overall services of the organisation.

Mr Tris Taylor commented that the paper did not address the specifics that were minuted at the previous meeting. He suggested that the Committee had been looking for a step change in the assurance information provided on delayed discharges, as currently the Board was unable to discharge its scrutiny duty on delayed discharges. That was mainly due to the fact that the Board was not furnished with enough data on what was going on. The paper described progress of work, however there was not enough real data in the report and the charts appeared to be less granular than those provided in the performance reports.

He further commented that it was not enough to cherry pick performance in the Borders General Hospital and ignore what was happening in the Community Hospitals. He sought a full picture of the worst position because the Committee needed to be able to recognise those challenges and support a response to them and stand behind the Executives and staff to enable them to address the position. The Committee was unable to do that as it did not have sight of the overall programme, performance indicators, or actions being taken to bring delayed discharges back under control. He commented that the assurance information system around delayed discharges was inadequate.

Mr Malcolm Dickson agreed with Mr Taylor's comments and suggested there were some issues in regard to ownership of delayed discharges. He was clear that everyone owned them, however too many owners may have added to the complexity and tensions that surrounded them. He commented that delayed discharges had been discussed at the Integration Joint Board (IJB) and suggested that was the place where they needed to be sorted. He thought that Mr McCulloch-Graham would be able to get the data that Mr Taylor had referred to and further commented that Mr Taylor was correct that the narrative description of the initiatives designed did not tell the Committee or management what was working. He was aware that Mr McCulloch-Graham was under resourced, however he was aware that moves were afoot to rectify that position and hopefully that would enable the provision of better data analysis. He suggested there might be too much discussion of delayed discharges instead of actually addressing them.

Mr Ralph Roberts commented that he acknowledged the comments the Committee were making and highlighted that there was an issue of governance and the organisations' ability to provide assurance to Committee members on progress with reducing delayed discharges. He suggested taking away the report, improving it and bringing it back to the next meeting. However, progress on delayed discharges would only be done in partnership with the Local Authority and he reminded the Committee that at a previous meeting of the Board, it had suggested the Integration Joint Board take ownership of delayed discharges. Elements of the solutions to address delayed discharges remained within the gift of NHS Borders and large parts of the solution were within the collective space with social care. He commented that there might be something around processes, actions taken and resources that were impacting on the situation and he suggested the Committee support a request to formally ask that delayed discharges were discussed by the IJB and that the IJB come up with a detailed action plan and revised trajectory to address delayed discharges in the near future. He committed to raising the matter at the Joint NHS Borders and Scottish Borders Council Executive Team meeting to seek an update of the trajectory and gain joint ownership of it by both organisations urgently.

Mr Taylor agreed that the issue of ownership was complicated, given the Health Board could only control what it was responsible for and had a clear picture of. However the impact of actions taken by either party would impact on the other to varying degrees and he queried that if on a basic level social care stopped the supply of packages of care, what was the actual impact on NHS Borders services. Regardless of ownership, it was essential that the organisation had the data required to control Board performance and expenditure.

Mr Bill Brackenridge enquired of the percentage of beds that were blocked currently and how that related to previous winter periods. Mr Gareth Clinkscale commented that in regard to previous winter periods the average number of delayed discharges were 30 which was just under 10% of the bed base, which was a significant proportion of beds.

Dr McCallum reminded the Committee that under all of the discussions and data were people and they were often people who were towards the end of their life and given the current pandemic situation and limitations on visitors, getting those people home or to a homely setting was of absolute paramount importance. People often viewed the hospital as a place of safety, however it was not and should not be viewed as such. It was more important to the individual, the clinician and the organisation to get people to the right place whether that was home or another care setting. She emphasised that 10 delays were 10 too many but an average of 30 was unacceptable and action was required.

Mr McCulloch-Graham apologised that the report had not met the expectations of the Committee. He commented that it did provide the Committee with the reasons for delayed discharges within the 5 categories that were recorded and associated cost benefit analysis. A review had been undertaken and a transformation programme going forward was agreed however the same cost benefit analysis was not undertaken due to a lack of available resource. He commented that data was available however he had struggled with the analysis of it in the timescale. He had commissioned Grant Thornton to take forward an internal audit and intention was to compare current performance with that from the beginning of COVID-19. The intention was that the paper would provide some indication of that verbal feedback that he had received from the auditors, that the policies, strategy, resources and the national report to the Scottish Government were correct. However, it had been highlighted that compliance with internal policies such as discharge to assess and the choices policy were not being consistently followed since the start of the pandemic. In terms of trend data, it had been used in the past for discussions with the IJB around investment and more would need to be done in the future. Grant Thornton had also suggested that a realistic target for delayed discharges be put in place and that had been suggested as the numbers that were achieved in April 2020.

He clarified that the Trusted Assessor had been put in place in the middle of April within Garden View and Waverley and would be rolled out across all sites by the end of the month (November).

Mr McCulloch-Graham concluded that ownership of delayed discharges was for all parties involved, however there appeared to be times when accountability shifted to the IJB. NHS Borders saw delayed discharges as a major priority and delegated function and over the past 3 years there had been some £500k moved from back office functions to services. He took on board all of the comments made and committed to provide a more granular paper in the future.

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

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted a more granular report would be received at the next meeting.

10. Performance Briefing

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

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

11. COVID-19 Remobilisation Plan

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted both the feedback from Scottish Government and our response.

12. Resurgence Plans

Mrs June Smyth provided a brief presentation on resurgence plans.

Mrs Fiona Sandford enquired if CPAP outwith the ITU was clinically justified. Mr Gareth Clinkscale commented that clinical teams were very supportive of the ability to deliver COVID-19 patients CPAP outside of the ITU. He further commented that CPAP was already provided outside the ITU for non COVID-19 patients.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the presentation.

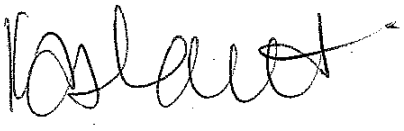
13. Any Other Business

The Chair commented that there had been no actions set against the intensive debate on delayed discharges. She suggested she follow up the conversation with the Chief Executive and circulate a set of actions outwith the meeting for the Board to agree.

14. Date and Time of next meeting

The Chair confirmed that the next meeting of the Resources & Performance Committee would take place on Thursday 21 January 2021 at 9am via MS Teams.

The meeting concluded at 11.10am.



Signature: ……..
Chair

RESOURCES & PERFORMANCE COMMITTEE: 5 NOVEMBER 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Malcolm Dickson:** Because the Finance Report mentions external providers and purchasers, and cross-border flows, I make my usual declaration, ie my sister-in-law is an executive member of the Board of Northumberland Health Trust. Should anyone wish to ask a question which could elicit identification of dealings with that Trust I will switch off the MS Teams call and return to the meeting when I am emailed to say that any such discussion has finished.	**Iris Bishop:** Thank you Malcolm I will note in the minute accordingly.
2	Declarations of Interest	**Sonya Lam:** I declare my partner is a specialist advisor for the Scottish Government	**Iris Bishop:** Thank you Sonya I will note in the minute accordingly.
		MINUTES OF PREVIOUS MEETINGS	
3	Minutes of Previous Meetings	**Malcolm Dickson:** **Item 10 Complex Care Unit:** I recall asking 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. I think someone, perhaps Simon, undertook to look into this. If that recollection is correct I think we should note that in the minute and put an action on the tracker.	**Iris Bishop:** I am happy to amend the minute and add to the Acton Tracker if the Committee agree.
		MATTERS ARISING	
4	Matters Arising		

		FINANCE	
5	Finance Strategy (Presentation)		
6	Finance Report for the period to end of September 2020	**Malcolm Dickson:** I'm asking these questions in light of the External Auditor's Annual Audit for 2019-20 so that we have a trail which takes account of more recent assessments of what may be possible and what may be delayed because of the latest developments in response to Covid-19. The Annual Audit recommended that we prioritise a resumption of the Turnaround Programme (or its successor I presume) and we accepted that recommendation. Does the Executive still assess that we will be able to do that any time soon and, if so, do we have a target date, or, as I suspect, are we likely to have to pause for an indefinite period of time until the C19 demand becomes clearer because we will need the staff who would otherwise work on such a programme to carry out similar sorts of vital work to that which they undertook during and after the first wave? If the latter is the case I suggest we communicate that to Audit Scotland.	**Andrew Bone:** Update will be provided to next Audit committee against all actions arising from the Annual Report and Auditor's recommendations. At this stage no target date for resumption of the Turnaround programme has been set. This issue will be discussed as part of the financial strategy item on agenda.
7	Finance Report for the period to end of September 2020	**Malcolm Dickson:** In response to another recommendation in the Annual Audit, we agreed to aim to be able to report actual expenditure in Set Aside services from 2021-22, as opposed to using the allocated budget figure. Are we confident that this will be possible or, because of the pressures on Finance staff to continue undertaking the same level of additional reporting to Scottish Government during the second wave as was required during and after the first, will this also have to be paused?	**Andrew Bone:** We have established a working group within finance to consider reporting changes for 2021/22. This will be part of our workplan. Further work required to clarify what is required in order to implement this but the intention at this stage would be to progress for implementation next year. Update will be provided to next Audit committee against all actions arising from the Annual Report and Auditor's recommendations.

8	Finance Report for the period to end of September 2020	**Sonya Lam:** With the underspend in operational budgets of £1.3m, how much of this staff vacancies v reduction in patient related activity? With staff vacancies, how much have we spent on agency to provide capacity for vacancies?	**Andrew Bone:** The main driver for underspend is in relation to reduced patient activity and corresponding impact on clinical supplies expenditure. Although there are vacancies within the core establishment the overall workforce has increased through use of fixed term and supplementary staffing. Agency spend in the first six months of 2020/21 has averaged £187k per month (against a prior year average of £180k per month). Medical agency increased by c. 50% (from £66k to £99k per month) with all other staff groups reporting a reduction in monthly spend. The main driver for increased spend on Medical staff is in relation to additional posts required to address Covid19 pandemic.
9	Finance Report for the period to end of September 2020	**Sonya Lam:** What is the reason for the £1.15m of C-19 related expenditure not being highlighted as part of the Board's response?	**Andrew Bone:** All identified C-19 expenditure (including these elements) is reported through the national reporting template (LMP) to Scottish Government. The treatment of the £1.15m is relevant only to internal NHS Borders reporting and reflects the way that costs are recorded and reported internally within the board, i.e. how costs are recorded within our financial reporting system. We adjust this for Scottish Government returns to ensure full costs are reported, but do not do this internally because this requires manual intervention and is based on an element of judgement (using standard assumptions agreed with Scottish government colleagues).

			For clarification: Where a ward is repurposed as Covid19, the expenditure continues to be recorded through existing mechanisms. Managers receive reports on their expenditure within the ward and will be fully sighted on the operational deployment of this facility to support Covid response. For GP prescribing where there is an expectation that an element of expenditure will be related to Covid19 treatment, this expenditure cannot be separately identified from the overall prescribing spend. A proportion of prescribing costs is attributed to Covid based on national assumptions – this is c.1% of total spend.
10	Finance Report for the period to end of September 2020	**Sonya Lam:** What is our confidence level in terms of achieving £1.6m of savings in Q4?	**Andrew Bone:** The majority of these savings are secured already and will begin to be delivered from October. A small element (c.£100k) remains unconfirmed at this stage. We will review as part of our mid-year forecast and provide a revised assessment. It is unlikely that there will be material change to this estimate.
11	Finance Report for the period to end of September 2020	**Sonya Lam:** Taking into consideration the Scottish Government feedback at the end of September 2020 (Item x), does this impact or change the risks identified in Section 4?	**Andrew Bone:** The individual risks described in section 4 are current following confirmation of resources and in light of issues arising from September feedback. The overall quantification of financial risk in current year is currently being assessed and will be revised following update to the board's financial forecast. Implications for the forecast are discussed further under item 7.

12	Finance Report for the period to end of September 2020	**Fiona Sandford:** P9 and Exec summary: Why is £1.15m expenditure in relation to Covid not reported as part of the response to the pandemic but as part of the Board's operational expenditure? What implication does that have for Covid funding?	**Andrew Bone:** Briefly, the reason for this expenditure being reported through core performance is because it is not recorded under the separate arrangements established for Covid19. Recording this expenditure separately is not necessary because it can be easily identified through existing arrangements. It is noted in the financial report to provide reconciliation to the LMP template. See also response to question 9, above. There is no implication for Covid funding. The Scottish Government have based allocations on the LMP submission template, which includes all relevant expenditure including those items that are not separately reported within the board's finance report.
13	Finance Report for the period to end of September 2020	**Fiona Sandford:** P9 #2 'The 13.7m excludes the under achievement of savings targets. .. and is broadly in line.' Not clear about this – in line with what?	**Andrew Bone:** Apologies. Text has been deleted from this sentence in error in the final report. It should read "in line with previous reporting to Resource & Performance Committee". The turnaround update provided to the committee in September advised that recurring savings of £1.6m were available in 2020/21. This is the basis for the figures included in both Q1 forecast and the most recent LMP submission.
14	COVID-19 Local Mobilisation Plan – Finance Update	**Malcolm Dickson:** Comment: I appreciate that Scottish Government Health and Social Care will be just as hard pressed in trying to manage and coordinate the national situation as territorial board executives, but the known unknowns of SG support continue to make life very difficult for the latter.	-
15	COVID-19 Local	**Malcolm Dickson:**	**Andrew Bone:** Fair point. Risks noted at 4.6 &

	Mobilisation Plan – Finance Update	Question: Page 9. 6.4 I presume the degree of uncertainty over what kind of support SG will offer for non-delivery of predicted savings ("to be discussed separately") has been, or will be, taken into account in the risks referred to at 4.6, 4.7 and 4.8 of the Finance Report	4.8 will be amended for future reports. The risk noted at 4.7 remains current, although it is likely that this can be managed in light of the funding situation described within the paper.
16	COVID-19 Local Mobilisation Plan – Finance Update	**Sonya Lam:** Noted.	-
17	COVID-19 Local Mobilisation Plan – Finance Update	**Fiona Sandford:** I commend Andrew of this report; the presentation of complex data is clear, and I look forward to discussions on Thursday. For now, I have three queries: 6.7.5 Waiting Times funds £1m to be used to offset core expenditure already in place? Might we be questioned on this?	**Andrew Bone:** The treatment of the £1M to offset core expenditure has been agreed with Scottish Government Access support team. For clarify, this "core" expenditure relates to additional investment agreed in 2019/20 on a recurrent basis to increase Waiting Times delivery. It is embedded within the board's core expenditure, but underpinned by a planning assumption that this will be resourced through Waiting Times investment.
18	COVID-19 Local Mobilisation Plan – Finance Update	**Fiona Sandford:** 6.7.10 Virement of resources to H&SC – again are we justified in doing this?	**Andrew Bone:** The Scottish Government have specifically provided for this within the correspondence in support of the allocation of funding. Funding allocations are made in 2 streams – delegated and non-delegated. The delegated funding stream covers Health & Social Care. The letter advises "We expect, in principle, that funding is allocated between NHS Boards and Integration Authorities on the basis of the tables of the Annex, however Boards and Integration Authorities may agree to allocate funding flexibly between categories to better recognise local pressures and priorities".

			It is therefore for the board to determine whether it would increase vire funding between delegated and non-delegated functions.
19	COVID-19 Local Mobilisation Plan – Finance Update	**Fiona Sandford:** 6.11 Mitigating Actions: Outturn of £3.1M underspend by September? Surely if continued that will have major impact on the forecast – interested to hear comments on that	**Andrew Bone:** Yes, this is true. The forecast at Q1 included an estimated increase to core expenditure over the remaining months as remobilisation plans are enacted, however current trend would suggest this was pessimistic (financially). It is likely that the extrapolation of the current trends will present an improvement to outturn forecast. This will be confirmed following review of the forecast to be undertaken in late November.
20	Capital Plan Update	**Malcolm Dickson:** **Comment:** Overall, I acknowledge that the method used to arrive at the adjustments and those adjustments themselves appear to be appropriate.	**-**
21	Capital Plan Update	**Malcolm Dickson:** Question: Audit Scotland made what I believe they termed a "note of emphasis" in their Annual Audit with reference to the reduced reliability of property evaluation, I believe because it had been carried out as a desk-top exercise because of C19 restrictions. They did not feel this amounted to a material concern, or words to that effect, but recommended that we aim to return to a more thorough methodology as soon as practicable. Do we have a plan to follow for this?	**Andrew Bone:** We have not yet developed an action plan in response to this recommendation but would expect to have discussed options in advance of Audit Committee and will provide update at that meeting as part of response to recommendations from Audit Report.
22	Capital Plan Update	**Malcolm Dickson:** Question: Para 5.1.6 - I presume that we can negotiate carry forward of the ear-marked capital funding provided by SG for specific purposes (eg the Forensic Medical Examination Suite) which cannot be completed this financial year because of C19?	**Andrew Bone:** At present we are anticipating that this will be the case however there is a risk that SG may need to reprioritise capital resources in future years as a result of the wider NHS Scotland impact (Covid, etc.) on delivery of its overall capital programme. Ring-fenced

			projects would be expected to be first call for reinstatement in future years. This is subject to ongoing discussion with SG colleagues. Agreed in principle but subject to wider pressures on overall NHS Scotland capital programme which is managing increased uncertainty in current operating environment and slippage arising from a number of major projects (e.g. elective centre programme).
23	Capital Plan Update	**Malcolm Dickson:** Question: Para 5.1.7 - I think I'm probably wrong in initially thinking when I read this that some of the funding from the allocated capital for the Borders Health Campus exploratory work in this financial year will be used for specific works for the BGH front door. But it has been mentioned under that heading, so I'm confused. If it is really intended that such work could anticipate what patient flow into the future campus will look like then that seems wrong-headed to me. I would have thought that much of the patient flow into a future campus would be handled online in advance and updated remotely on the physical arrival of a patient, largely negating the need for a single point of entry.	**Andrew Bone:** Apologies. There were 2 separate elements to plan: (1) Borders Health Campus (2) Front door (flow) The second item was earmarked for investment of c.£200k as an early priority for BGH in advance of developing the campus strategy. We are assuming that there will still be some requirement for adaptation of the Emergency dept. and associated front door areas to facilitate changes to flow management and issues arising from Covid, however the Reshaping urgent care may – as you note – influence this. At present we continue to hold provision in the plan at the existing level. We will continue to review as this programme becomes clearer. The campus strategy funding – by agreement of SG – is released to flexibility in year with expectation that we will discuss future requirements as part of the development of our capital programme for 2021/22 and beyond. SG have agreed that we can redirect this resource

			to local priorities, which include the development of our primary care premises strategy for which no resource had previously been agreed.
24	Capital Plan Update	**Malcolm Dickson:** Comment: Para 5.1.8 - I suspect I will not be the only NED to express much disappointment at the anticipated slippage of the creation of the Adult Changing Facility, especially since I think I recall that SBC lent us a member of staff to expedite the project. If slippage is unavoidable, then so be it, but if it has once again fallen foul of the argument that there are now greater priorities within the BGH, then that must be challenged because otherwise it might never be completed.	**Andrew Bone:** The slippage on timescales for this programme is separate from any issue in relation to project resources. The space earmarked for this facility is located at main entrance of BGH. Undertaking works in this location during current pandemic would have a significant impact on the ability to maintain social distancing and infection control measures. We continue to monitor this situation on an ongoing basis. A revised timescale will be agreed as soon as we have a clear understanding of the timing and process for restoring normal operations.
25	Capital Plan Update	**Sonya Lam:** The risks listed in 6.1 are noted. There are presumably risks associated with capital projects not proceeding or being delayed. Are there key risks the Committee should be aware of?	**Andrew Bone:** At a strategic level the main risks of projects not proceeding or being delayed would be within three main domains: • Service risk (including quality/safety risk) • Financial risk • Reputational risk It is intended to develop a capital programme risk register against individual projects through the new Capital Investment Group. Individual projects will undertake their own risk assessment in line with project management methodology.
26	Capital Plan Update	**Fiona Sandford:** 4.1.5 Estimated backlog maintenance = £13m (seems incredibly high – how do we plan to pay for this?	**Andrew Bone:** Progressing backlog maintenance will be subject to prioritisation within the board's capital investment plan. At present we direct between £0.5m - £1.0m

			annually to backlog maintenance. As part of the development of our longer term property strategy we would expect to discuss with Scottish Government how the Borders Health Campus can be maintained in advance of a longer term reprovision, including any additional capital resources that can be made available to support a reduction to estate risks. <u>Background</u> This figure is adjusted annually (with full review of the estate over a 5 year cycle) and we would anticipate this figure continuing to be revised. Recognising the age of BGH (32 years) the backlog figure includes a number of major plant/infrastructure elements which would be subject to planned replacement cycles. c.50% of this figure is assessed as high or very high risk, including c.£3m in relation to theatre ventilation.
		PERFORMANCE	
27	Delayed Discharges Update	**Malcolm Dickson:** It's not clear whether the measure in the chart at the foot of page 3 is similar to that in the next chart at the top of page 4, ie delays per 100,000 population.	**Rob McCulloch-Graham:** The chart on page 3 is the total number of delays, the second chart on page 4 is per 100,000.
28	Delayed Discharges Update	**Malcolm Dickson:** Page 5 - I'm still astounded that consultants generally work weekdays with weekends off. I appreciate that this a difficult nettle to grasp and that it must be approached on a national basis, but how can we expect the rest of our efforts to be efficient as long as this inefficient and out dated practice continues? [A rhetorical question, I don't expect an answer!]	**Lynn McCallum:** Consultants do of course work weekends but we do not have anything close to the capacity required to deliver the same processes (including ward rounds and senior decision making) as we have during weekdays. We need to be clear that it is not just senior decision making that is the issue here as no service truly provides a 7 day service including the essential discharge services such

			as AHPs and social work.
29	Delayed Discharges Update	**Malcolm Dickson:** The individual work programmes outlined on pages 6, 7 and 8 are very welcome, as are the new partnership-led workstreams within the H&SCP. However, we don't seem to have, or we're not being given, metrics which can help us understand to what extent each of these are contributing, or not, to reducing delayed discharges. I believe this is the granularity of data analysis that Tris has been arguing for and, until we get that analysis, we, and more importantly the Executive and managers, are not provided with the tools to focus improvement where it is most needed.	**Rob McCulloch-Graham:** As can be seen from the national report attached, there are many issues which impact on delays, it is therefore difficult to attribute specific actions directly to an impact or outcome on delays. There are qualitative measures which we continue to apply, and we do examine impact across a range of measures. The policy and strategies that have been employed have been endorsed by the national direction of jobs across Scotland.
30	Delayed Discharges Update	**Sonya Lam:** From the national lessons learned, intermediate care has been increased with additional AHP capacity. Am I right in thinking we have increased our AHP capacity for reablement and if so, is this a temporary solution or a sustainable one?	**Rob McCulloch-Graham:**
31	Delayed Discharges Update	**Sonya Lam:** What assurance do we have that all the measures highlighted in 4.3 will have an impact and what are the timescales for improvement?	**Rob McCulloch-Graham:** This is our intention, we have not achieved it as yet.
32	Delayed Discharges Update	**Fiona Sandford:** In the Executive Summary, I wonder whether it is wise to say that 'Every partnership .. were very successful reducing these delays…'? In the light of press coverage and enquiries into discharges to care homes without testing. While we are content that no harm was done in our board, I think we could be questioned about the rather sweeping statement.	**Rob McCulloch-Graham:** We take the point, however this was a national report, whilst we input to its writing we didn't have any editorial control.
33	Delayed Discharges Update	**Fiona Sandford:** P6 Monitoring and responding to demand. I read this paragraph multiple times and still don't understand it.	**Rob McCulloch-Graham:** We have many reports on delays which use different definitions as to what constitutes a delay. It is therefore not

		What is a single point of truth in a moment of time	possible to compare many of the reports. We have had differing local and national demands to address within plans. We have had to offer several trajectories for example on our targeted reduction of delays
34	Delayed Discharges Update	**Tris Taylor:** This paper doesn't address the observations minuted at the last meeting about assurance information systems. It lacks specificity and baseline data and is focused on narrative historical activity rather than cost/benefit analysis and clear quantification of the impact current actions are expected to have on current issues. There is no quantitative analysis of why initiatives to date have not improved the overall position - or indeed whether they have, but improvement is not visible because demand has increased. Indeed there is no data on demand or throughput in the paper. Contrary to the minuted request, there isn't anything to help me "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.	**Rob McCulloch-Graham:**
35	Performance Briefing	**Sonya Lam:** What are the variations in outpatient performance between specialities if any?	**June Smyth:** Please see Annex A at end of document.
36	Performance Briefing	**Sonya Lam:** Sickness absence: was discussed at the Staff Governance Committee last week in particular whether musculoskeletal cases were arising from clinical settings or Working From Home (WFH)	**Andy Carter:** A single MSK adverse event has been RIDDOR-reported in 2020 and it may ultimately not prove to be solely work-related. Looking at the Adverse Event System, NHSB has half the number of Moving & Handling Events which were reported in the same timeframe last year (17 c.f. 39). Further enquiry will be required but it may not be unreasonable to assume that the increase in self-reported

<table>
<tr><td></td><td></td><td></td><td>MSK absence relates to injury suffered whilst not working or onset of symptoms & conditions from an increasingly ageing workforce. Further communication is going out to line managers around the importance of employees carrying out home risk assessments and acting upon findings.</td></tr>
<tr><td>37</td><td>Performance Briefing</td><td>Sonya Lam:
Acute: What are our re-admission rates?</td><td>Nicky Berry: Comparisons for Oct-Dec 2019, Apr-Jun 2020 and July 2020 readmissions (as the latest data that will be complete) are as follows and shows rates are decreasing:
<table><tr><th rowspan="2">Period</th><th colspan="2">7 Day</th><th colspan="3">28 Day</th></tr><tr><th>No of Re-admissions</th><th>Total Admissions</th><th>Rate</th><th>No of Re-admissions</th><th>Total Admissions</th><th>Rate</th></tr><tr><td>Oct-Dec 2019</td><td>209</td><td>2926</td><td>7.1%</td><td>470</td><td>2926</td><td>16.1%</td></tr><tr><td>Apr-Jun 2020</td><td>125</td><td>1936</td><td>6.5%</td><td>308</td><td>1936</td><td>15.9%</td></tr><tr><td>Jul-20</td><td>38</td><td>667</td><td>5.7%</td><td>64</td><td>667</td><td>9.6%</td></tr></table>
The latest data available for the IJB, in the Core Suite of Integration Indicators that gives the annual position to 2019, shows us at 109 per 1,000 population compared to Scotland's 105 for 2019, and puts us middle of the pack of Integration Authorities.</td></tr>
<tr><td>38</td><td>Performance Briefing</td><td>Fiona Sandford:
Noted. Cancer Treatment performance good to see</td><td>-</td></tr>
<tr><td>39</td><td>COVID-19 Remobilisation Plan</td><td>Malcolm Dickson:
Comment: My following question harks back to my previous points about the possibly excessive expectations of those who seek too judge and govern us. I understand that the demands have to be made from an SG point of view, and that some of the larger boards may have the capacity to respond, but….</td><td>-</td></tr>
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40	COVID-19 Remobilisation Plan	**Malcolm Dickson:** Question: Page 4 of Ms McLaughlin's letter - 1st bullet, how are we going to resource the reassessment of options for savings that can still be delivered in this financial year for which she has asked? P.S. I have just read the Chief Exec's response to that letter and he has properly, and more tactfully, pointed out the difficulty.	No answer now required - MRD
41	COVID-19 Remobilisation Plan	**Malcolm Dickson:** Question: Page 5 - levels of remobilisation of services. This is useful information for the Board, but there was an aspiration for surgery that we'd start at 50% and hope to creep up higher. Am I expecting that to happen too soon? I appreciate all this may well fall back to zero if the pressure on ITU beds becomes any greater than it was during the first phase, or we feel we have to plan for greater numbers.	**June Smyth:** There was indeed an aspiration to increase levels above the 50% of clinic lists that had been restarted. An extended working day is being planned for, however, due to workforce restraints it will not be possible to implement until after the winter period. The resurgence of COVID-19 activity has also resulted in Theatres Recovery being converted to ITU 2 which has also stalled work to increase Theatre utilisation and therefore activity.
42	COVID-19 Remobilisation Plan	**Sonya Lam:** What is the balance of risk between administering CPAP outwith ICU and the risk of not providing this intervention? What are the barriers to the former?	**June Smyth/Lynn McCallum:** CPAP can be used as a first line of intervention without it people would potentially need more invasive intervention sooner. Some patients who wouldn't necessary be ready for full ITU intervention, people with co-morbidities for example, have been shown to benefit from CPAP. There are several drivers to deliver CPAP for COVID-19 positive patients out with ITU. Once ITU exceeds three COVID-19 positive patients, the unit expands into Theatre Recovery (ITU 2). At this point, depending on non-COVID-19 activity in ITU elective operations will be reduced. The ability to deliver CPAP for

			COVID-19 patients out with ITU increases the ability of ITU to remain in ITU and thus protective our routine elective programme. The risk of delivering CPAP for COVID-19 patients out with ITU is intro associated with the introduction of another COVID-19 pathway out with ITU. It is felt the benefit offered to our elective programme outweighs this risk.
43	COVID-19 Remobilisation Plan	**Fiona Sandford:** Noted: disappointed re escalation	-
44	Resurgence Plans		

Latest (2nd November) New Outpatients Performance breakdown as follows **ANNEX A – QUESTION 35**

New Outpatient - Patients Waiting - total list size, waiting >12, >26 and >52				
Specialty Description	**List Size**	**over 12 weeks**	**over 26 weeks**	**over 52 weeks**
All Specialties	**5774**	**2664**	**1435**	**4**
Anaesthetics	N/A	N/A	N/A	N/A
Cardiology	221	95	33	0
Dermatology	825	525	354	0
Diabetes/Endocrinology	105	42	17	0
ENT	454	266	117	0
Gastroenterology	96	24	17	0
General Medicine	39	1	0	0
General Surgery (inc Vascular)	812	427	154	0
Gynaecology	326	78	41	0
Neurology	240	155	107	0
Neurosurgery	N/A	N/A	N/A	N/A
Ophthalmology	1012	467	310	0
Oral & Maxillofacial Surgery	N/A	N/A	N/A	N/A
Oral Surgery	436	272	187	0
Orthodontics	33	26	24	0
Pain Management	41	1	0	0
Plastic Surgery	N/A	N/A	N/A	N/A
Respiratory Medicine	149	54	1	0
Restorative Dentistry	N/A	N/A	N/A	N/A
Rheumatology	45	2	0	0
Trauma & Orthopaedics	384	3	1	0
Urology	284	119	10	0
Other	272	107	62	4