Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 6 May 2021 at 9.00am via MS Teams.

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

In Attendance:
Miss I Bishop, Board Secretary
Mrs S Horan, Deputy Director of Nursing, Midwifery & AHPs
Dr A Cotton, Associate Medical Director
Mrs C Oliver, Head of Communications
Mrs S Paterson, Deputy Director of Finance
Mr G Clinkscale, Associate Director of Acute Services

1. Apologies and Announcements

1.1 Apologies had been received from Dr Janet Bennison, Associate Medical Director Borders General Hospital and Dr Nicola Lowdon, Associate Medical Director Primary & Community Services.

1.2 The Chair confirmed the meeting was quorate.

1.3 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

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

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

2.3 Mr Malcolm Dickson declared that as the Finance Report mentioned external healthcare purchasers and providers, his sister-in-law was an Executive Director on the Board of Northumberland Health Trust.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declarations made by Ms Sonya Lam and Mr Malcolm Dickson.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 4 March 2021 were approved.

4. Matters Arising

4.1 **Action 7:** Mr Andrew Bone advised that it was likely to be June before a final schedule of dates would be available. Mr Ralph Roberts reminded the Committee that the project would be tracked through the Capital Investment Group (CIG). The Chair enquired if the Committee were content to mark the action as closed on the Action Tracker given it would be tracked through the CIG and any slippage would be advised to the Committee through the normal Capital update mechanism. Mr Malcolm Dickson advised that he would be content provided the Police, Fire & Rescue & Safer Communities Board was kept up to date via James Ayling, once he demitted office.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 7 on the action tracker.

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

5. COVID-19 Remobilisation Plan 2021/22

5.1 Mrs June Smyth advised that the Remobilisation Plan was not yet in the public domain and had therefore been delegated by the Board to the Resources & Performance Committee. She provided an overview of the content and advised that an underpinning action plan was being developed. In regard to waiting times she advised that the usual submission of templates for waiting times was not required this year, however work had been completed on those locally. The remobilisation plan also outlined the capacity that had been remobilised whilst still dealing with the pandemic and that would be revisited. The acute team had also revisited the pathways in place for theatres and intensive care in order to increase overall capacity and those pathways had been fully risk assessed and would be scrutinised by the Pandemic Committee.

5.2 Mr Tris Taylor pointed out some minor formatting issues. Mr Taylor then enquired about the clinical prioritisation framework and if service users were involved in the process and if they should be in the future. Mr Taylor also enquired about the status of the screening programmes.

5.3 Mrs Smyth commented that in regard to the clinical prioritisation process it was the clinical voice and advice that was required in regard to decision making as the pandemic was progressing.

5.4 Dr Lynn McCallum commented that as a clinician on the front line during the early stages of the pandemic there were a range of difficulties to be overcome in terms of resources, oxygen flow, staffing and other matters. Due to clinicians being given the time to look for solutions and work with other colleagues a range of innovative changes were progressed. Where there had been struggles previously to engage clinicians in financial turnaround the pandemic had created an urgency for change across the system, which the whole system had embraced.

5.5 In relation to public engagement and stakeholder engagement at the time of the start of the pandemic clinicians had been desperate to work out how to manage the expected deluge of cases and fast spread of the pandemic, as currently being seen in India. As the country went into lockdown the focus of clinicians remained on the health care provision and the public were not in a position to engage at that time. In terms of the future it would be preferred to engage and collaborate with the public however at that time it was not possible.

5.6 Mr Ralph Roberts commented that at the start of the pandemic the Health Board had been operating under emergency powers and was required to make decisions quickly. At that time it would have been impractical to engage with the public in the timescales required, however, as patient and public involvement and engagement had been further developed over the past year the organisation would be in a better position to take that forward in the future. It was also noted in the meeting chat that an Ethics group involving lay members had been in place to review any difficult prioritisation issues.

5.7 Dr Tim Patterson commented that in regard to the screening programmes they had all been paused at the start of the pandemic. Since October 2020 screening programmes had been remobilised and their status had been shared with the Clinical Governance Committee. He advised that the remobilisation of screening programmes had been challenging in terms of public perceptions and confidence in attending for screenings as well as dealing with increased waiting times for appointments. Some additional capacity had been sourced to address the backlog of appointments and some public communications would also be progressed.

5.8 Mrs Smyth advised that in terms of assurance in regard to public involvement and engagement a lot of communications during the pandemic period had been shared with the organisations recognised public members.

5.9 Mrs Fiona Sandford commented that the remobilisation plan was a major shift in how services would be delivered and noted that public engagement and good communications were an essential part of the success of remobilisation. She commented that she would like to hear more about the communications and engagement programme potentially at a future Non Executives session. The Chair agreed to make it a feature of a future session.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** formally approved RMP3 for 2021/22, on behalf of NHS Borders Board.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the feedback received and our replies, and noted the underpinning action plan that has been developed based on the commitments outlined in RMP3.

6. Finance Performance March 2021

6.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: the forecast to achieve breakeven; work on the annual accounts; reporting of a small in year underspend; specific expenditure on COVID-19; the impact of COVID-19 on savings

targets; and the draw down of funding from the Scottish Government to support this position.

6.2 Ms Sonya Lam enquired what the medium term meant for the review of the decrease in prescriptions. Mr Bone advised that it recognised emerging information as there was normally a time lag on information flows. The information available was based on actual payments made up to the end of January 2021 and then indicative volumes for February and March. He commented that there had been a drop in terms of volumes for the last quarter.

6.3 Mrs Alison Wilson commented that it was a 3 month time lag period for information flows which meant the final year end figures would not be available until the end of June. She had received feedback from GP colleagues and Community Pharmacies that they expected volumes to increase from April.

6.4 Dr Lynn McCallum commented that prescriptions in the next financial year were likely to rise especially in regard to chronic disease management as that had been impacted by COVID-19. Mr Bone assured the Committee that a level of growth in prescribing levels consistent with the level of growth pre COVID-19 had been built into the financial plan for next year and would be monitored through the normal quarterly review process.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** took significant assurance that the Board would achieve its financial target (i.e. breakeven) at March 2021.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the Board was reporting a small under spend for the twelve months to 31st March 2021.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the position remained draft pending final audit of the Board's Annual Accounts.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in relation to COVID-19 expenditure and how that expenditure had been financed.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in respect of savings delivered in year and the additional support provided by the Scottish Government to offset further non-delivery of savings during 2020/21.

7. Draft Capital Plan 2021/22

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: an update in terms of the individual projects; the pharmacy service dispensing robot funding; and total carry forward.

7.2 The Chair enquired about capacity to carry out capital projects approved through charitable funds given that had been an issue in the past. Mr Bone commented that a discussion had taken place with the Trustees in regard to both NHS and non NHS projects and how they would be resourced. He suggested he bring back an overarching report of all the projects managed through the programme of work including both NHS and non NHS funded. The Chair welcomed the suggestion of an overarching report to show the full extent of projects.

7.3 Mrs Alison Wilson enquired when confirmation from the Scottish Government would be received in regard to the capital allocation for NHS Borders and also if there was any risk in terms of funding for the Road to Digital programme. Mr Bone advised that the capital allocation confirmation was likely to be received in June and he confirmed that the Road to

Digital funding was in relation to revenue and not capital. He further commented that the Road to Digital programme had been mentioned as a new revenue risk in the financial plan as the £1m level of resources were significant. The funding stream of "non cash delegated" had now been removed by the UK Government and did not exist in the Scottish Government or NHS Scotland. Mr Bone suggested a solution had been achieved for 2021/22 and further work would need to be developed and taken forward to find a solution for the long term funding of the digital plan for the future.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update provided on the 2021/22 capital plan

Mr Tris Taylor left the meeting.

8. Financial Turnaround Programme

8.1 Mrs June Smyth commented that the Financial Turnaround programme timeline was being revisited with the intention of bringing the programme back on stream. In terms of clinical engagement the learning from the pandemic would be valuable in engaging with the clinical community and supporting leadership on corporate issues.

8.2 The Chair enquired if the programme would be rebranded. Mrs Smyth confirmed that the intention was to rebrand as the conversation moving forward would be focused on financial sustainability as opposed to financial turnaround.

8.3 Mr Bone commented that he expected the Scottish Government to issue a letter to invite the Board to discuss the financial plan and the savings plan in the context of the deficit in the plan.

8.4 Ms Sonya Lam noted the intended relaunch of the programme in June and enquired at what point the Board would see the programme. Mrs Smyth commented that the programme would continue to report to the Board via the Resources & Performance Committee, however the intended June relaunch may be delayed in order to pick up the financial position and impact of continuing COVID-19 mitigations.

8.5 Mr James Ayling referred to the assumptions section of the report which suggested schemes that required capital monies might not be delivered, as capital monies were diverted to COVID-19 response schemes and he enquired if they were income or revenue based. Mr Bone commented that the assumption reflected the need for capital resources to be reprioritised in response to risks identified in early phase of COVID-19 but remained a risk at this stage. Capital financing for saving schemes is in relation to enabling activities to support service change and release of revenue savings. The caveat in relation to COVID-19 had been a standing assumption throughout the pandemic.

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

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

9. Performance Briefing

9.1 Mrs June Smyth provided an overview of the content of the report and highlighted the error in the table at item 1.7, and that the business intelligence team were still running the delayed discharges data.

The Chair enquired if there was sufficient focus on the assessment of individuals for care at home solutions. Mrs Nicky Berry commented that both she and Jen Holland were working on a phased approach and had noted a higher demand for packages of care and the need to flex up to meet demand. It was unclear if the demand was related to geographical issues and the intention was to merge Home First and SBCares to enable a larger pool of resource to be available. Phase 1 of the programme of work included: a weekly delayed discharge meeting to ensure systems and processes were followed; ensuring the Moving On policy was being followed; prevention of admissions; criteria and assessment of discharge to assess to take place at home and not in the hospital; and education across social care and nursing. Phase 2 would be the availability of flexible resources and the longer term would be to review the number of care homes and residential homes required.

9.2 Mrs Lucy O'Leary enquired how the conversation with care home providers would be taken forward. Mr Rob McCulloch-Graham commented that relationships with the independent sector were more positive than they had been pre COVID-19. Conversations had already commenced and a revised commissioning strategy would be taken forward with input from the independent sector, to look at care provision and the potential of a Care Village.

9.3 Dr Lynn McCallum suggested input from the Consultant Geriatricians should be a key influence in the revised commissioning strategy.

9.4 Mr McCulloch-Graham commented that given the impact of the pandemic and the uncertainty as to whether the recommendations from the Derek Feeley report might be agreed and the wish to revise the commissioning strategy in co-production with the independent sector the intention was to produce a final strategy by April 2022.

9.5 Ms Sonya Lam enquired when the Committee would receive the fuller performance report for performance measures across the whole organisation. Mrs Smyth commented that normally the format of the performance report would be agreed at the start of each financial year and it was slightly delayed this year. Over the past year whilst the Committee had received abridged reports, data collection had remained in place in regard to the HEAT Standards and discussions would take place with the Scottish Government in regard to their expectations of data collection around the Remobilisation Plan. There would also be conversations with the Non Executives outwith the meeting on the kind of performance data that they would wish included in a performance report.

9.6 Mr Ralph Roberts commented that the NHS Scotland Board Chief Executives were currently in conversation with the Scottish Government in regard to influencing what any incoming government might require in terms of a suite of performance reporting. It had been suggested the focus might be rebalanced from healthcare delivery and move towards population health and addressing inequalities and health outcomes.

9.7 Ms Lam commented that as a Committee it needed to be assured on organisational performance and given the abridged reports she was unable to confirm she was fully assured. Mrs Berry commented that she was not sure that any Health Board across the country would be able to provide its' Board with assurance given the current on-going pandemic. However, she wished to advise the Committee that the HEAT target standards and other important performance areas such as delayed discharges, were being regularly monitored with improvement plans being instigated where required.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Performance Briefing for March 2021.

10. Complex Care Unit – Learning Disabilities

10.1 Mrs June Smyth advised the Committee that the paper provided an update on the status of the discussions in regard to the provision of a new unit. The key issue on the provision of a new unit had been the potential use of NHS land and the complexities involved in that. Land had now been identified by Scottish Borders Council (SBC) and it was suggested that the NHS land issue be closed and the project be taken forward by SBC with the intention of the Learning Disability service providing a full case to the Integration Joint Board for agreement.

10.2 The Chair sought assurance that any new build would provide the required capacity for the future. Mr Rob McCulloch-Graham clarified that a potential supplier had been identified for 8 places and the current usage was 12 places, so further negotiation and modelling would take place to ensure any unit was future proofed in terms of capacity. He advised the suggested site would be in the central Borders areas and having a facility in the region would lead to savings.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update on the work to develop a local Learning Disabilities Complex Care Unit.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that in light of new options for the location of the unit having been recently identified, consideration of using NHS land will be paused.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the Chief Officer for Health & Social Care will be taking a paper regarding this development to a future meeting of the Integrated Joint Board (IJB) regarding the commissioning of such a unit.

11. Any Other Business

11.1 The Chair commented that she was in conversation with the Chief Executive and Board Secretary in regard to the formation of the Board papers packs and the addition of hyperlinks from the agenda to the papers was being progressed.

11.2 The Chair commented that she would circulate her master list of acronyms to Non Executive colleagues for their information.

12. Date and Time of Next Meeting

12.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 2 September 2021 at 9.00am via MS Teams

The meeting concluded at 10.49am.

Signature: ……
Chair

RESOURCES & PERFORMANCE COMMITTEE: THURSDAY 6 MAY 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Malcolm Dickson:** As external purchasers and external providers are mentioned in the Finance Report, I declare that my sister-in-law is an Executive Member of Northumberland Health Trust Board.	**Iris Bishop:** Thank you Malcolm I will formally note in the minute of the meeting.
2	Declarations of Interest	**Sonya Lam:** I declare that my partner is a specialist advisor for the Scottish Government.	**Iris Bishop:** Thank you Sonya I will formally note in the minute of the meeting.
		MINUTES OF PREVIOUS MEETINGS	
3	Minutes of Previous Meetings	**Harriet Campbell:** Sorry, expect lots of stupid questions from me over the next wee while: Point 4: Forensic Medical Examination Suite. What is this for and what would it do? I am imagining all sorts of Silent Witness type work but I bet that's wrong.	**Lynn McCallum:** No question is a stupid question! The FME suite is essentially a specific area within the hospital that is designed to support an examination following a rape or sexual assault. These areas are being developed to support more survivors of these experiences to come forward and should be a stark difference to police stations or Emergency Departments. As well as an examination area, they should have comfortable seated areas to allow appropriate support to the survivor. The examination is undertaken by a specially trained doctor or nurse.
4	Minutes of Previous Meetings	**Harriet Campbell:** On the Q&A (point 9) what is NRAC? And what is the significance of NRAC parity?	**Andrew Bone:** The majority of NHS funding is set based on a historic formula and is fixed as 'baseline'. This means that each year NHS Borders receives approximately 80% of its funding at the same level as previous years.

			NRAC (National Resource Allocation Formula) is a weighted population formula that is used to distribute additional funding to NHS regions (with some exceptions). It makes adjustment for demographic and health factors affecting the population. Because these factors continue to shift along with the overall size of the population, each Health Board's overall share of the available resources can shift away from their formula share over time. Scottish Government have made a commitment that no health board will be more than 0.8% from parity. A correction factor is applied annually to NHS budgets which distributes additional resources to those HBs whose share is below 'parity'. NHS Borders is currently within NRAC parity and has been for a number of years. Our share is c.2.1% of overall population. It is projected that the board will increase its share over the next 5 years due to size and age of population.
5	Minutes of Previous Meetings	**Malcolm Dickson:** Noted	-
6	Minutes of Previous Meetings	**Karen Hamilton:** Item 5 para 2 Messaging to staff on Financial savings? Any strategies agreed as to how this will be achieved?	**Andrew Bone:** We have not yet agreed a communications plan for how we will engage with staff on financial savings during the next 12 months. Work continues on development of our approach to savings for 2020/21 – we can provide a verbal update to the meeting if that is helpful?

		MATTERS ARISING	
7	Matters Arising	**Malcolm Dickson:** The action tracker includes: "Complex Care Unit – Learning Disabilities 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." There is certainly an update provided to the 6 May R&PC but no answer to my question which was something like - We seem to currently have 12 patients located in units outside the Scottish Borders and yet the proposal is only to build an 8 bed unit. Why don't we seek at least 12 and allow the operators to accommodate patients from outside the Borders if our numbers fall below 12?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
8	Matters Arising	**Karen Hamilton:** Action No 7 FME suite – do we have any update?	**Lynn McCallum:** We are awaiting an update from the design team but they are meeting next week and we are hopeful to have timescales from then. Currently aiming for this to be completed by the end of the year.
		COVID-19 REMOBILISATION PLAN 2021/22	
9	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** Appendix A – really silly point but would it be possible to have the glossary in alphabetical order in any future similar report?	**June Smyth:** Noted thank you- the teams have worked on the basis of order of appearance but happy to take the feedback on board
10	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** Another stupid question, sorry. I am a little confused as to why the draft plan submitted in February remains the plan to be approved. I see that there were no substantive changes but there were queries which have been responded to. Why is it not necessary to include these	**June Smyth:** In usual years, our Annual Operational Plan (which RMP3 replaces this year) would be updated/amended following feedback from Scottish Government (SG) and any comments received from local stakeholders on the submitted plan. This year, as a result of

		answers in the plan to be approved?	the pandemic and the ongoing pressures relating to this, SG advised of a lighter touch, whereby Board's would not be required to update their plans and re-submit them, and were happy to have confirmation that any feedback would be taken on board as plans were being implemented. We have therefore attached in the appendices the letter we received following our review meeting with SG representatives, and our responses for completeness rather than an amended plan. We didn't receive any substantive feedback / comments from local stakeholders, with no amendments requested.
11	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** And one substantive query: 11.12.2 says that 'patients should not be expedited solely because of time waited for surgery', but does there not come a time for some patients when this should be a relevant factor in person-centred care? If not do some P3/4 patients simply end up constantly pushed further down the list and effectively never treated?	**June Smyth:** Our first priority is clinically urgent patients. The risk of harm to these patients as a consequence of delay is high. Residual capacity is used for patients on routine waiting lists, and for this group we treat in strict date order. We aim to utilise all available capacity, which will on occasion mean booking out of turn where the alternative is capacity wasted. There is no doubt that high volume surgical services that undertake what are usually considered "routine operations" have been disproportionately affected over the last 15 months**.** Our response to meeting this challenge is aimed at improving productivity, and accessing additional capacity where possible. This is something the acute Quadrumvirate and relevant Clinical Directors are actively working

			on.
12	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Malcolm Dickson**: Noted. Well done to all concerned. Happy to approve RMP3 formally.	-
13	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Karen Hamilton:** Approval Pathways – correct to assume that this remains the same as the Draft already submitted? 1.4 Exec summary. Any bullet pointed activities that may present significant challenges – essentially are they all 'do-able'?	**June Smyth:** Yes the draft remains as submitted to Scottish Government (see also Q10 above). With regards to the bullet points, as things stand at this point in time there are no significant risks relating to these, although with regards to the last bullet point (expand the role of primary/community based care, embedding a whole system approach to Mental Health & Wellbeing) we are still awaiting further information from SG on what this will entail.
14	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**James Ayling:** Really useful document for me as a new member of the Board.	-
15	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Fiona Sandford:** Happy to approve. At some point, it would be good to hear about how we plan to communicate to the general public the planned changes in service delivery. (expectation management)	**June Smyth:** Scottish Government has asked boards not to publish their plans at this point given the election on 6 May. The Communications & Engagement team are, however, in discussions with services around how best to communicate with the public and other stakeholders in the interim around specific issues (such as waiting times and backlog, access to primary care etc). Once we receive confirmation from SG that we are able to publish RMP3 (and when) we will finalise a communications plan.

16	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Sonya Lam:** I acknowledge the considerable effort that has gone into RMP3. I recognise that RMP3 remains as per the draft which was submitted to Scottish Government in February. The Covid-19 and remobilisation has changed considerably since February, which makes the translation of RMP3 into a working action plan important for the Committee to be assured of delivery. The action plan for 2021/22 for noting is very high level with a focus around delivery in business units. To be assured the Committee needs sight of greater detail of outcomes of these plans and how these outcomes span across business units. A measurement framework including trajectories is required, so we can be assured of delivery. What are the timescales for the Committee to see the performance framework, the risk assessment and the health inequalities assessment?	**June Smyth:** The high level action plan attached to RMP3 is a first cut on an underpinning action plan, outlining the commitments that were contained within the 'story' outlined in RMP3. The business units are now working on developing a more robust plan which would include timescales etc.. Delivery against the plans will be monitored through quarterly performance reviews which we will bring back on stream during 2021/22 (having been stood down in 2019/20 due to the financial turnaround programme to free up capacity). An update on progress against the plans will also be included in the twice yearly *Managing our Performance* report. The Access Board will monitor performance against RMP3 waiting times trajectories, and report by exception through the performance reviews and performance reports to the Board / Resources & Performance Committee. The process to develop the more detailed action plans will include engagement with the necessary teams to ensure a risk assessment is conducted and the risk register is reflective of this and that also a HIIA is carried out. We are aiming for this work to be complete by end of June 2021.
17	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Sonya Lam:** There are elements in RMP3 not visible in the high level action plan such as:- • Page 6 of RMP 3 (1.9). 'It is therefore essential that	**June Smyth:** Thank you Sonya, we'll take this on board as we develop the more detailed action plans and ensure these omissions are included within the corporate/support service

		time for staff decompression is built into our • remobilisation plan and any expectation and targets for this set by Scottish Government. What is our understanding of staff decompression? What do we think SG will set for a target. • Pg 8 of RMP3 (1st para) 'Aim to work collaboratively with staff and service users; to be more agile and devolve decision-making and ensure greater shared accountability'. How will we action and measure this?	section. Staff decompression is a very real issue for the Health Board and its workforce. We are not yet entirely clear how SG will allow for this. The experience of the last 15 months has been sustained pressure for many. Restrictions formerly placed on taking annual leave have been lifted over the last 6 weeks and staff are now enjoying substantial blocks of time off. The Staff Wellbeing Group and Occupational Health & Safety Forum are evaluating the impact of the wellbeing offerings to staff e.g. Here 4 U, and planning support services for 'living with covid' in our communities. In terms of any targets relating to RMP3, we are waiting to hear from Scottish Government (SG) as to plans to monitor RMP3, and whether Board's will continue to be required to report on the previous HEAT standards. SG Operational Planning reps are currently having conversations around what proportionate monitoring should include and how this will be coordinated. With regards to our commitment relating to devolved decision making and accountability, we have internally been working on this over the last quarter of 2020/21. We are introducing a more streamlined approach to operational decision making from the end of May, which has been designed in conjunction with members of the Remobilisation Planning Group, supported by a commitment to embed a quality management system approach across the

			organisation. We are using an improvement approach to all of this, bringing the new ways of working into effect and refining as we go. The quality system discussions are at an early stage, and evaluation will be built in as the work moves forward.
		FINANCE PERFORMANCE MARCH 2021	
18	Finance Update Appendix-2021-11	**Malcolm Dickson:** I take significant assurance that the Board will achieve its financial target of break-even at March 2021. I note all the positions summarised at Section 2.	-
19	Finance Update Appendix-2021-11	**Karen Hamilton:** Very clear and readable report – Noted.	-
20	Finance Update Appendix-2021-11	**James Ayling:** Para 5.7 refers to recurring release (£1m) of the Board's contingency reserve for 2020/21. The RMP (18.7.1) refers to a further possible release of contingent reserves. How much is left of the reserves and is the recurrent depletion of the contingency fund viewed as a risk with consideration being given as to how to augment in time? Again a really useful paper for a new member.	**Andrew Bone:** Prior to 2020/21 the board held a £2m contingency reserve which was used to manage pressures emerging in year. The financial plan for 2020/21 released £1m of this recurrently against our financial deficit, leaving £1m held in reserve. Other reserves held by the board are related to specific investment programmes where costs in year are anticipated to be below the final projected cost. We review our financial plan and the risks within on a quarterly basis, with consideration of any adjustments to plan required as a result of emerging issues in year. Given the relative scale of our underlying deficit we have directed much of our 'flexibility' towards management of this position which diminishes our ability to mitigate new/emerging risks as they arise. We do however work closely with SG colleagues to consider how this position can be managed in year and to agree the conditions for any

			additional support required. Moving forward I would seek to agree a revised strategy for management of financial risk as part of our three year financial planning which will be undertaken during the course of 2021/22.
21	Finance Update Appendix-2021-11	**Fiona Sandford:** Clear report, thank you	-
		DRAFT CAPITAL PLAN 2021/22	
22	Draft Capital Plan 2021/22Appendix-2021-12	**Harriet Campbell:** Again, it's silly but it would be helpful if the glossary were in alphabetical order (less of an issue here as not many acronyms but all the same). Why is patient flow a capital commitment? I would have expected it to be a revenue one. Or doesn't the split work like that here? (sorry, probably another silly question). The same question applies to Estates maintenance.	**Andrew Bone:** Noted. I'll make sure we review this for future reports. Apologies – this heading is slightly misleading. This refers to the redesign of the emergency department and other areas of the Borders general hospital to improve the patient flow through the building. The maintenance costs are in relation to life cycle works to maintain the fabric of the building. This can include replacement of plant & machinery, as well as refurbishment of clinical areas (e.g. wards). Note - NHS capital expenditure has a slightly modified definition relative to private sector. I can provide further briefing on this if it would be helpful.
23	Draft Capital Plan 2021/22Appendix-2021-12	**Malcolm Dickson:** Page 4.- Innovation Fund, Q2 activity: "Assessment criteria to be introduced for project requests against this fund". I suggest that BCIG would be the best vehicle to agree draft criteria and that these then be considered for approval by R&PC since NEDs may wish to influence the	**Andrew Bone:** I will pick this up with colleagues and we will ensure that the proposed approach is presented to future meeting of RPC.

		nature of prioritisation. For instance, I've previously suggested that criteria should include improving patient experience, safety and outcomes, as well as seeking efficiency savings. In the latter case, it may be that a percentage of the savings accrued should be retained by the Business Unit concerned, with the remainder being retained centrally in the Capital budget.	
24	Draft Capital Plan 2021/22Appendix-2021-12	**Karen Hamilton:** I have to ask – where does the Adult Changing Facility sit here? I thought it was in the Capital Plan but perhaps I am mistaken? Were we not considering a standalone facility?	**Andrew Bone:** This report only describes the NHS funded capital schemes. Although we are using BCIG as the vehicle for coordinating the overall resource requirements to deliver capital projects the Adult Changing Facility is charitable funded and has been excluded from this report. If helpful we can consider whether there should be recognition of other capital works within this report moving forward.
25	Draft Capital Plan 2021/22Appendix-2021-12	**Fiona Sandford:** Echoing Karen – Adult changing facility?	**Andrew Bone:** As per above.
		FINANCIAL TURNAROUND PROGRAMME	
26	Financial Turnaround Programme Appendix-2021-3	**Harriet Campbell:** Alphabetical order again please? I'm only saying this three times as I have no idea if everyone sees all of my questions or if only the relevant bits go to each person. 3.2 Schemes totalling £1.3M FYE should be possible for 2021/22, however progressing of these will be subject to service capacity becoming available. Is it likely/realistic that this capacity will become available? Presumably that's what the validation process was assessing and can we have an update please?	**June Smyth:** Noted thanks. The current estimate is based on the desktop exercise. The validation process will confirm if this is possible and realistic. The validation process is currently underway and we will provide an update to the committee in September.

		There is a reference in Appendix 1 to income generating services. What are these (sorry, another newbie question I know).	Income generating activities are those such as our external facing laundry services and canteen.
27	Financial Turnaround Programme Appendix-2021-3	**Malcolm Dickson:** Noted.	-
28	Financial Turnaround Programme Appendix-2021-3	**Lucy O'Leary:** 3.2 – schemes possible for 2021/22 are "subject to service capacity becoming available" What kind of capacity is meant here? Operational staffing? Project management resource? Something else? A couple of examples would help, please	**June Smyth:** Through the PMO we have Project Management capacity available. Each service will need to confirm they have the clinical and management support needed to progress these schemes. Examples are a review of the medical secretary structure, review of admin in MH, and changes to the way polypharmacy is delivered.
29	Financial Turnaround Programme Appendix-2021-3	**Karen Hamilton:** Accepting of the challenge that will limit progress here however a continued focus on presenting a full savings plan for 22/23 will be achievable?	**June Smyth:** We are commencing discussions across all services regarding future savings, The paper and timeline we will present to the committee in September will clarify how we will be developing a full plan for 2022/23.
30	Financial Turnaround Programme Appendix-2021-3	**Fiona Sandford:** My points echo Karen's and Malcolm's	-
		PERFORMANCE BRIEFING	
31	Performance Briefing Appendix-2021-14	**Harriet Campbell:** What does "delayed discharges over 72 hours '3 days includes delays over 2 weeks mean'?" Am confused – surely 3 days is 3 days and 2 weeks is rather more than that? Does it mean that the numbers in the red boxes are cumulative (ie in March 21 there were a <u>total</u> of 27 DDs of	**Rob McCulloch-Graham:** Delayed Discharges are reported at two key points which match national targets, past and present. The original target for Delayed Discharges was for patients to be discharged within 2 weeks of being clinically fit and optimally functioning, which is

		which 18 were over two weeks? Sorry, just not clear (to me anyway). Looking at the breakdown of reasons, are these 'normal' proportions? Ie is the main difficulty often waiting for a residential home, or is this particularly high at the moment and if so do we know why?	why we continue to report this. The updated target was for patients to be discharged within 72 hours (3 days) of being declared clinically fit and optimally functioning. To make the reporting of both numbers clear we report both figures separately, so the number over 3 days is the total of the number over 3 days, and the number over 2 weeks is that figure. So to clarify the number reported over 3 days **includes** the number over 2 weeks delayed, so Harriet is right there were a total of 27 DDs over 3 days, 18 of which were over 2 weeks delayed. The descriptor for the line would read better as follows: **Standard** / **Dec-20** / **Jan-21** / **Feb-21** / **Mar-21** DDs over 2 weeks / 8 / 3 / 8 / 18 DDs over 72 hours (3 days) - includes delays over 2 weeks / 15 / 7 / 11 / 27 Occupied Bed Days (standard delays) / 688 / 478 / 528 / 903 Regarding the delayed discharge reasons - these have been assessed for the position as at 25th March 2021. A misapportionment has been made to one category of figures meaning that the waits for residential homes appeared higher than they should be. the table should read as embedded:

			<table><tr><th>Delay Discharge Reason</th><th>Number</th><th>Average Length of stay</th></tr><tr><td>Assessment</td><td>6</td><td>12.7</td></tr><tr><td>Waiting Residential Home</td><td>9</td><td>35.9</td></tr><tr><td>Waiting Nursing Home</td><td>6</td><td>25.3</td></tr><tr><td>Waiting Care Arrangements to go home</td><td>14</td><td>19.1</td></tr><tr><td>Patient and Family Related Reasons</td><td>2</td><td>2.0</td></tr><tr><td>Complex</td><td>6</td><td>78.3</td></tr><tr><td>Total</td><td>43</td><td>30.1</td></tr></table> Quality assurance processes will be reaffirmed to make sure this does not reoccur.
32	Performance Briefing Appendix-2021-14	**Harriet Campbell:** It might be helpful to see absences as numbers as well as percentages? I suspect that some of the larger percentages actually equate to not that many people. Is that right?	**Andy Carter:** Yes, formula is (Hours lost to sickness absence) divided by (Total available hours in that area) x 100, so 1 full-time person off sick in a team of 10 full-timers = 10% sickness absence. 78 employees were absent (unavailable for 1 work episode or more) for reasons associated with Covid-19, during March 2021. 435 employees were absent (unavailable for 1 work episode or more) for reasons **other than** Covid-19, during March 2021. Will revise dataset for next meeting.
33	Performance Briefing Appendix-2021-14	**Malcolm Dickson:** Disappointing to see both DDs and consequential OBDs both now increasing, despite the active efforts being made. Will we only ever see sustained improvement if available places in Nursing and Residential Homes increase significantly plus a substantial increase in the proportion of those elderly people needing high levels of care being cared for at home?	**Rob McCulloch-Graham:** It will be a combination of factors. Having the correct Policy, Strategy and Process to reduce delays, compliance with those and the capacity of reablement/intermediate care, home care and residential care. All of these factors impact on patient flow into, through and out of hospital.
34	Performance	**Lucy O'Leary:**	**June Smyth:**

	Briefing Appendix-2021-14	7.1 Not sure I understand these figures. Imbalance between admissions and discharges at month end implies a rise in occupied beds. Cumulatively over 4 months there are 271 net extra beds filled. That can't be right (only a 1.6% rise in occupancy and we don't have 17,000 beds!). So what's not being counted here – what accounts for the other "missing" exits from BGH beds?	The Board Performance Report includes all inpatient and day cases that have been admitted to the BGH in the table. The discharges from the BGH are all inpatients and day cases that are discharged from hospital care back into the community or have unfortunately deceased. The numbers that are not included in the discharge figures are the transfers onwards to hospital care, either within NHS Borders (Community Hospitals or MH wards) or to other Health Care Providers, such as NHS Lothian hospitals. This is because they are not discharges from inpatient care so are the "missing exists" from the BGH beds.
35	Performance Briefing Appendix-2021-14	**Karen Hamilton:** Exec summary 1.1 Delayed discharges I note Malcolm's comments and wonder if this is the only solution. Comparators' to other Boards of similar size and resources? The problem being as I am sure we are all aware that this performance adversely affects so many other targets and is not good for patients! 1.7 do we have a firm assessment base for the difference between '**residential** care' (not nursing) and care at home given this is the largest group waiting?	**Rob McCulloch-Graham:** 1.1 see reply to Malcolm above. 1.7 This is the question we are grappling with currently. The steering group has challenged a number of discharge demands for nursing care which have in the end should have been for normal residential care. Training and oversight has been improved and will need to be maintained as staffing cohorts change.
36	Performance Briefing Appendix-2021-14	**Karen Hamilton:** 3. Waiting times – how are we getting this message to the public that waits are and may get longer?	**Nicky Berry:** We have recently updated the 'added to waiting list' letter that is sent to all patients who are added to a waiting list for Surgery. This letter now includes a link to website that shares information on how long patients who have been operated on have waited. The website also includes a link to the national clinical prioritisation guidance. We are

			now looking at a similar letter for patients added to the Outpatient waiting list. A key opportunity for managing patient expectation is when they agree to a referral with their GP. As such, GPs have all been provided with access to the website with waiting times to encourage a conversation about likely waiting times. The waiting times team are also considering how we communicate further with patients when they have reached 26 weeks. The Head of Communications is working with the Chief Executive and Quadumvirates (via the RPG) to inform a regular dialogue with the public about the progress of remobilisation.
37	Performance Briefing Appendix-2021-14	**Karen Hamilton:** 9 Performance Standards going forward. Explanation of review referred to please?	**June Smyth:** On the onset of COVID-19 we reduced the number of standards/targets we reported upon to the Board to free up business intelligence (BI) team capacity to focus on the pandemic. The Planning & Performance team are in discussions with the BI team to assess if data is available for the wider suite of targets/standards that we previously reported on, and if the BI team have capacity to support this. We are also waiting to hear from Scottish Government regarding any reporting / monitoring arrangements for Boards on RMP3, which would be incorporated into the performance report to the Board.
38	Performance Briefing	**James Ayling:** Delayed discharges obviously remain a real problem for us	**Nicky Berry:** We don't seek feedback at present and I'm happy to look at this it's a good

	Appendix-2021-14	and for those patients for whom the delay does not result in a better long term outcome for them....I assume there may be some. I suspect it is very difficult to categorise any better outcome patients as a sub section of the overall delayed discharge figures. Do we ever speak to patients/their families post discharge and ask them about their discharge experience and where he/she felt it may have got bogged down by say duplication of work, communication issues etc and ascertain if there are any trends emerging?	point. I've asked patient experience if we've had any feedback through the complaints process.
39	Performance Briefing Appendix-2021-14	**Fiona Sandford:** Echo Malcolm's question	**Rob McCulloch-Graham:** It will be a combination of factors. Having the correct Policy, Strategy and Process to reduce delays, compliance with those and the capacity of reablement/intermediate care, home care and residential care. All of these factors impact on patient flow into, through and out of hospital.
		COMPLEX CARE UNIT – LEARNING DISABILITIES	
40	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Harriet Campbell:** I'm sure this has been previously discussed (another newbie question, sorry) but if there are currently 12 Scottish Borderers currently placed outwith the Borders and 2/3 new placements required each year, why is the proposal for an 8 bed unit?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these

			places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
41	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Malcolm Dickson:** See my comment under Matters Arising.	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
42	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Lucy O'Leary:** 12 out of area placements currently 2-3 new placements required pa Implies a 4-6 year average stay in a placement. Is this correct? (It sounded a bit low to me given the lifelong nature of the needs and the level of challenge). And is there any "churn" in individual placements, ie does the 2-3 pa include people moving between different out of area placements? if the person was placed in a stable environment closer to home, would we expect length of	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in

		stay to rise, requiring more places to meet current levels of demand?	this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
43	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Karen Hamilton:** Are we still confident that the size and capacity is sufficient and future proof and will revised plans impact on this?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
44	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Fiona Sandford:** Agree with Karen and Malcolm – have we got the capacity right?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we

			could match our demand without having a “void agreement” within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.