HIGHLAND NHS BOARD	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Fax: 01463 235189 www.nhshighland.scot.nhs.uk
MINUTE of MEETING of the FINANCE, RESOURCES AND PEFORMANCE COMMITTEE Board Room, Assynt House and TEAMs	**30 October 2020 at 10am**

Present
Alexander Anderson, Chair
Tim Allison, Director of Public Health and Health Policy
Ann Clark, Non-Executive Director, Chair of HHSC Committee
Sarah Compton-Bishop, Non-Executive Director
Pam Dudek, Chief Executive
David Garden, Director of Finance
Philip MacRae, Non-Executive Director
Heidi May, Board Nurse Director
Dr Boyd Peters, Board Medical Director

In Attendance
Ruth Daly, Board Secretary
Adrian Ennis, Improvement Director
Brian Mitchell, Committee Administrator
Mirian Morrison, Clinical Governance Development Manager (Item 8 only)
George Morrison, Head of Finance, Argyll and Bute
David Park, Chief Officer, Highland Health and Social Care Partnership
Katherine Sutton, Chief Officer, Acute
Elaine Ward, Deputy Director of Finance

1 WELCOME AND APOLOGIES

Apologies were received from Joanna Macdonald.

2 DECLARATIONS OF CONFLICT OF INTEREST

There were no formal Declarations of Interest.

3 MINUTE OF THE MEETING HELD ON 28 AUGUST 2020

The minute of the meeting held on 28 August 2020 was **Approved.**

The Committee agreed to consider the following Item at this point in the meeting.

4 INTEGRATED PERFORMANCE REPORT

Ms Dudek introduced the circulated report and advised this remained a work in progress, with Staff Governance aspects in particular being developed and defined. Members were then updated in relation to the following:

Clinical Governance – B Peters emphasised had been a challenging year for NHSH from a clinical governance perspective and drew the attention of members to the relevant Performance Exception Reports. He stated there remained an aim to modify and improve the Exception reporting element in relation to trend analysis etc, with specific discussion at Clinical Governance Committee in relation to Complaints/Serious Adverse Event data to establish if the meaningful consideration of these aspects may be improved. The potential for Patient Experience/Satisfaction reporting had also been discussed. It was felt the move to bi-monthly reporting would be beneficial, as would longer term trend analysis reporting.

H May advised as to the ongoing work in relation to Falls, and the associated Scottish Patient Safety Programme, advising associated resource matters were being actively discussed. On Tissue Viability, she advised NHSH operated with a small specialist resource and this would be fully re-established, repatriating staff from current Covid activity.

A Clark sought an update on sepsis activity, asking if this remained a key objective. She further sought an update in relation to the status of the Highland Quality Approach (HQA), in the context of NHSH Clinical and Care Strategy development. H May confirmed a continued focus on Sepsis activity, with appropriate SPSP resource being applied. Meetings had been held to consider what would replace HQA, however, there were a number of competing agendas at this time. Strong improvement activity was continuing. B Peters confirmed the Clinical Governance Committee were actively considering these points in detail, with Quality Improvement a key focus. The refresh of the Clinical and Care Strategy would be a key component in defining what NHS Highland seeks to deliver it's respective aims and values, and outline how that would be achieved.

A Clark, welcoming Clinical Governance Committee discussion, emphasised the need for the NHS Board to be clear as to how quality improvement was to be taken forward, through a Quality Management Framework approach if that considered appropriate, even if much of this was remained on hold at the present time. The HQA approach had provided for a clear identity, vision and commitment to quality improvement. P Dudek, in accepting these points, stated the need to continue to articulate that vision and ambition, highlighting the importance of clinical engagement in achieving that. B Peters emphasised activity was continuing, and Strategy consultation and development would take time to complete.

Operational Performance (Remobilisation) – K Sutton highlighted the 4 hour emergency access target was close to being achieved, with performance fluctuating throughout the year. In terms of seeking further improved performance, a number of elements would be involved such as minor injuries pathways, increased planned emergency attendance etc. There were no plans to schedule blue light individuals, thereby enabling direct access to critical care and other service pathways. With regard to urgent medical admissions and assessments consideration was being given as to how best to schedule this activity. The relevant Team had had developed a revised flow pattern and established a Clinical Decisions Unit to provide assessment, including patient Covid status. A number of initiatives were also being taken forward for Belford and Caithness General Hospitals, the latter developing a pilot programme that included increased use of Near Me for assessment activity.

Unscheduled Care – A Clark sought an update in relation to enhanced community services within the Inverness area and was advised this remained part of ongoing service redesign activity. It was advised the increased number of longer patient waits mostly related to late night activity and agreed greater detail on that would be considered for the next report. D Park went on to advise the enhanced community service activity focussed on two major workstreams relating to admission avoidance and patient discharge/home assessment. Whilst services were running as a pilot, additional resource and recruitment activity was being taken forward. A small number of patients were involved at this stage, a number of which would have required substantial hospital resource should they have been admitted. Progress to date had been encouraging and capacity would be increase over time. P Dudek

stated there was an opportunity to consider links with Health Improvement Scotland to enable them to provide a critical friend approach. She then referenced the current spotlight on delayed discharge, suggesting an Exception Report for future meetings and was advised by D Park issues relating to Care Home capacity were having a negative impact. Care at Home was in a better position, with no associated delays evidenced in the Inverness area where the pilot scheme was in operation. A sustained change was required before claiming success in this area. The Care Home position was impacted by operators being reluctant to move to full capacity at this time, with financial aspects less of an issue at a time when financial support was being offered to them. In addition, families were reluctant to see relatives being admitted to Care Homes during this period. On a point being raised in relation to review of Care Packages it was confirmed changes would only ever be made according to clinical need.

D Park advised Care Home Covid testing activity was a success, with over 80% of relevant staff having been tested to date. Positive tests incurred a 14 day suspension of admissions to the Care Home involved. The previous day had shown that 44 Care Home places in North Highland were unavailable due to such testing activity. Contingencies were being actively considered and better planning would also be beneficial in this area. A Clark took the opportunity to raise the matter of risk appetite relating to placing patients back in their own home, with D Park agreeing there was an opportunity to consider this point, depending on clinical need and subject to Care at Home capacity. P Dudek agreed preventative work was of high priority in this area and critical to reshaping community model activity however highlighted that significant change will be required to ensure unscheduled care sustainability given current workforce issues. Change would need to be transformational in nature, requiring strong locality planning, community engagement, and involving supporting unpaid carers etc. This would require senior programme management resource and would likely take a number of years to achieve. She emphasised that any patients subject to a wait of over 100 days for discharge are automatically reviewed on an individual basis. Delayed Discharge within Argyll and Bute was at an extremely low level.

A Clark went on to state, in the context of discussion around extra support and number of workstreams being taken forward, she would welcome future discussion around the impact of the Performance Recovery Board and ensuring appropriate workstream integration. The Chair echoed the request, with P Dudek suggesting this be the subject of a future NHS Board Development Session, including discussion on relevant reporting requirements.

Outpatients – K Sutton advised that achieving the reinstatement of 80% of activity (July 2020) was a major challenge, with system capacity issues involved under current Covid restrictions. Activity was taken forward under the auspices of the Performance Recovery Board, with oversight by Scottish Government. Despite the success to date, the existing position was reviewed twice weekly with a view to ensuring improvement. The position within Argyll and Bute was heavily impacted by a reliance on support from NHS Greater Glasgow and Clyde, and as part of support negotiations there had been discussion around further financial capacity with Scottish Government. With regard to noted spare capacity within Belford Hospital, consideration was being given to moving patients in to that Unit from elsewhere within the service. In summary, overall movement was in a positive direction.

The Chair queried whether the use of Near Me was being maximised to alleviate the existing position and was advised relevant issues were being discussed with relevant clinicians. It was important to recognise that some patients did require face to face assessment. G Morrison highlighted the reliance on visiting clinicians in Argyll and Bute and on the point raised in relation to the potential to repatriate activity across NHS Highland K Sutton agreed there was merit in considering this further. She emphasised this would be complex to achieve and that this would not be appropriate for all patients. The One Hospital, Four Sites approach would continue to be taken forward. Continuity of care was an important aspect.

TTG – K Sutton advised there were specific challenges within Argyll and Bute in meeting plan requirements and in relation to Raigmore bed numbers. The introduction of five bed bays (from 4 beds) and additional theatre capacity had been of real benefit. How best to maximise overall capacity over the Winter period, across the NHS Highland estate was being considered. It was emphasised that the level of ITU admissions can have a major impact on activity elsewhere within the hospital setting and as such satellite sites were being utilised, subject to ensuring a minimisation of the number of Covid patients in those settings. Additional enhanced recruitment was also being considered in relation to Theatre roles.

Cancer Activity – K Sutton advised NHS Highland had delivered well on the 31 Day cancer target although it was acknowledged there were a low number of patients presenting as a result of decreased levels of associated screening activity. A Sub Group of the Performance Recovery Board had been established to consider the development of detailed response to the pathway elements that had been highlighted to date including for Urology, Colorectal and early Diagnostic activity.

Cost Improvement Programme M6 report and Overall Financial Position – A Ennis advised progress continued to be made in relation to the Cost Improvement Programme, with a further 15 schemes having recently moved in to their implementation stage. At month 6, the forecasted outturn for the programme was £12.2m, an increase of £1.1m from month 5. The forecasted outturn of comprised of £9.8m of schemes on the delivery tracker and the risk adjusted pipeline was valued at £2.4m. The overall £24.1m target remained challenging, and the year to date delivery was £4.5m meaning strong performance would be required in coming months. Against the Annual Operating Plan (AOP), the in-month delivery was £1.285m against the AOP year to date target of £1.928m. Delivery tracker analysis highlighted some concern in relation to Diagnostics, Prescribing and Procurement elements. He advised 45% of current savings were recurrent in nature, with 55% to 60% a realistic target. The profile of savings against target was outlined, as was the Cost Improvement analysis of unidentified CIP against target, in relation to which increased management was required and could yet yield additional results. The three key risks and associated mitigating activity highlighted had related to Prescribing, Pipeline Scheme progress and Diagnostics (Managed Service Contract challenges and scheduling of Radiology reporting). A Ennis emphasised progress was being made, with NHS Highland demonstrating success in working toward financial efficiency. This had been recognised by Scottish Government, when comparing to other NHS Boards seeking to achieve the same. The Chair expressed frustration in relation to those areas where it had been highlighted that Scottish Government action could be of real benefits in achieving the desired savings targets.

A Clark referenced the contrasting performance in relation to Nursing Workforce productivity compared to that in relation to the Medical Workforce and was advised this had been impacted by the need to employ supplementary nursing staff during the Covid period, less so in relation to medical staff. Changing requirements in relation to nursing establishments were also having an impact in this area. The required nursing establishment review currently underway would help to define the up to date nursing requirements, with associated efficiencies to then follow. Activity in relation to medical staffing was easier to implement. H May further advised nursing capacity had been impacted by Covid, including the need for contact tracing staffing resource and additional support for Care Homes. Work in relation to legislative requirements relating to nursing establishment had been paused however the relevant establishment review had recommenced. She advised current legislative focus was on Nursing, using associated validated tools that were not yet available for use by other clinical groups. It was likely this activity may be placed on hold due to the impact of Covid.

Members took the opportunity to recognise the breadth and impact of savings activity to date and took the opportunity to thank all involved.

D Garden went on to outline the NHS Highland financial position as at end Month 6, advising the Year to Date overspend amounted to approximately £23.6m, with a forecasted deficit of £41.9m as at 31 March 2021. He advised much of the overspend to date (£15.2m) had been as a result of Covid response activity, with slippage within the Cost Improvement Programme (£7.5m) further contributing to this position. It was reported an initial Covid allocation (£3.5m) had been received, and an additional more recent allocation (£34.2m) had been included within the forecasted position. Unfunded elements related to unachieved savings (£9.8m), Adult Social Care transformation savings (£8.3m), and a proportion of the estimated spend on remobilisation plans. A further allocation of funding was expected in January 2021. It was noted brokerage of £8.8m had been assumed for the financial year.

D Garden took members through the underlying financial data relating to funding for 2020/2021; HHSCP; Acute Services; Support Services; Argyll and Bute; indicative subjective spend and additional data on savings delivery. The underlying Capital position was also outlined for members.

On the point raised by the Chair in relation to discussion with Highland Council on Adult Social Care, and whether the initial assumptions upon which these were based remained valid at this time, it was confirmed these assumptions remained. A paper had been submitted to the JMC the previous week, outlining an £8.5m funding gap. The Scottish Government were sighted on the current position and associated risk in relation to assumed funding, with a resolution expected by calendar year end.

The Committee otherwise Noted the Service performance and financial updates provided.

6 COVID ALLOCATION

E Ward spoke to the circulated report advising as to the associated impact of Covid-19 on the 2020/2021 financial position, and outlined anticipated costs to 31 March 2021 and the prevailing funding position. She advised relevant estimates were regularly reviewed, with a number of funding allocations having recently been received, as indicated in the report. At the end of Month 6 (30 September 2020) a year to date overspend of £23.6m was reported, with £15.2m related to Covid. The year-end forecast was for Covid expenditure to reach £63.4m, with £40.2m of additional resource having been confirmed to date. The allocation of £34.2m in September 2020 had been based on an initial Covid Finance Return submission (£75.7m). As time moved forward, relevant estimates relating to Covid expenditure were reducing. A further was provided in relation to submission of the Covid Finance Return and subsequent allocation of funding. It was reported a further funding allocation was expected to be to be received in January 2021. It was noted a number of elements had yet to be funded fully, or in part, including underachieved savings, winter planning, Argyll and Bute Social Care and FHS Payments. Remobilisation activity was being closely monitored by Scottish Government and managed via the Performance Recovery Board. As advised, relevant financial estimates were reviewed on a monthly basis, and were reflected in monthly reporting processes to Scottish Government. It was noted further separate submissions had been made to Scottish Government in relation to the scheduling of Unscheduled Care, increased laboratory capacity and SIREN Study activity. E Ward finally reported a number of funds and allocations had been received since production of the circulated report including for Urgent and Unscheduled Care (£1m approx.) and Winter Planning (£625k)

The Chair made reference to evidence of the current position on savings activity and was advised this was in place, as was the case for the articulation of cost savings and cost reduction activity, with Scottish Government understanding of the current position in Highland. The issue was raised as to whether all NHS boards in Scotland were subject to the same approach in relation to funding, and whether there was potential for receipt of more funding than identified as being required. On these points, D Garden confirmed the position

was being mitigated as far as possible and E Ward advised future allocations would be based on a previous cost benchmarking exercise and respective NRAC share, subject to appropriate review.

As a final point, D Garden advised as to a potential risk relating to remobilisation funding and cross-boundary charging activity, and advised the key issues been raised to national level. It was further expected that additional funding would be allocated should a Covid vaccination programme be agreed.

The Committee otherwise Noted the Report.

7 FINANCE, RESOURCES AND PERFORMANCE RISK REGISTER

There had been circulated a report providing an update on the progress with embedding Risk Management across NHS Highland and updating on progress in relation to an overall Board Assurance Framework.

The Committee Agreed to Defer consideration of this Item to the next meeting.

8 CODE OF CORPORATE GOVERNANCE

R Daly spoke to the circulated report, this having been considered by the NHS Board and advised this was now being made available for consideration by NHS Board Governance Committees from their individual perspective and in the round. The updated document would be presented to the December 2020 Audit Committee and the NHS Board again thereafter. This would be reviewed annually by both the Audit Committee and NHS Board.

The Committee Noted the Report.

P Dudek and K Sutton left the meeting at this point in the meeting.

9 PROCUREMENT ANNUAL REPORT

There had been circulated the third NHS Highland Annual Procurement Report, covering all relevant areas as defined by the Procurement Reform (Scotland) Act 2014. The report provided visibility of NHS Highland's procurement activities, and demonstrated how NHS Highland was meeting legislative procurement requirements. It further outlined how NHS Highland procurement activity was contributing to the delivery of its broader aims and objectives. Key areas covered included regulated contracts entered into, contracts where a contract process had not been undertaken, and future procurement requirements.

A Clark raised the matter of inclusion of community benefit requirements in NHS Highland contracts and was advised as to the challenge for officers in providing relevant detail to the procurement team to enable that to be included. The identification of such benefit accrual was difficult to capture and articulate although was included in some cases. Improvement was being sought in this area. D Park emphasised the usual tendering processes were not in place at the current time and highlighted that Capital Programmes did include that detail.

The Committee:

- **Noted** the Report.
- **Agreed** the Director Finance establish the position relating to development and agreement of the next Three Year Strategy.

10 ASSET MANAGEMENT GROUP 23 SEPTEMBER 2020

The minutes were circulated for information.

The Committee Noted the Minutes.

10.1 ASSET MANAGEMENT GROUP 21 OCTOBER 2020

David Garden advised the draft Minute had still to be formally reviewed and highlighted particular discussion in relation to replacement of equipment, capital resource relating to Covid and the potential development of a Business Case for Dunoon GP Practice.

The Committee otherwise Noted the circulated Minutes.

11 AOCB

12 FOR INFORMATION

12.1 Major Project Summary Report

The report had been circulated for information.

The Committee Noted the circulated Report.

12.2 Dates of Future Meetings

27 November (Development Session)

13 DATE OF NEXT MEETING

The next scheduled meeting of the Committee will be a Development Session held on 27 November 2020 at 10am via Microsoft Teams.

The Chair also sought the views of members in relation to holding the December 2020 meeting, and there was agreement this be cancelled in favour of a January 2021 meeting.

The meeting closed at 12.20pm