APPROVED

Board Meeting
04.08.22
Open Session
Item 12.4

NHS Grampian (NHSG)
Minute of the Performance Governance Committee
Wednesday 20th April 2022 10.00-12.00
Microsoft Teams Meeting

Present

Mrs Rhona Atkinson, Non-Executive Board Member, NHS Grampian (RA) (Chair)
Ms Luan Grugeon, Non-Executive Board Member, NHS Grampian (LG)
Mr Derick Murray, Non-Executive Board Member, NHS Grampian (DM)
Ms Joyce Duncan, Non-Executive Board Member, NHS Grampian (JD)

In Attendance

Professor Caroline Hiscox, Chief Executive (CH)
Ms Kate Danskin, Chief Nurse (KD)
Ms Sarah Duncan, Board Secretary (SD)
Mr Paul Allen, Director of Facilities & eHealth (PA)
Mr Alan Sharp, Deputy Director of Finance (AS)
Ms Pamela Wight, (PM) (Minutes)

Item	Subject	Action
1	**Welcome** RA thanked everyone for attending. **Apologies from Committee Members** Ms Lorraine Scott, Director for Planning, Innovation and Programmes. Councillor Shona Morrison, Non-Executive Board Member, NHS Grampian Prior to starting the meeting, RA expressed her appreciation for Else Smaaskjaer's support during previous Performance Governance Committees. The Performance Governance Meeting will no longer be supported by Else and PW will replace her, who was welcomed to her first meeting of the committee.	

2	**Minute of Meeting Held on 16th February 2022** During the previous meeting held on 16th February 2022, the committee had agreed that the following reports should be presented at this meeting. • An update regarding communications to long waiting patients with assurance that they are being appropriately supported. • How the Performance Governance Committee can best provide assurance regarding infrastructure projects to the Board. RA clarified both of these issues are/have been addressed in the following ways; Firstly, Paul Bachoo discussed the communication regarding long-waiting patients at the April 2022 Board meeting, and it was agreed that this issue related to remit of clinical governance committee. In addition to what was discussed during the board meeting, RA has asked clinical governance to ensure patients are receiving the information they need. The second report request was regarding how the Performance Governance Committee can best provide assurance on infrastructure projects. RA confirmed that there has been a change in infrastructure leads with PA now taking on this role and within agenda item 3.3, the future remit and function for the committee will be covered in this meeting. The Committee reviewed the minute of the meeting held on 16th February 2022 and clarified the following: On page 5 of the previous meeting minutes, it is noted that a working group has been established to review the use of locums. LG asked how this would be reported and if it sits with staff governance. CH advised that it would depend on the group's needs; it is a long-standing group and aims to address the financial risks associated with the use of locums. This is an issue related to both operational and financial management. The minute of the previous meeting was then approved as an accurate record.		
3	**Items Discussed**		
	3.1	**<u>Financial Report</u>** Due to the end of the financial year, AS could not provide the full report but provided an overview via a presentation.	

		The first slide summarised 21/22 where the following points were covered: • Year-end position is being finalised • Spend in the last quarter has been higher than forecast but Scottish Government will support NHSG to meet financial targets • Higher spend on covid (£4m) due to impact of surge wards (especially agency staffing) • Increase in untaken Annual Leave accrual of £3m (mainly medical staff related) • Increase in operational spend of £2m due to a variety of factors; accrual for HCSW regrading, non-compliant banding of junior medical rotas, increase in high-cost drugs and increased waiting time payment. The second slide covered the financial impact on NHS Grampian and included the following: • Scottish government have confirmed additional costs will be fully funded for 21/22. • Total spend for the year on NHSG services (excluding HSCPs) was £68.5m. • The main elements of the covid spend were on the following: - Vaccination Programme £23m - PPE £10m - Additional staff input (overtime & excess hours) £10m - Contact tracing & testing £8m - Infection Prevention £4m • At the end of March, around 1,000 WTE staff charged against Covid. • Position of funding and planning assumptions for 22/23 remain unclear. The final slide covered the financial position for 2022/23 and included the following : • One year (22/23) Finance Plan submitted to Scottish Government in March and updated to board in April.	

		• NHSG is facing a £20m financial gap next year, after assuming 1% savings target (£5m). • A combination of underlying overspends (£10m), and new cost pressures (£42m) offset by new funding of £27m. • £5m to be invested in new service commitments – prioritisation being undertaken by CET budget setting group. • IJBs likely to have significant reserves at the end of March 2022 (circa £80m). • Significant risks identified on the slide: - The pay awards are yet to be finalised. Advised to plan on the basis of a 2% pay increase but with inflation higher, the staff side organisation may push to increase the pay award. - Increase in energy prices. During March, AS received information that the cost of gas for NHS Grampian will increase by 159%, which is approximately £7m. - Covid funding assumptions Following the financial slide presentation, CH asked when financial clarity is likely to be received to support the strategic delivery plan. AS had no specific guidance on the financial budgets however he has been asked to submit a three-year plan along with the delivery plan by July therefore more concrete assumptions expected by then. With the increasing cost of energy, JD asked if alternative energy providers have been considered. PA confirmed alternatives are being investigated within the wider work around sustainability. LG asked for an understanding of the change in approach to budget setting. AS advised there are pros and cons to planned approach to the budgets. If a lump sum for covid is received, a choice can be made where to distribute around work streams, providing greater flexibility. Negatives include costs associated with covid that are overlooked by the government such as catering income which is currently low due to	

		a reduction in visitors to hospitals. As we move forward, we will be faced with some difficult decisions. DM asked if the new budget structure is based on portfolios and if so, would that give us a chance to rebuild the budget from the bottom up using the portfolio system. AS advised they are currently restructuring budgets and will move from the previous sector structure to the new portfolio structure. This format will be used for reporting in the next financial year. However, some of the budgets are based on an annual basis, therefore we zero base our medical staffing budget on an annual basis simply because it is a volatile budget and do not wish to miss a consultant post. If we were to rebase everything this would be a huge exercise and would result in a budget request that would be far more excessive than the government funding. RA noted we operate within a whole system and we are aware of the IJBs' reserve funds. Is it possible for NHS to help them spend that money in a way that would benefit them and potentially reduce some of the issues we are facing. AS advised that we cannot ask the IJB for reserve funds and then pull it from the budget. However, we can discuss patient pathways with them e.g. frailty care or unscheduled care and that we need to review the costs and how we use our resources to achieve the best outcome for patients. Additional points were raised by CH in relation to the discussions above: The removal of Covid funding and the issue relating to catering has resulted in one of the most frequently asked questions regarding the provision of hot food for NHS staff. There will be a choice point as to how we manage the experience of our workforce and the capability to manage budgets differently. On the requirement to provide a three-year financial plan, CH advised her understanding of this process is that it usually an annual financial plan and if Covid funding does not continue, we may have issues due to the non-recurring nature of funding. It would be helpful to know if there are any further discussions with Scottish Government about moving away from non-recurring funds. AS stated he does not perceive this improving in the near future. There will still be a requirement for an annual financial plan and a three-year plan.	

	3.2	**<u>Performance Summary</u>** KD presented the Performance Summary and advised the position hasn't changed significantly since system performance was discussed at the April 2022 Board meeting. Despite everyone's best efforts, we remain a system under extreme pressure. Our workforce is experiencing society returning to normal but working in healthcare feeling very different from that. For example, masks will continue to be encouraged in healthcare settings. There is hope that we are passing this wave of Omicron, however absence and occupancy levels remain high and are impacting significantly. The report continues with previous format, set out around Operation Iris objectives. **Objective A - Keeping staff safe and help them maximise wellbeing**. There have been a number of positive developments that have occurred within the cross-system working. The We Care programme continues, however, we accept that it doesn't necessarily have an immediate impact. The Best Practice Australia (BPA) culture survey conducted its first phase involving nurses, midwives, and support services. The Chief Executive team received the high-level results at their meeting on 19 April and going forward, there will be a focus on the way we communicate and work with the results. **Objective B – Responding to demand on the health & care system.** Across the entire system we are operating at extremely high occupancy/capacity levels and this remains unchanged. Prof Fluck shared with Chief Executive Team on 19 April some early modelling information that may give us some hope for the future. However, too early to have any certainty. **Objective C – Protecting critical services and reducing harm** We are still struggling to achieve consistency with our ED performance, which essentially serves as a proxy measure for capacity across our entire system. A great deal of contact and collaborative working continues around this, however, it remains a challenge as it does throughout Scotland. During the last board meeting, Paul Bachoo spoke on the cancer delays. It has always been a priority to maintain surgery but the	

		inability to match the demand has meant our waiting list continues to grow. The latest quarterly update on progress against RMP4 plan will be submitted to Chief Executive Team meeting on Tuesday 26th April 2022. Questions regarding the performance report were raised by DM. Q1**.** Are there enough geriatric beds throughout the system. Q2. Over one-third of the beds are unavailable at Cornhill, this appears to be high. Q3**.** The children's hospital is improving but ARI and Dr Gray's are still a concern. Is the emergency unit particularly bad due to covid. In response to the above questions, CH provided the following response: - A1. In our first year of delivering our program, we will understand the need for geriatric beds across the system. The hosted element of geriatric care is now located at ARI, ward 102. Our remaining geriatric services are dispersed across Moray, Shire and Aberdeen City where we face a challenge in staffing and resourcing those models. From our data, we have observed that we have geriatric patients boarding and being delayed in their care every day. We see a very clear correlation between the performance of our social care system and the flow of geriatric patients. There are no longer geriatric beds on the Woodend Hospital site. Rosewell House in Aberdeen City now has 60 geriatric beds. They are mostly used for step down due to the pressure throughout the system. However, the goal is to position them as a step up so we can provide alternatives to care for that segment of society. There is no doubt that we need more beds. The challenge is whether we can create those beds at home rather than in a hospital or care home. In order to support a hospital at home model, we must understand the demands and move specialists outside of secondary care and into the community. A2**.** Cornhill beds fluctuate every day based on the availability of staff, infection control measures, closures of wards and the infrastructure improvement programme around Cornhill does impact this. A modelling piece of work is required around the pathways and adult psychiatric bed base. This will be undertaken with community services. A3**.** The emergency department at the Royal Aberdeen Children's Hospital is high performing. Currently, we do not suffer from an	

		inability to maintain access to our paediatric pathways, as children behave differently than adults and we do not experience the same level of demand in that area. Dr Gray's and Aberdeen Royal Infirmary have not necessarily been directly affected by covid but they are the funnel of the entire system and anything that relates to covid, such as a reduction in bed base, staff absences or the closure of care homes, can be observed in our performance metrics as a proxy indicator. Adult services are generally much more pressured irrespective of covid but following implementation of the living with covid infection prevention control guidance last week, we should see better flow through medicine and geriatrics. Two questions regarding the performance report were raised by LG. Q1. Are we conducting research on public behaviour change and how we are accessing services differently? For example, some people prefer e-consultations and at-home prescriptions. Q2. The Scottish ambulance service is under immense pressure, what is being done to alleviate this. CH provided the following responses: - A1.CH will find out if research is being done with regards to societies and behaviours in accessing healthcare and share with the committee. There is a piece of work being undertaken in regard to the demand profile and how people access services. The data from this work will be used to plan our first year of delivery of the new strategy, with society/individual behaviour being a focus area. A2. In relation to the Scottish ambulance service, CH understands the concerns about this Ambulance stacking has never been an issue before. CH meets with Pauline Howie, Chief Executive of the Scottish Ambulance Service, on a weekly basis to understand how our performance is moving and to be sure we are demonstrating leadership on this front. There are three pathways that are affected, which include Dr. Gray's, the Emergency Department at ARI and the Acute Medical Initial Assessment Ward. While we have an improvement programme around all the small factors that can be improved, the fundamental problem is the flow in our system and the mismatch between demand and patient capacity. Reducing infection control measures and returning to pre-covid guidance should improve the flow. The final question regarding the performance report was raised by JD-	**CH**

		Q1. Can you confirm that families and the third sector are involved in the planning of treatment pathways for patients who may be treated at home rather than in a hospital. CH provided the following response: - A1. The pathway design has been completed but there is room for improvement. As part of the delivery plan for the new strategy with pathways and partnership, it will be explicit that the pathways from home to home need to be co-created with families and service users. We also need to think differently around how we engage and work with the third sector. During the next year, assurance, milestones and oversight can be sought. No further points raised.	
	3.3	**<u>Future remit & function for this committee</u>** RA noted that since the agenda was reformed, the proposed strategic intent and the trajectory for the delivery plan were shared with the Board. Instead of going through the proposed Terms of reference in detail, CH, KD and SD led a discussion. KD went through the slides that covered connecting outcomes, strategies and objectives and highlighted the following - • Some of the strategic objectives will be specific to NHS Grampian and others will be shared. This will lead to smart objectives for the Chief Executive team as well as the organisation as a whole. • There will be many delivery milestones, some will have an executive lead, and some will have several executive leads. • A discussion has taken place around need for a different level of performance report for PGC and how we report to the board. • Our performance reporting has always been focused on Operation Iris objectives as well as the other measures provided by Scottish Government, however, what CH has been doing with individual portfolios and developing for performance is breaking down RMP4 data and sharing that with the specific portfolios.	

		• A tiered approach and a balanced scorecard are being considered. The challenge will be integrating the hard outcome measures with the harder to measure elements of the strategy. SD touched on the terms of reference and advised committees will receive assurance on behalf of the board. This will give the committee responsibility for issues that fall within their remit. In regard to the performance reporting structure outlined by KD, SD advised the Board will receive reports on the outcomes. Currently, every level of the system receives the same performance report. The role and remit of the committee is very broad, especially when there are four distinct sections within it. We need to consider whether the remit of this committee is too broad. For the June Board meeting, the Board will require assurance that the role and remit is realistic and will allow the committee to focus on important issues. There are some golden threads that would work for every committee, such as sustainability, it is a lens for looking at inequalities and CH has stated repeatedly she wants the Board to have a much greater focus on engagement and co-production with our communities. SD refers to these as golden threads because they are not just for one committee to work on, all committees must take them into account. CH sees the Performance Governance Committee as offering the greatest opportunity and highlighted the following points: On the difference around this strategy and how it will be implemented, we have never had board committee oversight of a strategy with a delivery plan containing milestones. It is a huge step forward, but CH needs the committee's support to make this a reality. The strategy is very ambitious and seeks to take us in new and sustainable directions. Finance and Infrastructure – As previously stated by AS, there will be increasing challenges moving forward with financial governance, also noting the change of Director of Finance. Golden threads – Through our strategy, some of the results that we are achieving will be slow burn, but we will monitor the quarterly improvements we're making through this committee. This strategy redefines our relationship with citizens, communities, and the third sector. Continuing on from the points raised by CH, the committee members discussed the following issues:	

		JD asked for confirmation that if something isn't meeting a standard and is not deemed acceptable that committee members and the Board will be notified before anything goes wrong. CH advised that an integrated performance report is being developed, which will provide a visible overview of our performance, which will hopefully alleviate the concern raised. LG believes that this committee should address agendas that link-in and perhaps longer or more frequent meetings may be required. DM asked in terms of decision-making, what authorities are retained by the board. SD responded by explaining that is specifically stated in the Board's standing financial instructions and standing orders. There are certain decisions the Board must make, particularly on capital expenditures and finance. Accordingly, SD will refer to the Board's standing orders and financial instructions and ensure that it is clear where the decision-making authority lies and where you can find that information. JD agreed that we need support as we work to build this framework. SD advised this is where priorities and the annual delivery plans are so important. During the 1st year, priorities are being set, but in future years, the priorities will be formed based on what goes well and what doesn't. Our understanding will become clearer once we have the results of the strategy and the delivery plan. We now meet as a group of committee chairs; this should be a part of our formal structure. SD is hoping to have a board SharePoint site implemented that contains agendas, business plans and other information that we can all access. Data integration shouldn't be the primary focus of committee work; this is something you can all access, but we need trends and projections of where we should be 18 months down the road. JD highlighted she only receives one day a week to do NHS work however those on an IJB receive an additional day therefore two days a week for non-executives. Workload demands need to be realistic with the time allocation. RA is not comfortable with increasing the frequency of the meetings and suggested a longer day would be a more suitable resolution. Another improvement would be ensuring the papers are submitted well in advance.	

		Committee members were collectively asked if they were comfortable with the content of the meeting and the direction the group are heading in. The committee members confirmed they were pleased on both accounts. A final question was raised by SD about this committee's remit being too broad and whether they are fine with everything remaining in one place or whether they would prefer SD to explore alternative methods to managing this. The committee responded by stating that they are satisfied with the current set-up and cannot see how it would be improved without creating a new committee. In closing, CH emphasised that a board level committee for financial governance and infrastructure management is needed. The level of financial risk will be different over the next few years and because of this, CH is not wedded to having this grouped together. While recognising others have been involved longer, there is potentially duplication of topics raised at committee and board meetings that could be streamlined to regain individual time back. Gaining the right level of papers and data may change time demands on everyone. Finally, having seen the Best Practice Australia output, one of the biggest issues we have been told to address is cultural issues by being present and visible as Board members with our colleagues. Before the meeting ended, SD advised everyone will receive the terms of reference by email and will be asked for final comments.	**SD**
4	**Matters to Highlight to NHSG Board** KD to draft Board Report for review by Mrs Atkinson		
5	**Date of Next Meeting** Wednesday 15th June 2022 14.00 – 16.00 Microsoft Teams		