**NHS Board Meeting**
**27th January 2021**

**Lanarkshire NHS Board**
**Kirklands**
**Fallside Road**
**Bothwell**
**G71 8BB**
**Telephone: 01698 855500**
**www.nhslanarkshire.scot.nhs.uk**

**SUBJECT:** **QUALITY ASSURANCE AND IMPROVEMENT PROGRESS REPORT**

## i. PURPOSE

This paper is coming to the Board:

| | | | | | |
|---|---|---|---|---|---|
| For approval | ☐ | For endorsement | ☐ | To note | ☒ |

The purpose of this paper is to provide NHS Lanarkshire Board with an update on the Lanarkshire Quality Approach and on progress with quality initiatives across NHS Lanarkshire.

## ii. ROUTE TO THE BOARD

The content of this paper relating to quality assurance and improvement initiatives has been:

| | | | | | |
|---|---|---|---|---|---|
| Prepared | ☐ | Reviewed | ☐ | Endorsed | ☒ |

by the Medical Director and Director of NMAHPs. The information within this report is also shared with, and discussed by, the Quality Planning and Professional Governance Group and the Patient Safety Strategic Steering Group, and is also presented in detail to the Healthcare Quality Assurance and Improvement Governance Committee.

## iii. SUMMARY OF KEY ISSUES

NHS Lanarkshire is committed to delivering world-leading, high-quality, innovative health and social care that is person-centred. Our ambition is to be a quality-driven organisation that cares about people (patients, their relatives and carers, and our staff) and is focused on achieving a healthier life for all. Through our commitment to a culture of quality we aim to deliver the highest quality health and care services for the people of Lanarkshire.

NHS Lanarkshire's Quality Strategy 2018-23 was approved by the Board in May 2018. Within it are four NHS Lanarkshire Quality Plans 2018-2023.

The paper provides an update on the following areas:

- Assurance of Quality
- Quality Improvement
- Evidence for Quality

## 4. STRATEGIC CONTEXT

This paper links to the following:

| | | | | | |
|---|---|---|---|---|---|
| Corporate objectives | ☒ | AOP | ☒ | Government policy | ☒ |

| | | | | | |
|---|---|---|---|---|---|
| Government directive | ☒ | Statutory requirement | ☐ | AHF/local policy | ☐ |
| Urgent operational issue | ☐ | Other | ☐ | | |

## 5. CONTRIBUTION TO QUALITY

This paper aligns to the following elements of safety and quality improvement:

***Three Quality Ambitions***:

| | | | | | |
|---|---|---|---|---|---|
| Safe | ☒ | Effective | ☒ | Person Centred | ☒ |

***Six Quality Outcomes***:

| | |
|---|---|
| Everyone has the best start in life and is able to live longer healthier lives; (Effective) | ☒ |
| People are able to live well at home or in the community; (Person Centred) | ☒ |
| Everyone has a positive experience of healthcare; (Person Centred) | ☒ |
| Staff feel supported and engaged; (Effective) | ☒ |
| Healthcare is safe for every person, every time; (Safe) | ☒ |
| Best use is made of available resources. (Effective) | ☒ |

## 6. MEASURES FOR IMPROVEMENT

We will measure the progress we make towards our aim of delivering the highest quality health and care services for the people of Lanarkshire against the strategic priorities identified in the Quality Strategy and the Measures of Success contained within the associated Quality Plans.

## 7. FINANCIAL IMPLICATIONS

No financial implications are identified in this paper.

## 8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

The Healthcare Quality Assurance and Improvement Committee oversee a corporate risk with controls in relation to achieving the quality and safety vision for NHS Lanarkshire. Corporate Risk 1492 - Consistent provision of high quality care, minimising harm to patients - is rated as Medium.

## 9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

| | | | | | |
|---|---|---|---|---|---|
| Vision and leadership | ☒ | Effective partnerships | ☒ | Governance and accountability | ☒ |
| Use of resources | ☒ | Performance management | ☒ | Equality | ☒ |
| Sustainability Management | ☐ | | | | |

## 10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An E&D Impact Assessment has been completed for the Quality Strategy 2018-23

## 11. CONSULTATION AND ENGAGEMENT

The NHS Lanarkshire Quality Strategy 2018-23 was approved by the Healthcare Quality Assurance and Improvement Committee and the NHS Board in May 2018.

## 12. ACTIONS FOR THE BOARD

The Board is asked to:

| | | | | | |
|---|---|---|---|---|---|
| Approve | ☐ | Endorse | ☒ | Identify further actions | ☐ |
| Note | ☒ | Accept the risk identified | ☐ | Ask for a further report | ☐ |

The Board is asked to:

1. Note the range of work throughout NHS Lanarkshire to improve the quality and safety of care and services;

2. Endorse the governance approach to this work and in particular the assurance being provided by the Healthcare Quality Assurance and Improvement Committee; and

3. Support the ongoing development of the Lanarkshire Quality Approach.

## 13. FURTHER INFORMATION

For further information about any aspect of this paper, please contact Karon Cormack, Director of Quality. Telephone 07779421465

**QUALITY ASSURANCE AND IMPROVEMENT**
**January 2021**

## 1. Introduction

This report provides an update on the current progress over November 2020 to January 2021, of plans and objectives set out in the Quality Strategy to achieve the **Lanarkshire Quality Approach**. The routine monitoring of this work is with Executive scrutiny from the Quality Planning and Professional Governance Group which submits a Highlight Report to each meeting of the Healthcare Quality Assurance and Improvement Committee.

## 2. Assurance of Quality

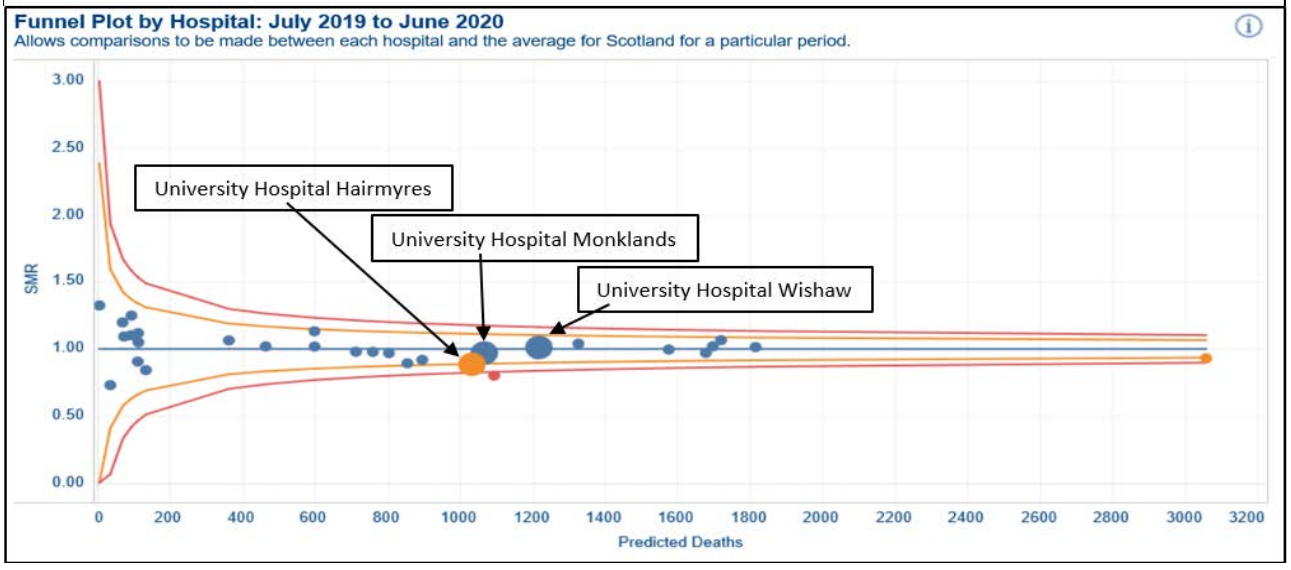
### HSMR

The latest release of HSMR data using updated methodology (introduced in August 2019) was published by ISD on 11th November 2020.
The data includes case-mix adjusted 30-day mortality on admissions from July 2019 to June 2020. Data is presented as a Funnel plot to allow comparisons to be made between each hospital and the average for Scotland for a particular period.

The 3 NHS Lanarkshire hospitals are represented on the funnel plot by the 3 large dots on the chart. University Hospital Monklands and University Hospital Wishaw are both within normal limits. University Hospital Hairmyres is below the lower control limit by between 2 and 3 standard deviations from the Scottish average.
This will continue to be monitored through Healthcare Quality Assurance & Improvement Committee (HQAIC).

**Health Board of Treatment:** NHS Lanarkshire  **Period:** July 2019 to June 2020

| Location | Observed Deaths | Predicted Deaths | Patients | Crude Rate (%) | HSMR | Comparison to Scotland on the Funnel Plot |
|---|---|---|---|---|---|---|
| **Scotland** | **26,606** | **26,606** | **621,762** | **4.3%** | **1.00** | **n/a** |
| NHS Lanarkshire | 3,182 | 3,321 | 71,416 | 4.5% | 0.96 | n/a |
| University Hospital Hairmyres | 915 | 1,034 | 19,185 | 4.8% | 0.88 | ▼ |
| University Hospital Monklands | 1,035 | 1,068 | 21,965 | 4.7% | 0.97 | ● |
| University Hospital Wishaw | 1,232 | 1,219 | 30,266 | 4.1% | 1.01 | ● |



## COMPLAINTS

The Complaint Handling Procedure (CHP) has remained in place throughout the pandemic. As highlighted in the chart below, the volume of complaints has been changeable, initially falling in the first wave, but since rising. Complaints related to the flu programme contributed to the peak in Oct/Nov however waiting times and delays to treatment were also common themes in this time period.

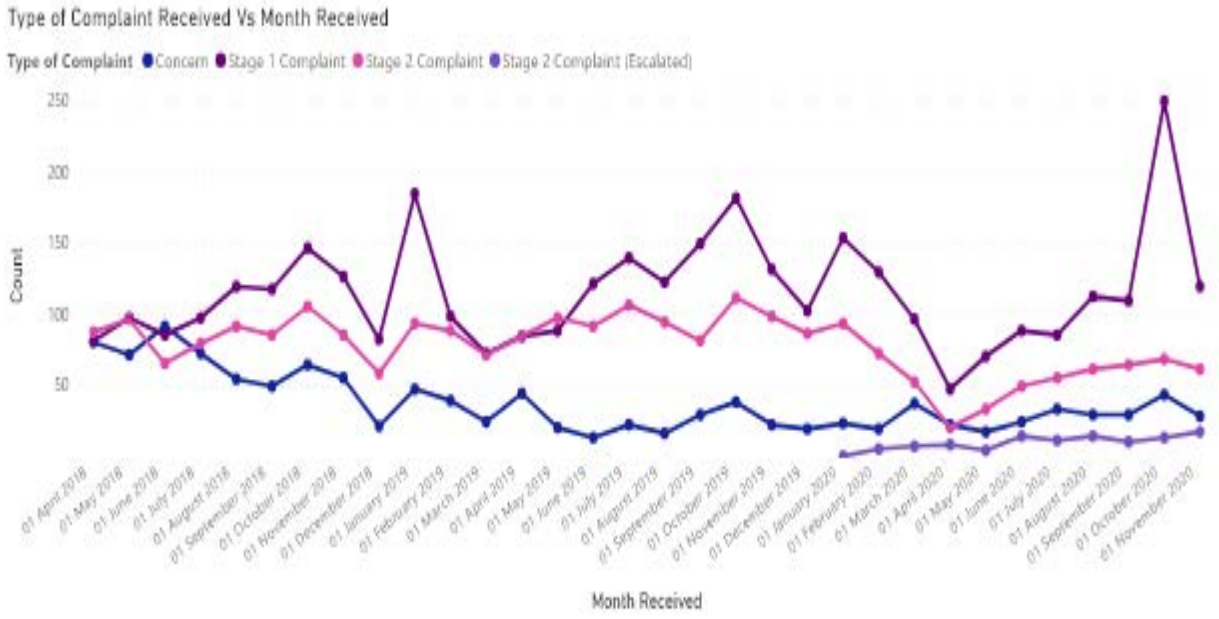
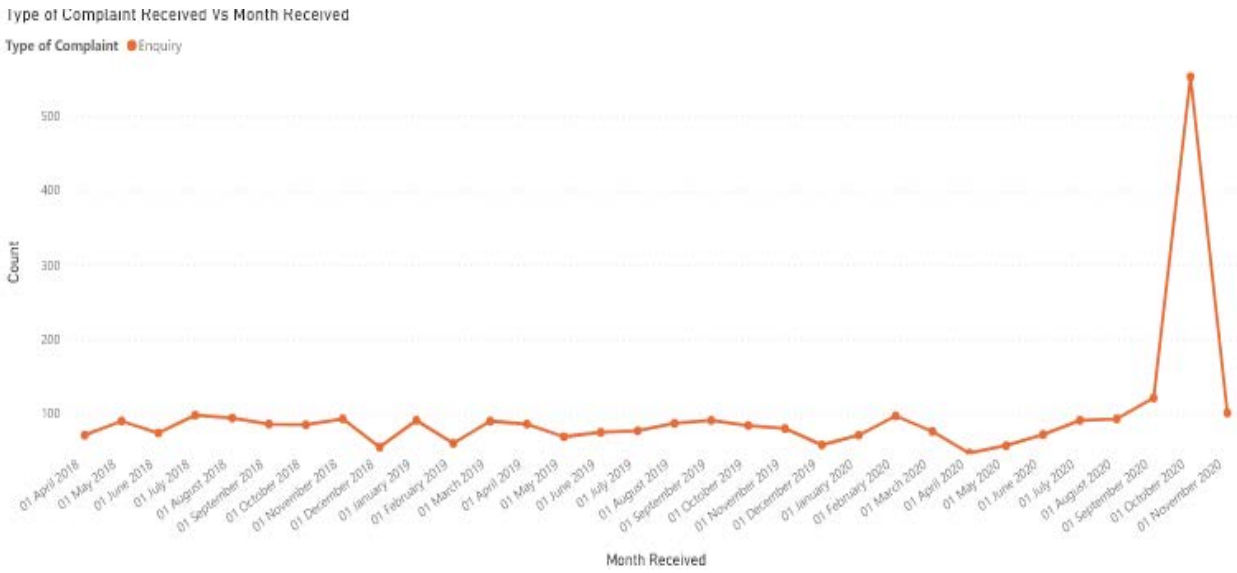



Chart 2 below highlights a significant increase in Patient Affair enquiries. These primarily relate to increased activity relating to the Flu Programme. Enquiries were either responded to or referred to the Flu Programme, to make arrangements directly with the patient for appointment, outlining prioritisation and scheduling etc.




The implementation of the complaints module in Datix web has improved reporting functionality and reliability. We have used the mid-year complaints report as a means of consulting with staff on making improvements to reporting, for example, incorporating issues and learning from

complaints. Enhanced reports will be produced for Quarter 3, covering the period October-December 2020.

## ADVERSE EVENTS

### COVID-19 Vaccination Programme

As part of Public Health Scotland's (PHS) responsibility to monitor the safety of the COVID-19 immunisation programme, the national vaccine safety work stream developed a framework for monitoring and escalating adverse events which has been distributed to all Boards.

Due to the novel nature of the COVID-19 vaccine and the introduction of a country wide mass vaccination programme there is a desire to collect any adverse events related to the vaccination programme to enable a contemporary review of implementation. To be able to collect these adverse events, new coding has been added to the Datix system to make this easier to report and also to produce reports.

A process has also been agreed for the adverse events team to work in collaboration with the Immunisation Coordinator for NHSL to submit the weekly returns to PHS.

### Duty of Candour

The Duty of Candour annual report was produced for time period April 2019 to March 2020 and an addendum was added to this report in December 2020. This provided an update to include the outcome of all SAERs that were open at the time of the initial annual report being developed.

This update now demonstrates the number of events reported as duty of candour events within NHS Lanarkshire during time period April 2019 to March 2020, as 33. All reviews have now been completed.
The opportunity was taken to add to the addendum report a section on staff support available during adverse event reviews.

Notification was sent to Scottish Government and Health Improvement Scotland notifying that a copy of the Addendum to the NHS Lanarkshire Duty of Candour Annual Report has been published on the NHS Lanarkshire website.

### NHS Lanarkshire Adverse Events Bulletin

The 2nd edition of the bulletin was published and circulated in October 2020, providing more information for shared learning and improvements resulting from SAERs carried out. This has been well received by services.

## QUALITY DATA & MEASUREMENT

The Data & Measurement Team have liaised with members of the Internal Audit Consortium for Lanarkshire to assist in completion of the internal audit of quality processes to "ensure relevant, reliable and sufficient data is collated appropriately and reported accurately and timeously to the right people." The audit review was undertaken in accordance with the 2020/2021 Operational Audit Plan. Results of the internal audit included one recommendation related to ensuring the identity of data sources for each of the performance measures is included when reporting and recording a disclaimer where data is unverified. This action has been implemented and closed, with no further action required.

The team have worked closely with the Adverse Events Team to streamline the reporting processes for pressure ulcers and falls through Datix, and will seek to continue this work to improve the reporting process for cardiac arrest data.

The team continue to liaise with the Systems Development Team to develop and maintain a data warehouse system through Extract, Transfer, and Load (ETL) processing, whilst integrating new reporting software (Power Bi). Both teams continue to review current data sources/systems used to extract data, to assess functionality and how these systems could be incorporated into the data warehouse.

The team have made progress with the development of an online Data & Measurement Master class to give insight into the analytical tools and processes applied across multiple data dashboards within NHSL. The course content will be finalised and first session delivered in early 2021.
The team continue to provide monthly updates to all Acute Sites.

Work to review potential Equitable Care Indicators for inclusion within future Quality & Safety Dashboards is progressing well. These are longer term indicators and a series of potential measures have been proposed, as displayed in Table 1 below:

Table 1: Proposed Equitable Care Indicators for inclusion within Quality & Safety Dashboards

| Measure Code | Measure |
|---|---|
| EQ_1 | Access to GP's/Number of GP's per head of population |
| EQ_2 | Number of Avoidable Admissions |
| EQ_3 | Number of Repeat Admissions |
| EQ_4 | Avoidable Mortality |
| EQ_5 | Palliative Care - End of Life Cohort |
| EQ_6 | Uptake of Adult Screening Programs (by SIMD):<br>• Breast<br>• Cervical<br>• Diabetes<br>• Bowel |
| EQ_7 | Parenting Responsibilities |

The COVID-19 Dashboard continues to be submitted on a weekly basis for review by CMT.

## 3. Quality Improvement

### QUALITY IMPROVEMENT EDUCATION

The Achieving Excellence in Quality Improvement Programmes of education for individuals and teams has been running in NHS Lanarkshire for the last few years. In 2020 we would have been running cohorts 9, 10 and 11 of the teams programme with 25 members of staff in each cohort.

The programme involves 5 teams of five members of staff attending face to face classroom learning over 5 days over a 6 month period where they learn the theory of quality improvement and importantly how to apply this theory to an improvement project of their choice in their work area.

The programme is popular and over the years hundreds of staff have now developed a foundation level of quality improvement skills which they can apply to their work areas to make improvements in quality and safety and continue to support the safety culture within NHS Lanarkshire.

In addition the programme now runs in South HSCP following support and coaching from the Improvement Team a small team of staff in South HSCP now run their own aEQUIP programme.

The cohorts for 2020 were suspended and in April 2020 the programme content, format and delivery methods were reviewed by the Improvement Team aEQUIP Faculty. In addition national and international best practice examples for virtual learning were researched by the Improvement Team to identify potential alternative approaches.

A bespoke programme was designed which would enable a member of staff to identify an area that could be improved and work through the improvement journey steps to understand the wider system, identify the aim of their project, implement quality improvement tools and techniques to identify and test change ideas, use data for measurement and improvement, evaluate the impact of the change and sustain the improvements.

aEQUIP Faculty created learning activities and scenarios which could deliver the desired learning outcomes using a virtual rather than face to face classroom learning approach.

Cohort 1 of this new aEQUIP Going Virtual Programme was tested in September 2020. The programme consists of 4 two hour sessions. Sessions are held once per week on alternative days and morning/afternoons to provide as much flexibility in attendance as possible. Following evaluation cohort 2 was held in October and cohort 3 was held in November. This programme has been delivered to 3 cohorts totalling approximately 50 multi-disciplinary staff members across health and social care in Lanarkshire between September and December 2020.

A detailed evaluation of the first three cohorts is taking place in January 2021 and cohort 4 is booked for February 2021. This work demonstrates a commitment to support training and education of the workforce increasing our capacity and capability to improve quality.

## MORTALITY CASENOTE REVIEWS

NHS Lanarkshire undertakes site based mortality case note reviews on each hospital site each year as part of the Quality Strategy Safe Care Plan. This provides assurance on delivery of safe care and supports staff learning.

The aim of the review is to:

- Identify & review deaths at acute sites &/or in community
- Identify episodes of physical harm experienced by patients
- Aid learning
- Highlight positive aspects of patient care
- Identify areas for improvement

A standard methodology is used to undertake each review with:

- Identification of 50 cases for review per annum
- Multidisciplinary review team established

- Lead reviewer with experience of mortality review in each group
- Approximately 20 minutes to review each case
- Complete 3x2 matrix document
- Complete appropriate Institute of Healthcare Improvement forms for each case
- All harms reviewed by site chief &/or MDT review group
- Duty of candour legislation considered

During 2020 each acute hospital site carried out a mortality case note review focussing on COVID-19 deaths.

**University Hospital Hairmyres** carried out the first rolling mortality review 28th March to 31st May 2020, with survivor's data for comparison. The aim was to review the deaths from Covid 19 in real time to identify any learning to improve practice in treating subsequent patients and was not for scrutiny. Medical staff who were unable to work clinically due to shielding carried out the reviews.

The review included 57 deaths and 51 survivors. The data is comparable with global data known at that time demonstrating that older male patients more likely to have a worse outcome and patients with Covid 19 tend to have more co-morbidities. Frailty was noted in both cohorts, but the mortality group were frailer. There were 11 category I harms noted which were all nosocomial infection with no Duty of Candour.

Communication and Treatment Escalation/Limitation Plans (TELP) were generally identified as done well with 100% of patients who died and 78% of survivors having a TELP in place. Multiple potential QI projects were also identified.

Learning from undertaking the UHH mortality case note review process during a pandemic was then used by **University Hospital Monklands** who identified 50 deaths from a total of 131 patients admitted to University Hospital Monklands, from 24th March to 31st May 2020. For sampling purposes, the cases were split into COVID-19 (or suspected COVID-19) and patients with another diagnosis and whether they were for full escalation or not.

During the month of August 2020 a total of 4 sessions were arranged. Reviewers from a wide range of specialities and disciplines were divided into teams of 3 or 4 staff. Approximately 40 cases were reviewed by this method. The remaining 10 cases were completed by pairs of reviewers.

Communication, particularly with the family, was noted by the majority of reviewers as an area of good practice.

Areas for improvement were noted for electronic documentation and ward moves/team changes. In terms of identified harms of the 50 patients reviewed using the Global Trigger Tool:

- 27 patients had 'no harm' identified during their admission
- 23 patients experienced harm (10 patients experienced 1 harm & 5 patients experienced 2 harms, 6 patients experienced 3 harms and 1 patients experienced 4 and 5 harms respectively)
- 47 harms were identified with severity categories
- 9 patients experienced harm that contributed to their death

All harms that were identified as 'Category I' were reviewed and discussed with the site Clinical Lead and Practice Development lead and all appropriate actions and communication occurred. These were mostly due to nosocomial infection but also included a procedural complication and abnormal blood results. No Duty of Candour issues were raised. If an issue relating to Duty of Candour had been identified, these would have been dealt with according to the NHSL guidance for clinical reviews identifying significant adverse events.

In August 2020 **University Hospital Wishaw** carried out a mortality case note review of 50 cases; 25 COVID-19 deaths and 25 Non COVID-19 deaths. The Chief of Medical Services identified clinicians who had previous experience of conducting mortality reviews. These clinicians were randomly assigned cases and asked to review them. Following review of all cases, two multi-disciplinary sub-group meetings were organised to review all harms that had been identified.

In terms of identified harms of the 44 patients reviewed using the Global Trigger Tool:

- 40 patients had 'no harm' identified during their admission
- 4 patients experienced harm (2 patients experienced 2 harms, 2 patients experienced 1 harm)
- 6 harms were identified with severity categories
- 2 patients experienced harm that contributed to their death

The 4 harms that were identified as 'Category I' were reviewed and discussed with the site Chief of Medical Services and all appropriate actions and communication occurred. These related to different issues such as a fall and an issue with medication. No Duty of Candour issues were raised.

Areas of good practice noted were good communication/documentation with patient and family members, good/timely decision making and care. Areas noted for improvement were documentation, inappropriate treament and unclear goals of treatment.

These reviews focused on patients who died during the first wave of the COVID-19 pandemic. The health service was subjected to a fast pace of change and there is an opportunity to learn from the changes that worked and those that were less successful. With the start of the second wave of the pandemic the importance of focussing on areas for improvement is heightened.

Following each site mortality case note review a detailed action plan is developed to address any areas for improvement.
Learning and reflections are also being captured from Lead Reviewers, review team members and Improvement Team members who took part in the process to identify areas for improvement to inform future mortality case note reviews.

Areas have been identified to improve the Mortality Review Process which will be incorporated into the planning for the 2021 case note reviews which include:

- Ensure a clear strategy for sharing learning is put in place following mortality reviews
- Fix dates in advance in the calendar for annual reviews & reporting outcomes at each acute site
- Agree the continuous process for conducting mortality reviews at acute each site
- Develop the paper work used in the mortality reviews based on experience in 2020
- Develop and agree best process for both data collection and reporting

- Provide clarity to all reviewers about the agreed IHI definition of harm & system within which harms are to be assigned
- As part of the review process, build in time to review all identified harms with an MDT team

Areas for improvement have also been identified in Clinical Processes which have been included in the site specific action plans which include:

- Patient choice of place of palliative care: Explore the process for supporting patients who wish to die at home
- Review the process for identifying and communicating end of life care plans
- Review process for DNACPR documentation
- Review current processes for prescribing and monitoring intravenous fluids to include review of all documentation and recording
- Explore the feasibility of a specific "bundle" within portal for when a patient has died

## 4. Evidence for Quality

**KNOWLEDGE SERVICES**

**Searching**

A total of 58 literature searches and 3 copyright permissions requests have been completed since the previous Board Report was submitted at the end of July. The searches include 21 for the Monklands Redevelopment Project and 2 relating to COVID-19. A further search on COVID-19 is currently underway but not yet completed – this will support work by Public Health in developing specific messages for targeted groups within the community to help them understand why the spread in Lanarkshire is so significant compared to other relative Boards and help them devise the best approach to reduce the rates of COVID-19 within Lanarkshire.

**NATIONAL AND LOCAL EVIDENCE, GUIDELINES AND STANDARDS:**

**Effective Use of New Technologies**

The current process for the review and assessment of Health Technologies publications from Scottish Health Technology Group (SHTG) and National Institute for Health & Care Excellence (NICE) has been revised following feedback from stakeholders. The governance group for this is Quality Planning & Professional Government Group (QPPGG) and they will decide which Health Technologies are relevant to NHS Lanarkshire and are for further consideration at the governance groups of Acute, North HSCP and South HSCP.

**New Guidelines Website and App**

The new NHS Lanarkshire website and mobile app was rapidly developed to initially contain information and guidelines relating to COVID-19. It was successfully launched in May 2020 and currently holds over 140 COVID-19 guidelines.

Work has also commenced to further develop the website and mobile app which will host all local clinical guidelines for NHS Lanarkshire in the future on this application. The Clinical Guidelines Governance Group has been established and has met to discuss and develop the priority actions.

**Existing Local Clinical Guidelines**
In March 2020 it was identified that there were 82 Clinical Guidelines held on the current Clinical Guidelines website which were due for review between March and December 2020.

With the increased challenges faced with the COVID-19 pandemic the review of these guidelines may not have been the author's immediate concern. To assist with this situation it was agreed to offer the authors extensions to their review dates of up to one year from the original review date. A process to track Clinical Guidelines due for review and which have been affected by the COVID-19 pandemic has also been put in place.

**CLINICAL AUDIT**

**Cancer audit**
The Cancer Audit Team have been working closely with the West of Scotland Managed Clinical Network (MCN) and the national team at PHS to agree data items to facilitate the use of Cancer Quality Performance Indicators to measure the impact of COVID-19 on patient outcomes. The agreed data fields have been added to each of the Cancer QPI datasets and will be reported at a regional and national level.

Locally individual patient related delays and outcomes due to COVID-19 have been incorporated into the quarterly/biannual reporting process. Further analysis can be carried out on request. No request have been received to date, however reporting on Quarter 1 and Quarter 2 2020 cases has commenced and requests for more in-depth analyses are anticipated.

The scheduled tumour specific Strategic Leads meetings for 2020 were impacted by COVID-19, but has now recovered and meetings have been rescheduled. To date QPI data has been presented for Gynaecology, Colorectal, Melanoma, Breast, Head & Neck and Haematology. The QPI data has facilitated discussions within the services to improve quality of care and also allows the opportunity to celebrate achievements. A full schedule has been agreed for 2021 which includes 9 tumour specific meetings and 3 all tumour meetings for shared learning.

## 5. Monitoring Quality

The Internal Audit Consortium for Lanarkshire completed an internal audit to review clinical governance and improvement, clinical risk management and assurance by auditing the performance of HQAIC.

The specific areas covered as part of this review were:

- The committee has an approved terms of reference, which are regularly reviewed;
- A committee work plan has been developed, updated following each meeting and scheduled work not presented is carried forward;
- Work programme and reporting schedule are in place to oversee progress of the Board's Quality Assurance and Improvement Strategy and provide assurance to the committee;
- Sub committees have been identified with agreed terms of reference that include role/responsibilities, membership and reporting arrangement and ensure appropriate assurance is provided;
- The committee received appropriate information and devotes sufficient time and focus to be able to conclude effectively on the clinical risk within its remit;

- Review clinical governance arrangements during and post Covid 19 to ensure that the changes to the risk profile and ensured appropriate levels of assurance are maintained.

The audit found that HQAIC was compliant with the criteria above apart from 2 reports (Public Protection Mid-year Highlight Report and Realistic Medicine Update Report) that were not reported at the meeting they were scheduled to be reported at. This was due to staff capacity issues during the pandemic. Both these reports were presented at subsequent meetings therefore there are no outstanding actions.

The Internal Audit Consortium for Lanarkshire completed an internal audit to review the 'safety plan' translated to the Quality Strategy Implementation Plan.

The specific areas covered as part of this review were:

- Risks and controls in relation to patient safety are appropriately identified, mitigated, monitored and controlled
- An appropriate patient safety plan identifying priorities and incorporating all relevant SGHSCD guidance has been approved and its currency maintained
- Operational plans to deliver identified priorities have been developed and include meaningful and realistic trajectories for implementation and spread
- There are appropriate governance and management arrangements in place to monitor and support successful delivery of the safety plan throughout NHSL
- Effective remedial action is identified and implemented where progress is not on track
- There is a process to review the quality of data used to assess risk and measure improvement
- Procedures have been revised to take account of the impact of Covid 19 on the Patient Safety objectives and on the organisation as a whole. Data is being gathered to allow the impact of changing working practises to be assessed in order to inform future service delivery

The audit found that the plan was compliant apart from the following two points;

1. Although the implementation plan highlight report is received at each QPPGG and HQAIC meeting, there is not a formal review of Risk ID 1750, Delivery of the Quality Strategy 2018 – 23 which relates to the risk of the quality strategy not being met. This will be rectified by review of this risk becoming a standing agenda item at QPPGG.

2. In relation to some of the sub-committees of HQAIC, although mid-year and annual reports have been presented, no highlight reports have been presented to the HQAIC or QPPG. This has been reviewed and the findings reveal that the annual and mid-year reports are sufficient therefore the terms of reference of these groups will be changed to reflect this.

**Dr J Burns**
**Executive Medical Director,**
**January 2021**