Item 3.

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NHS Lanarkshire

Minutes of the Healthcare Quality Assurance and Improvement Committee held on Thursday 14th September 2023 at 11:30am via MS Teams.

Chair:

Mrs M Lees	Non-Executive Director (Chair)

Present:

Mr A Boyle	Non-Executive Director
Mr P Couser	Non-Executive Director
Mr C Lee	Non-Executive Director
Mr D Reid	Non-Executive Director

In Attendance:

Mr P Cannon	Board Secretary
Mrs C Clarke	Chief Midwife, Maternity & Neonatal Services
Mrs K Cormack	Director of Quality
Mrs E Currie	Quality Programme Manager, Business Support
Mr E Docherty	Executive Director of Nursing
Dr C Deighan	Executive Medical Director
Mrs L Drummond	Head of Assurance, Quality Directorate
Dr R Mackenzie	Consultant in Critical Care, Chair Information Governance Committee
Mrs T Marshall	Nurse Director, North Lanarkshire HSCP
Mrs M McGinty	Head of Improvement, Quality Directorate
Mr P McCrossan	Director, Allied Health Professionals (AHPs)
Mrs A Minns	Head of Evidence, Quality Directorate
Dr L Munro	Medical Director, North Lanarkshire HSCP
Dr M Russell	Medical Director, South Lanarkshire HSCP
Mrs L Thomson	Nurse Director, South Lanarkshire HSCP
Mrs R Thompson	Nurse Director, Acute Division

Apologies:

Dr J Keaney	Medical Director, Acute Division
Prof. J Gardiner	Chief Executive
Mr M Hill	Board Chairperson
Dr J Pravinkumar	Director of Public Health

1. WELCOME

Mrs M Lees welcomed colleagues to the meeting and apologies were noted.

2. DECLARATION OF INTERESTS

There were no declarations of interest.

3. MINUTES

The minutes from the meeting held on 8th June 2023 were approved, pending an amendment requested by Dr C Deighan i.e. the Corporate Safety Dashboard, HSMR rate was noted as 1%.

THE COMMITTEE:

1. Noted the amendment and approved the minutes.

4. ACTION LOG

a) The action log from the meeting held on 8th June 2023 was reviewed and approved. Dr C Deighan advised that a review of the Audiology Service was complete and a paper published in August 2023 has been shared with the service. The service lead has been asked to draft an action plan and share this with the Quality Planning & Professional Governance Group (QPPGG). The Committee noted that the SPSO action within the action log was relevant to North HSCP only.

b) Mrs C Clarke presented the NHS Lanarkshire Benchmark of Ockenden, Summary Paper, noting the paper highlights the very positive position of NHS Lanarkshire nationally. Mrs C Clarke advised members regarding safe staffing and noted that NHS Lanarkshire is labelled as an employer of choice for maternity and neonatal staff nationally, which reflects very well on the service and the organisation. Members heard there are no risks highlighted from the report and the work reviewed demonstrates the service is performing very well. Mr E Docherty noted how well NHS Lanarkshire is benchmarking nationally and thanked Mrs C Clarke and her team for the leadership they have shown and great work they have undertaken, strengthening the safety culture. Dr C Deighan also thanked Mrs C Clarke and her team and noted that the report was shared with QPPGG and a further update to close off the item will be shared at QPPGG in approximately 6 months.

THE COMMITTEE:

1. Noted and approved the action log. Agreed that QPPGG will receive a further update re Ockenden (the NHS Lanarkshire position) in approximately 6 months.

5. QUALITY PLANNING & PROFESSIONAL GOVERNANCE GROUP (QPPGG) – HIGHLIGHT REPORT

Dr C Deighan presented the Quality Planning & Professional Governance Group (QPPGG) highlight report, noting the approach that was approved with regard to medicines management; a new SOP has been implemented to support staff on site who require access to basic analgesia. Several update reports were reviewed by the group including the Quality Strategy 2018-2022 close and evaluation summary (including flash report) and the Ockenden report (as per action log item on today's agenda). QPPGG members also received an update regarding the Ophthalmology incident, noting that 26 patients triggered Duty of Candour and the appropriate actions have been taken, therefore this item has been closed.

Dr C Deighan updated members regarding the Corporate Quality & Safety dashboard discussion, which covered re-admission rates, falls and sepsis. In terms of re-admission rates, QPPGG heard that there has been a 30% decrease in the number of 28-Day Medical Readmission cases within University Hospital Wishaw (UHW) for April-2023, after removal of cases processed through Ambulatory Care Pathways. There has been a 69% decrease in

number of 28-Day Medical Re-admission cases within UHW for April-2023, after removal of cases processed through Ambulatory Care Pathways. QPPGG members noted that by removing the ambulatory care data in UHW, the three acute sites are more aligned.

With regard to the total falls rate, it was noted that UHW were previously reporting non-random variation due to an 8-point shift in the data below the median and the improvement has been sustained, with consecutive decreases in total falls rate from Feb-23 to Apr-23, resulting in a positive recalculation of the median. University Hospital Monklands (UHM) experienced an increase in total falls rate over consecutive months (Nov-22–Feb-23). This has been reversed, with a significant decrease for March-23 below the median, and the latest data point for April-23 also displaying below the median at 6.7 falls per 1000 OBD.

Members noted there had been an increase in Sepsis Mortality % within University Hospital Hairmyres (UHH) from March-23 (23.8%) to April-23 (35.9%). It remains within performance control limits for UHH and work is ongoing to ensure accuracy of coding.

QPPGG received the first Cancer Audit highlight report and noted that the Cancer Audit Team will inform the Cancer Clinical Lead regarding any concerns and seek clarification on the requirement for further action. The Cancer Audit Team will continue to monitor performance through local reports and any exceptions will be reported via the Clinical Effectiveness Group and the Cancer Service Clinical Governance Group.

The Committee heard that Mrs K Cormack presented the Laboratory Incidents SBAR paper to QPPGG on behalf of Mr M Downey, noting that 75 patients had been re-biopsied and treatments given within a few weeks. Due to the extra procedures performed, the incident has impacted on waiting lists. All patients re-biopsied meet the criteria for Duty of Candour and have been followed up and the group agreed to close off this action.

In relation to Duty of Candour, it was noted that the laboratory and ophthalmology incidents discussed earlier will be included in the addendum for the Duty of Candour annual report. An audit of SAERs has been completed to ensure accuracy of Duty of Candour and this has provided assurance regarding communication with patients affected by significant adverse events.

QPPGG reviewed the Annual Summary of SPSO Final Determinations between 01/04/2022 and 31/03/2023 and heard that it reflects the very good performance of NHS Lanarkshire complaints handling, including the high quality of complaints responses. 99 cases were determined by SPSO during the year; 22 (22%) were determined at the advice stage, 66 (67%) were determined at early resolution stage and 11 cases (11%) were determined at investigation stage.

Dr C Deighan informed members regarding the Complaints Improvement Plan update shared at QPPGG, noting that the number of complaints received continues to rise. In terms of Complaint team staffing ratios for other NHS Boards; NHS Lothian has double the number of staff who are of the appropriate grade to draft complaint letters compared with Lanarkshire. Plans are in place to continue improvements including reviewing guidance, building on the stage 1 process, improving health literacy and regular engagement. Committee members noted that QPPGG discussed the updated targets and what could be challenging but achievable, agreeing that 20 days for stage 2 complaints is extremely challenging and affected by multiple factors. It was noted that

discussions regarding complaints are ongoing at CMT as part of the balanced scorecard and IPQR.

With regard to the 2022-2023 Annual Reports presented to QPPGG, members heard that the Resuscitation Committee, the Organ Donation Committee and the NMAHP Practice Development Centre reports were approved. The Radiation Safety Committee Annual Report was not approved, therefore the author will add further information and re-submit the report to the next meeting of QPPGG, scheduled for 9th October 2023.

Committee members discussed the process with regard to Annual Reports, noting the current arrangement for those that come to HQAIC for discussion in May each year. QPPGG is also responsible for the review of a number of Annual Reports from the Governance Groups that feed into it. These are received and discussed at different meetings throughout the year, causing confusion in terms of time period being reported on and a lack of standardisation. To help overcome this, Mrs K Cormack suggested the authors are required to submit their reports in May each year and the schedule adjusted to support QPPGG to review the Annual Reports at one meeting similar to the model for HQAIC.

THE COMMITTEE:

1. Noted the Quality Planning & Professional Governance Group highlight report and the Radiation Safety Committee Annual Report 2022-2023 to be updated and returned to QPPGG 9th October meeting.

6. QUALITY & SAFETY DASHBOARD

Dr C Deighan presented the Quality & Safety dashboard report, 1st quarter (April to June 2023) which included data regarding Re-admissions: Medical/Surgical Specialties: Review Update, total falls rate and sepsis mortality %.

Dr C Deighan advised that the “ambulatory adjusted” recalculated re-admissions data (i.e. removing the ambulatory care patient’s data) demonstrates the three acute sites re-admissions data is very similar; the new methodology indicates greater alignment across the hospitals. As per the report, the 28 day re-admission data shows a significant reduction at UHW and similarly, at UHH and UHM. Overall, re-admission rates across the three acute sites are less than the national average. In addition, members heard that charts 9-12 detailing the 7 day surgical re-admission rate indicate the surgical care pathways are efficient.

In terms of falls, Dr C Deighan highlighted non random variation at UHW, where there has been a sustained decrease in total falls, resulting in a recalculation of the median; this reflects positively on the improvement work undertaken by staff in these areas. Similarly, UHM are now reporting a decrease in falls, having previously reported an increase in the Care of the Elderly ward. Recent Quality Leadership Walk-rounds at UHM have also highlighted the targeted falls prevention work in those areas.

Members noted that sepsis mortality remains within control limits at UHH and data from the Discovery system indicates that NHS Lanarkshire is in alignment

with sepsis performance nationally. It was also noted that UHH are continuing work to ensure accurate coding of sepsis.

Mr D Reid thanked Dr C Deighan for the update and enquired regarding falls; he noted the leadership walkround in ward 20 and the reference to a survey of slips, trips and falls (including flooring issues) and whether there is an action plan with timeframe. Mr E Docherty advised that he was aware of work being undertaken by PSSD (responsible for estates maintenance). He added that Mr P McCrossan's team are working with areas who are experiencing an increased level of falls due to high traffic. Dr C Deighan advised that there is a lot of work being undertaken with regard to pressure on hospital beds, high occupancy and average length of stay. He added that the average length of stay benchmarks well nationally, with Medicine for the Elderly having the highest lengths of stay. These issues are discussed weekly via the Corporate dashboard and he suggested they also remain visible to the Committee.

Mr A Boyle stated that it was very positive to see the impact of the falls improvement work in the acute sites and enquired regarding whether similar work is happening in the community, i.e. community falls prevention work. It was noted that Mr P McCrossan and team are also leading this work in the community. Mr P McCrossan stated that the NHS Lanarkshire Falls Strategy is a key element of the improvement work, as well as community engagement; he noted that the Falls Team are small in number and therefore have limited capacity. He is in discussion with Mrs M Russell and Strathclyde University at present regarding delivering staff education. Mr A Boyle noted his concern regarding the sepsis data at UHH. Dr C Deighan advised that the team are continuing to monitor this and he emphasised the importance of accurate code of sepsis; there is a concern that some other infections are being incorrectly coded as sepsis.

Mr D Reid enquired regarding whether patients who are frequent fallers are known to our services and what impact the patient group has on overall falls statistics. Mr E Docherty confirmed that systems do hold data regarding frequent fallers (i.e. the Falls Register) and referred to a positive risk taking approach which he hopes will be adopted nationally, helping to understand the risk profiles for individuals. Mr P McCrossan added that staff work hard to maintain the falls register, developing the system and a care and repair service in NHS Lanarkshire. He also emphasised the importance of educating patients and staff regarding falls risks.

Mr P Couser enquired as to whether there are any plans to utilise more Discovery data with regard to sepsis for a national perspective. He also asked if members feel they should be referring to IPQR at this Committee, where appropriate. Dr C Deighan advised that there is a desire to use more data from Discovery and discussions are taking place regarding how best to utilise this. In terms of IPQR, he advised that a plan will be tabled for the Committee going forward.

Mr C Lee noted the performance trends and asked whether there is a point where we see a "red flag" instructing us to intervene and take action, e.g. when we notice unusual trends. Dr C Deighan replied yes, the funnel charts are very helpful for that and also for comparing with other Boards. He highlighted page 13, the sepsis run chart, which displays control limits and triggers and these

may suggest there is an issue which prompts us to look into this to understand where the issue(s) lies.

Mrs M Lees noted it was useful to see the national comparisons in terms of sepsis data, however the data tabled today is for April 2023 and we are now in September. Dr C Deighan recognised the delay and noted the importance of cross referencing this data with other sources including adverse events and other intelligence to support our understanding. Mrs K Cormack noted that it has been agreed (as part of the governance group review) that the Quality & Safety Dashboard update will come directly to this Committee in future and no longer come via the QPPGG.

THE COMMITTEE:

1. Noted and approved the Quality & Safety dashboard.

7. QUALITY STRATEGY 2023-2029, TRUE NORTH UPDATE:

Mrs K Cormack presented the Quality Strategy 2023-2029 True North update report. Members noted the co-production of the actions with services and that some of the actions also feature on local action plans. Mrs K Cormack advised that this is the first iteration and therefore it will evolve and will include RAG status updates going forward, to indicate progress against the actions. Looking ahead, members noted that the action owners will be contacted in February 2024 to start thinking about their plan for the following year, April 2024-Mar 2025. Mrs K Cormack advised the Committee of an excellent session she attended with colleagues in North HSCP who arranged the session dedicated to agreeing their True Norths for this year. This was a very effective approach to discussing and developing the actions they would take forward.

Mr P Couser noted that it was good to see this first draft and he acknowledged the amount of work required to progress the actions. He stated that he was thoughtful about how we will know the effectiveness of the actions being completed and how we could further our understanding of what makes a difference to patient care and to staff. Mrs K Cormack advised that several key governance groups are responsible for monitoring the benefit and managing the actions and these groups will be held accountable. For example, the Clinical Effectiveness Group will be accountable regarding Realistic Medicine true north in relation to Treatment Escalation Plans and work around DNACPR. It is acknowledged that there is a need to triangulate work across various groups where there will be some overlap. Mrs K Cormack suggested the accountable governance groups are asked for their views on how they could support an ongoing evaluation of their true north action plans, capturing the impact and sharing learning. Going forward, the action plans will be added to LanQIP to provide automated reports and a central system for logging updates, etc. Mr P Couser stated that this was very helpful.

Dr C Deighan added that hand hygiene is continually monitored; with regard to other actions, the teams delivering on these should provide their views on how they are going to evaluate and measure their outcomes.

Mr A Boyle advised that he was mindful regarding the level of detail that should be presented to the Committee and whether a higher level report would be sufficient to provide assurance around good governance of the plans going forward. Mrs K Cormack agreed and advised that she was interested to hear views on what level of detail members feel would be required. She added that

what we can be assured of is the detailed monitoring that will be completed by the accountable governance groups for the true north actions. It was suggested that the Committee would benefit from receiving the overview and the governance groups who have accountability review the details. Mrs C Lee stated that he was in agreement with this approach and enquired as to how to build inequalities into the Person Centred Care work.

Mrs M McGinty spoke to members regarding the Whole System Quality (WSQ) approach being taken, as described in the NHS Lanarkshire Quality Strategy 2023-2029. She stated that there are key pieces of work to support the implementation of the true norths with regard to quality planning, quality control and quality improvement. The accountable governance groups will develop clear aims and measures and be responsible for providing the Committee with assurance that the actions are on track and highlight any delays, risks, etc. Mrs R Thompson enquired as to whether medical leads have been identified with regard to quality and safety actions. Dr L Munro advised that she has taken over the role of Chair at the North HSCP Support Care & Clinical Governance Group. She agreed that there is a requirement for medical leadership at all levels.

Members discussed an example of one of the true norths and the actions developed to achieve the true north, i.e. "we will make NHS Lanarkshire a great place to work"; one of the actions is to undertake the NHS Lanarkshire staff culture survey starting on 30th October 2023, aligning with Staff Wellbeing Week 2023.

THE COMMITTEE:

1. Noted and approved the Quality Strategy 2023-2029 True North action plan update.

8. EXTRACT OF CORPORATE RISK REGISTER (CLINICAL) AND HIGH LEVEL CLAIMS

Mr P Cannon presented the Extract of Corporate Risk Register (Clinical) and High Risk Level Claims report to the Committee, noting that Mrs C Hope has commenced maternity leave and Mrs A McLean will be providing cover in the role. Members were advised that the report pertains to the period June – August 2023 and details the risks aligned to this Committee. Mr P Cannon advised that he will include overlaps in the next report with regard to risks that sit across more than one of NHS Lanarkshire's Committees.

THE COMMITTEE:

1. Noted and approved the Extract of Corporate Risk Register (Clinical) and High Level Claims report.

9. DUTY OF CANDOUR ADDENDUM

Mrs K Cormack presented the Duty of Candour (DoC) addendum and advised that this covers the incidents that have been closed since the previous report. All elements of DoC legislation have been met and this includes the incidents previously reported to the Committee regarding the laboratory error and ophthalmology incident. The report includes updated figures. Members were advised that Scottish Government are in the process of reviewing their Duty of Candour guidance and an update is expected by the end of the year.

THE COMMITTEE:

1. Noted and approved the Duty of Candour addendum.

10. INFECTION PREVENTION AND CONTROL (IPC) STANDARDS HIGHLIGHT REPORT

Mr E Docherty presented the Infection Prevention & Control (IPC) Standards highlight report to members and noted that the report is based on changes to national standards and how NHS Lanarkshire benchmarks against these.

The Committee were advised that NHS Lanarkshire is performing well and with regard to standard 5, no Boards are achieving this therefore this will remain an ongoing aim. With regard to standard 8, active engagement of people receiving care, there is a desire to involve volunteers again, aiming to have something in place in 2024.

Mr A Boyle expressed his support for the aspiration to involve members of the public.

THE COMMITTEE:

1. Noted and approved the Infection Prevention & Control (IPC) Standards highlight report.

11. a) SPSO ANNUAL REPORT 2022-2023

Mrs L Drummond presented the SPSO Annual Report 2022-2023, noting the overview of annual statistics; 11% went to full investigation and a high percentage closed at the early resolution stage due to good complaint handling. Members noted that one complaint is at Parliament as a public investigation and there is assurance that the recommendations have been completed.

Mr A Boyle enquired as to how we can be assured regarding learning from SPSO complaints. Mrs L Drummond advised that we are continuously monitoring actions and learning from complaints and added that the best source of learning is from all complaints as a whole, not only those that go to SPSO.

b) PATIENT AFFAIRS & COMPLAINTS HIGHLIGHT REPORT

Mrs L Drummond presented the Patient Affairs & Complaints highlight report and advised that the three new targets are being reported monthly. Members heard that 65% of complaints were closed at stage 1 and stage 2 complaints performance has improved i.e. 6 points above the median. In addition, the average response rate is showing a positive consistent, downward trend.

Mr P Couser advised that it was great to see the improvements made and noted the resource implications highlighted within the team and how these could impact performance long term.

THE COMMITTEE:

1. Noted and approved the SPSO Annual Report and the Patient Affairs & Complaints highlight report.

12. COMPLAINTS IMPROVEMENT PLAN

Mrs K Cormack presented the Complaints Improvement Plan paper and highlighted the increase in complaints overall and some of the reasons why. Members were advised regarding staffing levels within the team and how this compares with other NHS Boards, e.g. NHS Lothian; we have significantly fewer staff and lesser banding within the team which impacts directly on complaints responses.

The Committee heard that stage 2 compliance timescale of 20 days is very tight and the team are doing their best to meet this. Significant work has been completed to clear the inherited backlog and the team are now working hard to maintain this. Appendix 2 of the report refers to all actions completed to date and when, with Appendix 3 referring to the new action plan for the updated process. The team are working with Mrs D Armstrong to develop resources and a complaints dashboard has been created, this is working well.

Dr C Deighan thanked the team for their work and the improvements they have achieved. Mr A Boyle agreed and added that this is another great example of improving performance and advised that he found the report very helpful. He enquired regarding staffing and how best to respond to the resource issues in terms of a business case. Mrs K Cormack advised that temporary staffing measures have been implemented i.e. upgraded two Band 4 team members to Band 5 until the end of this financial year; there will be a gap when this arrangement stops. Mrs M Lees thanked Mrs K Cormack and the team for their work and the update report.

THE COMMITTEE:

1. Noted and approved the Complaints Improvement Plan.

13. INFORMATION GOVERNANCE COMMITTEE HIGHLIGHT REPORT

Dr R MacKenzie presented the Information Governance Committee highlight report to members, noting the staff training uptake e.g. Learnpro module completion 90-95%. Members were advised regarding a number of IG incidents in the period June to August 2023, which category they were and emerging themes. Dr R MacKenzie advised that the Service Management Board for the MORSE system is being established and that group will be responsible for reviewing incidents involving incorrect information being found in the wrong record, rather than the IG Committee and a member of the Data Protection Team will be a member of the Service Management Board.

The Committee heard that the Information Commissioners Office have now issued the Board with a reprimand for the breach where health visiting staff used WhatsApp to communicate during the pandemic and then continued to do so. A number of actions have been identified and an action plan developed. A short life working group has been pulled together to identify any other use of WhatsApp within the Board so that these services can be transferred on to an appropriate channel of communication.

Dr R MacKenzie noted the work of the Cyber Security Group including a focus on improving compliance for support and stability of Microsoft Windows and Office versions, as well as reducing the numbers of servers that are already out of support or soon to be out of support. The work plan also monitors progress on vulnerability test mitigation and the migration of systems still on legacy Converged Infrastructure (CI).

Members heard that performance in relation to Freedom of Information (FOI) is very good, with a response rate of 91% achieved for this year.

Mrs M Lees enquired regarding incident number WEB 280751, the Facebook incident relating to a meta pixel tracker; she noted the unintended consequence on this occasion of trying to do the right thing, highlighting the importance of being aware with regard to the wealth of digital platforms available. She noted the great performance with regard to FOI. Members discussed Cyber Security and certification expiring and heard that Dr R MacKenzie is working to attain certification again.

Mr D Reid enquired regarding whether there is a risk to the organisation in relation to network management. He further asked whether the organisation responds to all FOI requests, or can choose which requests will receive a reply. Dr R MacKenzie responded, noting that he was not sure regarding sanctions in relation to network management however he will check with Mr D Wilson and update members. In terms of FOI, members heard that clear guidance is in place and we adhere to this rigorously.

Mr A Boyle commented that this was a great report and enquired as to how much time we spend reviewing themes (with regard to FOIs), and is there a view on how we could improve efficiency. Dr R MacKenzie advised that a benchmarking report against other Boards shows no pattern or thematics. He will however raise this with the IG Committee; there are sometimes concerns regarding the motives of some of the enquiries.

Mr P Couser asked about the number of incidents and whether there would be any value in tracking trends over time. He noted the heightened risk with regard to cyber security and whether all mitigations are in place and is there any sense in whether we will see a reduction of risk level for cyber security. Dr R MacKenzie advised that he is mindful of what is in place currently in terms of

hardware, our staff and training, noting a great deal of attention is given to the issue. He added that work is ongoing to further raise awareness of managing behaviours and is supportive of reporting incidents so we can continue to address any weaknesses identified in the system. Mr P Couser noted that the risk register scoring for Cyber Security has not changed in a long time and he would feel more assured if it changed to reflect mitigations, therefore it could be beneficial to review this.

Dr R MacKenzie noted the issue raised previously by Mrs R Thompson in relation to a NMC complaint regarding a data protection breach committed by a staff member and the subsequent investigation NHS Lanarkshire completed. It was noted that the staff member accessed the records of colleagues; there is a question as to why this was not identified via the Fair warning system. From the data protection side, poor practice including shared log-ins, not logging out correctly, were identified. This was disclosed to those affected and a criminal investigation has commenced. It was noted that continuing to raise staff awareness regarding data protection could help prevent future recurrences.

THE COMMITTEE:

1. Noted and approved the Information Governance highlight report.

14. COMMITTEE WORK-PLAN

Members noted and approved the Committee Work-plan.

15. ISSUES OF CONCERN – BY EXCEPTION ONLY

- Operational
- Safety
- Independent Sector
- Staffing

There were no issues of concern noted by the Committee.

16. ANY NEW RISKS IDENTIFIED TO BE CONSIDERED FOR INCLUSION ON THE CORPORATE RISK REGISTER

The Committee discussed the Junior Doctor strike risk which has been closed following discussion at the Staff Governance Committee meeting. It was noted that there remains opportunity for future industrial action. Dr C Deighan advised that the BMA accepted a 6% pay increase however a BMA survey of consultants concludes that they are dissatisfied therefore have not ruled out future industrial action. Members discussed where the risk sits and confirmed it is with HQAIC as it is a clinical risk. Mrs M Lees advised the recruitment and retention issues are with the Staff Governance Committee.

17. ANY OTHER COMPETENT BUSINESS

a) L20/23 Review of Operational Performance (Pharmacy/Ward Level) 2022-2023

Mr E Docherty presented the L20/23 review of Operational Performance (Pharmacy/Ward Level) 2022-2024 report to the Committee. Mr D Reid stated

this was a great audit report and provided substantial assurance and thanked the staff for their work. In terms of sustainability, he enquired regarding the scrapping of patients being given their own prescriptions upon hospital admission and whether this would be considered again as a possible cost cutting measure. Mr E Docherty noted the approach could be re-started and is currently being reviewed.

b) L20/23 Operational Performance (Pharmacy/Ward Level) Action Plan

Covered under item 17 (a).

c) L06 & L07 /23 Annual Internal Audit Report 2022/2023

Mrs K Cormack highlighted page 19 of the Internal Audit Report regarding the section covering the HQAIC Annual Report meeting which is scheduled for May each year. Members noted that the Board requires to review the HQAIC Annual Report in April each year, before HQAIC has had an opportunity to review the annual reports for the governance committees and groups that report into it.

It was agreed that Mr P Cannon will update the Board's Annual Report template to ensure there is a section for HQAIC to add a statement to the Board concerning the timing.

Mrs K Cormack advised members that work is underway to review the governance structure supporting HQAIC to improve effectiveness, remove any repetition and further increase visibility. Further updates will follow.

18. DATES OF MEETINGS FOR 2023-2024

a) Thursday 9th November 2023, 1:30pm

b) Thursday 8th February 2024, 1:30pm

c) Thursday 11th April 2024, 1:30pm