Unapproved Minutes

Meeting: **Planning, Performance and Resources Committee**
Date: **Wednesday, 24th June 2026 10:00-13:00**
Venue: **Meeting Room 10, NHS Lanarkshire HQ with MS Teams Option Available**

Members:
Katharina Kasper, Chair NHS Lanarkshire (Chair)
Donald Reid, Non-Executive Director and Vice Chair NHS Lanarkshire
Philip Couser, Non-Executive Director
Scott Haldane, Non-Executive Director
Louise Long, Chief Executive NHS Lanarkshire
Colin Lee, Non-Executive Director (Ms Teams)
Eileen Logan, Non-Executive Director
Trudi Marshall, Executive Nurse Director
Lesley McDonald, Non-Executive Director
Fiona McEwan, Director of Finance
Brian Moore, Non-Executive Director
Siobhan White, Non-Executive Director

In Attendance:
Calvin Brown, Director of Communications (MS Teams)
Ben Hannan, Director of Strategy, Transformation and Performance
Jennifer Haynes, Board Secretary
Jacqui Jones, Director of HR & Deputy Chief Executive (MS Teams)
Lucy Munro, Medical Director, North HSCP
Jacqui McGeough, Interim Director of Property and Performance (MS Teams)
Claire Rae, Chief Officer, North Health and Social Care Partnership
Graeme Reid, Project Director, Modernisation & Planning (MS Teams)
Arwel Williams, Director of Acute Services
Donald Wilson, Director of Digital Services

Apologies:
Michael Coyle, Non-Executive Director
Chris Deighan, Executive Medical Director
Jane Duffty, Non-Executive Director
Charlotte Hope, Chief Risk Officer
Claire James, Non-Executive Director
James Muir, Non-Executive Director
Josephine Pravinkumar, Director of Public Health
Soumen Sengupta, Chief Officer, South Health and Social Care Partnership
Sylvia Stewart, Non-Executive Director

Minutes:
Liam Hanlon, Personal Assistant

1 Preliminaries:

1.1 Welcome and Apologies:

Katharina Kasper opened the meeting, noted the apologies and welcomed all attendees.

1.2 Declarations of Interest

Katharina Kasper invited Members to declare any potential conflicts of interest. There were no changes to the standing declarations of interest recorded for this meeting.

1.3 Minutes of Planning, Performance and Resources meeting held on 29th April 2026

The draft minutes from the previous meeting held on 29th April 2026 were presented for review.

The Committee approved the minutes as an accurate record of the previous meeting.

1.4 Matters Arising:

Action Log:

Katharina Kasper advised that action one could now be closed with a few more actions likely to close after discussion at today's meeting as some of the actions had associated paper which were on the meeting agenda.

Scott Haldane requested an update on Mental Health action given there had been another incident

Claire Rae advised that ligature work had continued and there would be an update paper on this at the next Corporate Management Meeting (CMT). The paper on Community Mental Health improvements was not expected until September 2026.

The committee approved the action log.

2 Governance and Assurance:

2.1 Corporate Risk Register: PPRC Corporate Risk Extract as at April 2026

Jennifer Haynes updated that the corporate risk register covered the period of February to April 2026. There are 27 risks on the register, 12 of which sat with Planning, Performance and Resources Committee (PPRC). Four risks were rated as very high, six as high, 1 medium and 1 as low. Two of the risks were assessed as being in the optimal zone, 5 within the tolerable and 5 out with the tolerable zone. Two risks had reduced since the last round of reporting: Risk IP#82 and 1P#141, both of which were financial risks. Risk 82 was reduced after it was assessed that the overall financial impact would be less than £10,000. Risk IP#141 was reduced as

more robust financial plans were now in place and Sustainability and Value (S&V) work was progressing appropriately with all plans to be in place by 30th June 2026.

Phillip Couser queried that with this being the last iteration of meetings prior to the new committee governance structure, was there work underway to re-align the existing risks to the new committee structure. He was seeking reassurance that risks would be clearly aligned to the proposed committee structure.

Katharina Kasper answered that there was also an ongoing piece of work on the assurance framework which would pick up aligning risk within the new structure. In the immediate future the Audit and Risk Committee had an overarching responsibility to manage all risk and they would be tasked with not losing sight of any risk as we move to the new structure.

Jennifer Haynes added that mapping work, which was the first phase of the assurance framework has just been completed, and regular updates would come to the committee as milestones were reached.

Louise Long further commented that the CMT have sight of all risks as a regular item on the CMT agenda. The first phase of the assurance framework had involved mapping out which areas the new committees would cover, what their role and remit would be and some initial assessment of risk. However, it was anticipated that a dedicated Board Seminar session would also be convened to further develop the detail and agree the most appropriate alignment of risks within the revised structure. Ben Hannan would lead on two upcoming Board Seminar sessions in July and August dedicated to the *Our Health Together* refresh and this would also provide a good opportunity to discuss and define the risks in time for September.

In response to a previous query regarding the recording of ligature work on the risk register, Claire Rae confirmed that this had now been captured as Risk 1137.

Donald Reid added that it was encouraging to see the risk register becoming more dynamic as for example the financial risks were reduced into a more tolerable positions based upon discussions which were held with relevant people and relevant committees.

The committee approved the Corporate Risk Register: PPRC Corporate Risk Extract as at April 2026.

2.2 2025-26 Corporate Objectives Year End Report & 2025-26 Annual Delivery Plan Year End Report

Katharina Kasper noted that both named reports as outlined on the agenda were annual reports their purpose was to provide assurance on work throughout the previous year. As such Ben Hannan who was newly appointed in his role, was merely relaying the Board position and could not affirm the position from personal experience.

Ben Hannan advised that both year-end reports acted as good governance, providing a useful audit trail that the committee had considered the year end objectives and how the objectives had been achieved. It may also be important to note that within this year's approach it had been confirmed that there would be a more direct relationship

to personal objectives and as such this would require a different measurement approach also. Appendix one of the report gave a detailed outline of this more personalised approach and the objectives which would sit with each director. The personal objectives as outlined would soon go to the Remuneration Committee for formal sign off.

The Committee approved 2025-26 Corporate Objectives Year End Report & 2025-26 Annual Delivery Plan Year End Report.

3 Governance Sub-Committee Updates:

3.1 Monklands Replacement Sub-Committee: Highlight Report – 21st May 2026

Graeme Reid summarised that the ongoing key items for Monklands Replacement Project (MRP) were the ongoing external reviews on NHS Scotland Design Assessment Process (NDAP) and Key Stage Assurance Reviews (KSAR) on which the MRP team have regular weekly meetings with NHS Scotland. Initial feedback from the external reviews had been received but an internal review would take place to assess the impact when the final report was received. There would also be a scheduled meeting with Louise Long at the end of the week to discuss the reports.

Graeme continued that the summer period would be helpful in providing good on-site opportunities to progress enabling works and also for the summer school programme. Some of the risks relating to Monklands Replacement Project were also outlined within the report however the team feel that monitoring of risks was sufficiently embedded within regular day to day work and were appropriately reported through the Project Board and Sub Committee's.

The committee noted the Monklands Replacement Sub-Committee: Highlight Report – 21st May 2026.

3.2 Monklands Project Sub-Committee Annual Report 2025-26

The Committee considered the Monklands Project Sub-Committee Annual Report 2025/26 in conjunction with the preceding Highlight Report, recognising the overlap in matters relating to programme progress, governance and assurance. The following points were highlighted during the discussion.

Scott Haldane queried around the that findings from the Queen Elizabeth Inquiry and learning from Edinburgh hospital review had been discussed but they were not mentioned in the annual report. Those should be included in the report as it could be perceived that by omitting them, they were held as having been valuable.

Donald Reid agreed with this as there was some aspects of the design elements of the building including the technical memorandum and ventilation that was subsequently changed following the feedback received from those reports.He highlighted that these had impacted on cost of the project.

Lesley McDonald queried around risk 0163 and how intensive time and resources required to meet Full Business Case (FBC), NDAP and KSAR programmes could

significantly impact the overall period of design change and also have a significant associated cost. Had it been considered to potentially front load more resources now to combat this issue and use future savings to provide the cost injection.

Graeme Reid answered that the NHS Assure finance resource was established but was not limitless and would still require to be managed appropriately. In addition, the financial resource from NHS Assure was partly split into required spending for some specialised areas. The MRP team would always seek to be proactive in decision making regarding intensive use of resources in order to produce results and meet requirements.

Phillip Couser also pointed out that within the annual report it outlined the attendance of the Monklands Project Sub Committee and some regular expected attendees had a poor attendance record. Were the MRP team confident that they had the correct levels of representation at their meetings.

Donald Reid stated that in most of the cases where those expected had not attended, they had managed to send a deputy. Most of the discussion within the last year had largely focussed on the NDAP and KSAR and also the day to day aspects of the project had progressed appropriately out with the meeting.

Louise Long agreed that further clarification of the attendance record would be helpful and asked Liam Hanlon to liaise with Jacqueline Eve to review this and confirm accuracy. However, in support of Donald Reid's comments Louise too was confident that works and healthy discussions to help progress the work did happen out with the meeting on a regular basis.

The Committee noted the Monklands Project Sub-Committee Annual Report 2025-26**.**

4 Performance and Transformation

4.1 Planned Care Update Report

Arwel Williams informed that NHS Lanarkshire has demonstrated strong progress, with waits over 52 weeks which had reduced by 84% for New Outpatients (NOP) and by 41.4% for Treatment Time Guarantee (TTG) as of 31st March 2026. Progress has continued in these areas and the current position as of 8th June was there were currently 974 NOP Patients waiting 52 weeks or more reduced from a figure of 7302 in March 2025. The TTG patients who had waited 52 weeks or more was currently at 1348 reduced from 2230 in March 2025. This represented a substantial commendable progress in these areas. However, it may also be important to note that where success is gained in processing patients at a quicker rate that also puts an increased pressure on scheduled care as more patients now had planned operations and this was reflected in the trajectory data within the paper. The trajectory data projected forward to estimate expected data in 2027 also and there were expected to be 1019 NOP in March 2027 and 1800 TTG in March 2027. This was in breach of the Scottish Government target, and all areas would seek to prioritise improvements against the data. The estimated data was set in February and regarding NOP the real time figures already showed improvements against the estimated milestones. Regarding TTG and inpatients the data was generally on track to what was estimated and therefore

improvements would be required. However, all Health Boards within the West of Scotland were experiencing largely the same issues.

Awel Williams continued that as per a recent Scottish Government request to utilise additional potential funding. A bid had been made for £3.7 million of funding for further support for NOP and TTG and also a bid for £2.5 million for Diagnostics. This would be mainly used to make improvements in planned care paediatrics, cancer and imaging. The bid for the £3.6 million included £640,000 for independent sector work which would provide 270 operations, around 1% of the total surgeries per annum. The bid for the £3.6 million.

It may also be important to note that Ear, Nose and Throat (ENT) and paediatrics remain the most challenging areas at both national and regional levels. This was something which had been discussed regularly at Sub National West meetings, including scoping of any opportunities to have cross border solutions. The situation which would be most difficult to resolve would be reducing the number of patients waiting over 78 weeks and bringing that down in line with the Scottish Government target of 52 weeks by the end of March. The sub national meetings have shown that the majority of Health Boards face the same issue and are equally as challenged in this regard.

Katharina Kasper commented that Scottish government were clear that the no patient waiting longer than 52 weeks was their long-term aim and the Board should continue to maintain a focus on achieving this target.

Siobhan White queried regarding the latest bids for additional funding and do Scottish Government require evidence that the money was being used to drive performance against the longest waits, such as those waiting longer that 104 weeks for example.

Arwel Williams explained that in more general terms the recent bids were all in relation to areas which required improvement against such targets and Scottish Government would likely not entertain bids which did not have this remit in mind.

Siobhan further queried that at the outset validation exercises were conducted in order to provide detailed info on the waiting lists, were validation of lists a continual process as was this useful data to have.

Arwel Williams responded that validation of waiting lists was a continual process where the longest waiting patients at the top of the list were continually validated.

Brian Moore commented that the paper mentioned an upcoming rollout of a digital, Theatre Scheduling System. What type of positive impact was anticipated from this system. He also asked about the level of buy in from senior clinical leaders, do NHS Lanarkshire have buy in form their clinical leads and was this something which had a great impact.

Arwel Williams answered that some areas already used the digital scheduling system and they do report a benefit from its use. It allowed for surgical lists to be more efficient which means less operations were cancelled and it allows planning to be more effective which can provide continual gradual improvements. The system also helped with clinical buy in and public engagement because the system allows for more

effective and detailed monitoring of longest waits and helps to ensure that additional capacity of staff goes to the correct areas. This can also help to build trust with staff as clinical leaders can feel confident in leading conversations around buy in when they know that resources are being diverted appropriately.

Lesley McDonald commented that it was interesting to see that two patients still remained on Paediatric ENT as being over 78 week waits, they had been offered a date for surgery but were unavailable. In that sense those patients are still recorded as long waits despite having had a date offered to them.

Arwel Williams explained that under the policy a certain number of reasonable offers must be made to the patient and there are also circumstances where the patient could be removed for declining three reasonable offers. It would be possible to remove a patients period of unavailability when reporting on the wait time however it may also be important to note that in most cases this would not be a significant reduction of someone's overall wait time. Under the policy unavailability was not necessarily classified as a person being unavailable it was more a catch all term to describe someone's current status and fitness for surgery.

Siobhan White queried around section 3.12 of the report, planning components. Within future versions of the report would it be possible to have a data driven or narrative driven description for each sub section to show the movement that had happened in each area since the previous report.

Louise Long explained that the Centre for Sustainable Development (CFSD) have started doing modelling work called PMAT. This modelling shows all the patients under each speciality, how long it takes to process such patients and where there were hot spots and areas for concern., Louise Long was confident that the medical teams were very proficient at their jobs and were experts at diverting resources and taking necessary actions on a daily basis. There was a lot of ongoing innovation, and it may be better if Arwel Williams highlighted one or two areas of innovation in the future within each report.

Donald Reid commented that it was very useful now to see reflected in the report the speciality breakdown for each area and the relevant data. The report also mentioned that sub national work focussed on Orthopaedics as a priority, had there been any positive impact which had come from this.

Awel Williams pointed out that there was a Scotland West Orthopaedic group who regularly meet and send out correspondence and reports, but it had not yet translated into realistic results for local health boards. Realistically these regional discussions would identify areas which have additional capacity and then there would be discussion on how those extra spaces were shared out.

Brian Moore queried that section 4.1.6 mentioned active clinical referral triage and patient initiated reviews however there was nothing on that within the report, would it be possible to provide a paper dedicated to this at a future meeting.

Arwel Williams advised that the services do map data on this subject and agreed to bring a future paper.

Katharina Kasper commented that she was looking forward to seeing the PMAT modelling and the hot spots which were mentioned this would help the Board to have informed discussions about where the priorities would lie.

The committee noted the Planned Care Update Report.

4.2 2026-27 Unscheduled Care Progress Report and Winter Planning Update – June 2026

Arwel Williams explained that the usual report had been updated and some tweaks had been made. Table 1, NHS Lanarkshire – Monthly Unscheduled Care Performance, had an updated formatting. This table was more in line with the making data count approach. There was a weekly version of the Unscheduled Care Performance data and this fed into the monthly data.

Regarding interpreting data within the table an area would show as blue when it was compliant with the target however it would require to meet, the target on 7 consecutive months in order to meet the target. The data showed that challenged remain within the 4-hour emergency access standard, high occupancy and ambulance turnaround times. The acute teams would like to particularly focus on ambulance turnaround times and there was currently a regular meeting in place with senior ambulance staff and partnerships to provide solutions. In general, across all of Unscheduled care the position remained fairly static with little improvements.

With regards to winter planning. CMT have visited the three acute sites in order to hold discussions on winter planning. This had involved conducting a review of the winter planning on each site, developing a new plan and seeking engagement on the new plans from the staff situated on those sites. The formal feedback process was now open and one of the main feedback themes was that staff were keen to focus on a minimum of number of targeted actions in order to provide improvements and that previous plans had been too broad. In addition, staff feel it would be good to spread the focus to be all year round as improved performance across the piece would likely lead to improvements in winter also. The report on the winter plannings sessions should be available at the start of July 2026

Claire Rae added that the target which showed ‘bed days lost to delayed discharges’ for North HSCP was quite high within the data however that figure had now come down and was within the Scottish Government target. The Integrated Performance and Quality Report (IPQR) describes in more detail all the positive action actions which were taken to achieve this. The bed days figures was prone to being susceptible due to very complex patients with complex needs who had a high number bed days.

Scott Haldane mentioned that at a recent Integrated Joint Board (IJB) meeting there had been a discussion on delayed discharges. It appeared that a lot of patients had been assessed for discharge but sometimes they could not be discharge due to their daily living requirements. Could more be done to triangulate data across the corresponding services and local authorities. Perhaps if there was an agreement to increase funding across shared areas it could provide a big boost to things such as delayed discharge.

Lesley McDonald added that there were a number of positive developments in this area from the IJB's including increased funding, work on power of attorney, AWI's and reducing length of stay in Mental Health.

Phillip Couser highlighted his concern regarding the lack of demonstrable improvement, noting that performance figures had remained largely unchanged. Despite seemingly many examples of attempts to innovative and have projects with a positive influence like the Flow Navigation Centre (FNC). Was there perhaps a way to report on the totality of the demand and measure how many patients were being appropriately diverted away from essential services with the help of FNC. Assessing performance against the totality of the demand may allow for a more positive narrative.

Arwel Williams commented that he would be able to add in FNC figures to future version of the report.

Ben Hannan added that managers do regularly have access to such data. Ben's team were keen to start advancing the making data count policy, but it may be that some of it would take longer to come through as it should also align to the new refreshed IPQR report.

Brian Moore commented that there was a similar paper which went to the most recent IJB meeting which had also included data on inappropriate attendances to Emergency Departments. Was there a way to measure if there was a negative impact on performance from this and were there any ways to resolve it. In addition, the report showed that there was a variation across the sites in how front-line staff respond to the standard operating model and did this have any negative impact on performance also.

Arwel Williams explained that across the three sites there were variations in how front-line staff respond in their attempts to enhance triage however none of the perceived responses were deemed as inappropriate. However, there was an ongoing piece of work which would seek to measure if there was a more effective method of working that could be borne out from the statistics. None of the sites were deemed as not following the process appropriately.

Louise Long added that she was now leading on the Emergency and Urgent Care Sub National group. Based upon known examples from other Health Boards Louise Long believed that there was room for work to provide better pathways to appropriately divert some patients away from Emergency Departments.

Calvin Brown commented that Communications Department had conducted a recent test of change within the Lanarkshire community which had asked people to identify their reasons for attending A&E. Work like this would be helpful in how to frame future communication with the public on these issues.

Donald Reid concurred with Philip Couser in terms of reframing the narrative more toward totality of activity and it would be good if future versions of the report included a narrative on where activity had been diverted away by departments who have corelation with each other.

Louise Long agreed that FNC had been particularly successful at diverting patients in such a manner that other unintended services had come to rely on it like care homes

for example. FNC had not necessarily directly improved the A&E targets as initially hoped but they had become a very successful service who reduced attendance to A&E and offered very good outcomes for patients. Louise Long asked for Ben Hannah to provide a paper on the impact FNC had on adjacent areas and to send it to Phillip Couser for approval.

The committee noted the 2026-27 Unscheduled Care Progress Report and Winter Planning Update – June 2026.

4.3 Unscheduled Care – Evaluation of Investment

Ben Hannan explained that the Unscheduled Care Evaluation of Assessment paper was a review of investment made in 2023-24 on a range of posts and initiatives to support Unscheduled Care improvement, winter resilience and Operational Flow. Further investment was subsequently made in Ambulatory Care, Frailty and winter or discharge-related schemes. This paper provided the Committee with assurance on the review undertaken of Unscheduled Care posts and initiatives approved through 2023/24 and subsequent investment decisions.

The review was undertaken to fulfil the commitment that investments would be evaluated once sufficient implementation experience was available. It also provides a structured basis for future decision-making, recognising the need to align unscheduled care investment with winter planning, the refresh of Our Health Together, the development of the refreshed IPQR, and the 2027/28 planning cycle.

The report also summarised how the Unscheduled Care posts and initiatives had since been categorised following the review. All posts and initiatives would now sit within the following categories: Baseline, safety or enabling infrastructure, continue with strengthened evidence requirements, Formal review or re-design before longer term commitment and Portfolio arrangement. All of the schemes had been attributed within the categories as outlined in the paper. This approach would allow for flexible assessments on the effectiveness of such schemes. A forward decision timetable was included to show how and when schemes would be embedded into winter planning, *Our Health Together* and the refreshed IPQR.

Doanld Reid commented that he felt it was not just defining the process which had value but evaluating the output and being able to define the benefits realisation of any scheme which was helpful to keep a focus on across all projects moving forward.

Brian Moore added that the evaluation process would be useful moving forward as a way to assist decision making as it gives a more complete picture and allows for better comparison of alternative options at the outset.

The Committee accepted the update and took moderate assurance from it.

4.4 Integrated Performance & Quality Report May 2026

Ben Hannan summarised that the IPQR for May 2026 highlighted a lot of positive highlights and improvements including delayed discharge, CAMHS, Cancer 31-day performance and some directional movement in unscheduled care. However, the report also showed that significant pressures remain in: Emergency access, turnaround, occupancy, diagnostics, sickness absence and agency usage.

The Committee should note this would be the last version of the IPQR in its current form. The future report would be streamlined and focused on providing greater insight into meaningful operational and strategic questions, including whether the organisation was working effectively and delivering improvement in key performance areas. It would also include reporting on matters of significance to the Board, such as Sustainability and Value, progress against the Annual Delivery Plan, and risk performance.

The Committee accepted the update and took moderate assurance from it

4.5 Pharmaceutical Care Service Plan

Chris Miller introduced Ellen Jo Fowler, who presented the Pharmaceutical Care Service Plan 2026–2029.

Ellen Jo Fowler explained that NHS Lanarkshire's current Pharmaceutical Care Service Plan (PCSP), published in 2011, was no longer fit for purpose and required to be updated. over the last 5 years the picture had become quite complicated with several new community pharmacy services being introduced at different stages including Pharmacy First in 2020 and Bridging Contraception in 2021. The proposed 2026-2029 PCSP fulfils the legislative requirements to publish and maintain a PCSP as required. The new plan outlined a strategic roadmap for the development of Community Pharmacy services, proactively addressing both current and future healthcare needs whilst reducing health inequalities by focusing on improved access, efficiency and service delivery. The plan included several recommendations designed to address emerging needs through innovation and partnerships, aligning with local and national health recovery sustainability, and redesign initiatives over the next three years.

Katharina Kasper complimented the report and advised that it was nice to see a spotlight shone on the useful service of community pharmacy as outlined.

Scott Haldane queried the report made reference to linking with the Population Health Framework and also with prevention work. Did community Pharmacy feel that there were any obvious aspects which were currently being missed which could help to address the Population Health Framework super priorities especially for example in maintaining a healthy weight.

Chris Miler believed that the 3-year plan was a good starting point for such work to develop and would provide a baseline for meaningful conversations to take place in the future and progressing against the super priorities was a priority for community pharmacy.

Scott Haldane also queried that since the reaction to the Covid pandemic had diverted patients to pharmacy as a first port of call had this been a lasting change that pharmacy now had sustained a higher level of patient engagement.

Ellen Jo Fowler responded that Pharmacy had maintained a higher level of patient numbers and were now successfully embedded across the public perception as a legitimate first point of contact for common conditions. There has also been a drive to provide more pharmacy prescribers and as more prescribers came through the system pharmacies capability to process patients would increase. Pharmacy services feel that more work could be done to further embed pharmacy as a first point of contact and to promote the new prescribing led services. Data showed that NHS Lanarkshire pharmacy services save around 4,300 appointments per year which was now likely to increase.

Scott Haldane further queried on that point and asked if anything more could be done for NHS Lanarkshire to provide more prescribing courses for example or other methods of providing capacity for patients.

Ellen Jo Fowler explained that there was work being done to align undergraduate courses with the future needs of pharmacy. In addition, there was also work being done to upskill the community pharmacy workforce in association with the Royal Pharmaceutical Society (RPS) framework.

Scott Haldane queried whether NHS Lanarkshire could progress this at a faster pace through the engagement of independent contractors. Ellen Jo Fowler advised that, whilst this may be an option, it could also add complexity as independent contractors were not required to adhere to the RPS framework.

Donald Reid added that two requests for new local pharmacies within his local area had been recently declined. In terms of the desire to have a Pharmacy Prescriber in every pharmacy by 2030 and the general push to utilise pharmacy as a first port of call could declining new applications for pharmacies lead to less competitiveness and make a landscape less capable of fulfilling our goals.

Pharmacy colleagues responded that maintaining an appropriate balance between service quality and competitiveness would be the best approach to meet future demands. In England for example the cap was removed, and local markets were flooded with larger high street chains which in a lot of cases ended up pushing out local independent business. However, the 3-year plan would seek to offer more competitiveness in areas where it was needed on a case-by-case basis.

Calvin Brown queried that with the new policy being approved it should go up on the NHS Lanarkshire website also as it is a public facing document and for that reason it would be best if it had 2-page public summary document to go with it.

Katharina Kasper thanked Pharmacy colleagues for joining the meeting and complimented the report and their hard work in updating the policy.

The committee approved Pharmaceutical Care Service Plan.

4.6 Fire Safety Annual Report

Jacqui McGeough highlighted that there were no major issues or concerns for Fire Safety in NHS Lanarkshire since the previous report. There has been a 19% reduction in Fire incidents which were also in a downward trend year on year. Something that remained as a concern was a high number of unwanted fire alarms. There were only 10 incidents which involved a fire, all of which had no significant injury or damage. However, it did serve aa a reminder that fire incidents were real, and NHS Lanarkshire face such incidents each year. NHS Lanarkshire competed 98 fire audits which was 2 short of the target of 100. Unfortunately, there was now an identified risk regarding having appropriate capacity to undertake fire audits at the new level required by SHTM 86. There had been an increased ask regarding an increased time scale for mandated reviews.

Scottish Fire and Rescue Service also carried out 13 of their own regular audits with only minor issues being flagged. Action plans have been made to address any identified issues. Fire safety mandatory learnpro training had also increased to 87% which was an increase of 3.2% from last year.

Siobhan White queried if there was also any data which showed incidents which involved the fire service but were not fire incidents.

Louise Long suggested that NHS Lanarkshire do not hold this data, but that Jacqui McGeough would be able to ask Scottish Fire Service who would likely keep their own data on such incidents.

Colin Lee queried that the report mentioned an under resourcing in the fire risk assessment programme, what were the reasons for this and were there any appropriate actions which could rectify this.

Jacqui McGeough answered that this was in relation to the increased ask from SHTM 86 and how risk audits had only been required every 4 years, but this had now increased to annually in all hospitals. A workforce assessment had been conducted to calculate what staff would be required to meet the demand. Investigation work was also underway to assess any opportunity for cross border working and whether the standard of audit could be changed.

Colin Lee asked that the group should be updated on the options available to NHS Lanarkshire at a future meeting.

Brian Moore commented that there was an unusual incident in the report in which liquid from an intravenous drip had caused a fire. Was that just a one-off incident and not a cause for concern.

Jacqui McGeough confirmed that this was a rare one-off incident with no causes for further concern. All such incidents were logged on the InPhase system and investigated thoroughly.

Colin Lee further queried regarding fire drills and what type of methods NHS Lanarkshire used to conduct fire drills.

Trudi Marshall and Jacqui McGeough advised that health settings find it particularly difficult to run drills in their truest sense as inpatient areas could only conduct tabletop exercises. It is often counterproductive to inconvenience sick patients during their stay. In addition, patients would also have to be informed prior to the drill which removes the element of surprise as intended. It may be important to note that site teams also continually research incidents from other areas so that they can adopt any learning into NHS Lanarkshire practices.

5 Finance:

5.1 Finance Report May 2026 (Month 2)

Fiona McEwan advised that the Finance Report (Month 2) was the first financial report of the year. The finance team were also working on updating the report and so this should come through within future versions. For Month 2 the Financial Plan had been agreed and there was a challenge £73.8 million in total for NHS Lanarkshire. The Board have £51.6 million which includes £20.3 million of sustainability savings. North IJB have £12.1 million and South IJB £10.1 million. There was a net expenditure underspend for the Board of £160,000. There was a reported overspend of £750,000 in Acute Services however this had been offset by underspends in Corporate and Service Level Agreements. The overspend in Acute was primarily driven by overspending on pay especially in pressurised areas. Both IJB's have an underspend in net expenditure of around £555,000 each which gives an overall underspend of £1.23 million.

Regarding Sustainability & Value the current target for savings is £19.2 million. So far £5.3 million had been achieved and a further £7 million identified in planned schemes. The total forecast is £12.3 million which is 63.9% of the target.

For current year savings which includes recurring and non-recurring savings. The target for current year savings was £51.6 million. £10.7 million of savings has been achieved by month 2 with a further £35 million identified for the remainder of the year. There was a gap of £5.8 million to break even.

North JB have a target of £12 million of savings and have achieved their target. South IJB have a target of £10.1 million and have achieved 60%. South have since improved against their remaining target and this would be reflected in the next report.

With regards to Capital, the total allocation for 2026/27 was £13.67 million. There were plans to over commit and spend £14.4 million with the extra funding to be supported by slippage. Only £920,000 had been spent so far and so there would be a lot of work required to get all of the spending through on time. The Capital plan was

in the process of being updated and there would be a formal paper on that in the near future.

Scott Haldane queried that there had been previous conversations that it would be ideal for Sustainability and Value schemes to attempt to provide savings in the future however the S&V schemes this year were mainly to close the gap and break even. Fiona McEwan confirmed that this was correct.

In general, the group felt that it was a positive overall position for the board.

Katharina Kasper queried that the report showed that £2.6 million of funding was dedicated to SLA agreements, which seemed to be a substantial figure. Were these kind of figures standard across other board also.

Fiona McEwan explained that NHS Greater Glasgow and Clyde (NHSGGC) had significantly increased their request regarding SLA's for all boards and that had now been factored in for 2026/2027. It has been phased and the first year included a 75% of the increase. Investigations were being carried out to try and reduce the figure for example by decreasing length of stay and improving on delayed discharges. There were quarterly meetings with NHSGGC currently regarding SLA arrangements. This also impacts our ability to bring down costs for NHS Lanarkshire as it was reliant on NHSGGC's performance around these elements.

Katharina Kasper commented that it was good to have some reassurance that there were regular conversations with other health boards on this.

The Committee was content with the review and scrutiny of the report.

6 Forward Look:

6.1 Our Health Together Refresh

Ben Hannan summarised that as previously touched upon *Our Health Together* would undergo a refresh alongside the IPQR report as the first initial steps of the refresh which will set the groundwork for ultimately providing one integrated plan and one performance framework for NHS Lanarkshire. The main actions which were currently ongoing were: finalisation of the draft refresh, engagement in July and August for all staff, patients and partners, the final draft version completed by 22nd July 2026 for the following Board Seminar meeting, feedback and refinement of the draft and the final paper to go through the appropriate governance routes and to be approved by 30th September 2026.

Brian Moore commented that at a recent IJB meeting included a presentation on the North Strategic Commissioning Plan which was aligned to a Strategic needs assessment. That same meeting also had the Public Health Annual Report. It would be ideal if the Board had a single joined up strategic needs assessment which was applied universally.

Louise Long commented that providing this would be one of the expected outcomes from completing the Our Health Together Refresh.

6.2 Any Other Competent Business:

There was no other competent business raised.

6.3 Risks and Reflections

No new risks were noted.

6.4 Date and Time of Next Meeting

The next meeting is scheduled for 26th August 2026 at 10:00am Meeting Room 10, Kirklands.