

Unapproved Minutes



Meeting: Strategy, Planning and Performance Committee

Date: Wednesday, 26th August 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 (MS Teams)
Claire James, Non-Executive Director
Scott Haldane, Non-Executive Director
Louise Long, Chief Executive NHS Lanarkshire
Colin Lee, Non-Executive Director (MS Teams)
Trudi Marshall, Executive Nurse Director
Lesley McDonald, Non-Executive Director
Fiona McEwan, Director of Finance
Brian Moore, Non-Executive Director
James Muir, Non-Executive Director (MS Teams)
Siobhan White, Non-Executive Director

In Attendance:

Calvin Brown, Director of Communications
Charlotte Graham, Chief Risk Officer (Item 2.3)
Ben Hannan, Director of Strategy, Transformation and Performance
Jennifer Haynes, Board Secretary
Ian Hunter, Director of Medical Education, (Item 4.5)
Claire Kavanagh, Head of Transformation & Performance, South Lanarkshire HSCP (MS Teams)
Jacqui Jones, Director of HR & Deputy Chief Executive
Jacqui McGeough, Interim Director of Property and Performance
S Josephine Pravinkumar, Director of Public Health
Claire Rae, Chief Officer, North Health and Social Care Partnership (MS Teams)
Daniel Saunders, Executive Medical Director
Arwel Williams, Director of Acute Services
Donald Wilson, Director of Digital Services

Apologies:

Michael Coyle, Non-Executive Director
Jane Duffty, Non-Executive Director
Eileen Logan, Non-Executive Director
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, NHS Lanarkshire Board Chair, 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 24th June 2026

The draft minutes from the previous meeting held on 24th June 2026 were presented for review. A member identified a missing word in the section relating to the Monklands Project Sub-Committee Annual Report and the incorporation of learning from hospital inquiries. It was agreed that the wording would be corrected

The Committee approved the minutes as an accurate record of the previous meeting subject to the suggested amendment.

1.4 Matters Arising:

Action Log:

The Committee agreed that the three actions proposed for closure could be closed. The Mental Health and Learning Disability action remained open pending a meeting to work through the outstanding issues, with an update to return to the next meeting. The action relating to fire risk assessment resource pressures would return following consideration by CMT, anticipated for the January committee cycle. It was agreed that this action should be closed through SPPC, while future quarterly property and resource reports would sit with the Finance & Resources Committee and the annual fire safety report would continue to come to SPPC.

The Committee approved the action log.

2 Standing Assurance & Performance:

2.1 SPPC Terms of Reference

Jennifer Haynes introduced the draft Terms of Reference for the Committee, noting their relationship with the developing Board Assurance Framework. Members discussed the proposed Executive Lead, meeting frequency, formal membership and the expected attendance of Executive Directors. The prevailing view was that Non-Executive Board Members should constitute the formal membership, with Executive Directors attending as required to support the business, and that matters requiring a formal vote would ordinarily be escalated to the Board. This would be mirrored across all Committee Terms of Reference. Louise Long, Chief Executive, confirmed

that Ben Hannan, Director of Service Transformation, Planning and Performance, should be named as the Executive Lead for SPPC.

Members also requested that office titles, rather than individual names, be used where possible. The wording on meeting frequency should also allow for flexibility to meet more than six times per year if required.

It was clarified that financial appraisal and business-case scrutiny would sit with the Finance & Resources Committee (FRC), while SPPC would consider the effect of investment on strategic outcomes and performance.

The Committee approved the Terms of Reference subject to the agreed amendments.

2.2 SPPC Proposed Workplan

The Committee considered the proposed workplan as a live document aligned to the draft Assurance Framework. Members requested appropriate coverage of inequalities, population health metrics, women's services, delegated and hosted services, primary care, infection prevention and control, and environmental sustainability.

It was agreed that women's services should be described broadly rather than as a maternity-only review, and that the timing of the stroke update should reflect the public engagement. Routine assurance of Infection Prevention and Control should be maintained through the Healthcare Governance Committee. In addition, Infection prevention and control could usefully be considered via discussion at a Board seminar in order to have better strategic alignment and to drive performance in Infection and Prevention Control.

The Committee should maintain visibility of delegated and hosted services, including primary care and GP services, without duplicating the statutory role of the Integration Joint Boards. Annual report for IJBs and specific reporting for noting could be provided to ensure that delegated and hosted services were visible to the Board without duplicating the statutory role of the Integration Joint Boards. Environmental sustainability obligations should also be visible.

It was confirmed that all the suggestions would be mapped into the Board Assurance Framework, which would be shared with the relevant lead for review.

The Committee approved the workplan on the basis that it would continue to evolve.

2.3 Corporate Risk Register: PPRC Corporate Risk Extract as at June 2026

Charlotte Graham presented the closing Planning, Performance and Resources Committee (PPRC) aligned risk extract. There were 26 corporate risks at the end of June. Eight previously aligned PPRC risks were included in the report, with four finance and Monklands-related risks having transferred to the FRC. Of the eight reported risks, three were rated very high, four high and one medium. No risks had

increased or decreased since the previous report. Further realignment of risks would follow approval of the committee Terms of Reference and the Board Assurance Framework.

The Committee noted the report and confirmed that more detailed scrutiny would take place at the next Audit and Risk Committee meeting (ARC).

The Committee took reasonable assurance and approved Corporate Risk Register: PPRC Corporate Risk Extract as at June 2026

3 Governance & Committee Effectiveness:

3.1 NHS Lanarkshire Board Response to the Public Service Reform Committee's Pre Budget Scrutiny 2027-28

Ben Hannan summarised the response submitted to the Scottish Parliament's Public Service Reform Committee. The response emphasised planning at the most appropriate scale, while retaining delivery as close as practical to the communities served; working across traditional public-sector boundaries; recognising that reform was not synonymous with an organisational merger; aligning workforce change with redesigned service models; distinguishing savings, productivity, capacity and cost avoidance; and avoiding additional layers of complexity.

Members strongly welcomed the tone and balance of the submission. Support was expressed for the focus on value-adding activity rather than indiscriminate back-office reductions which can be a common approach. Members considered it important that NHS Lanarkshire had placed an evidence-based position on the public record and contributed constructively to the national debate.

The Committee were content to note the NHS Lanarkshire Board Response to the Public Service Reform Committee's Pre Budget Scrutiny 2027-28

4 Strategy and Planning:

4.1 Our Health Together

Ben Hannan outlined progress with the refresh of Our Health Together. The long-term ambition remained valid, but the refresh provided a candid account of progress and continuing pressure, updated the planning context, and strengthened the connection between strategy, priorities, delivery and performance.

A four-week public, staff and partner feedback process had opened on 10 August and would remain open until 6 September 2026. Early feedback broadly supported the direction while asking for greater clarity on what would happen next and how delivery would be demonstrated. The final engagement findings and response would be presented to the Board on 30 September 2026. It was emphasised that publication would be the start of delivery process with a focus on continued development.

A member asked whether the Board would see a summary of engagement responses and the resulting actions on 30 September. This was confirmed, while

noting that a complete three-year delivery plan would not be available at that point. Members praised the document's balanced presentation of achievements, challenges and the links to supporting material, which helped show how the strategy connected with delivery.

The Committee approved the Our Health Together report.

4.2 Winter Evaluation 2025/26 and Planning for 2026/27

Ben Hannan presented the evaluation of the previous winter and the proposed approach for 2026/27. Approximately £5.6 million had supported 73 initiatives across occupancy, discharge, seven-day working, admission avoidance and community capacity. The evaluation found evidence that funding had supported resilience, with the strongest evidence around discharge and community capacity, but it was not always possible to demonstrate a clear measurable impact on occupancy, delayed discharge, flow and urgent care performance across such a large number of individual schemes.

The proposed response was to move towards a year-round unscheduled care investment model, mainstreaming schemes where evidence supported it, using fixed-term investment for defined outcomes, and retaining contingency for emerging pressure. Fixed-term investment would require clearer baselines, outcome measures and exit criteria. Once the national flow plan was issued, NHS Lanarkshire intended to translate this into a focused 100-day local plan, setting out accountability, actions and the realistic improvements expected before winter.

The evaluation was informed by recent on-site engagement process, where staff from sites and partnerships had given their feedback directly as part of the evaluation. The feedback highlighted a smaller number of schemes that made a practical difference to safety and daily operations, including straightforward measures such as access to prescriptions and transport. This reinforced the case for focused, year-round support rather than a winter-only programme.

Members welcomed the retrospective evaluation and asked whether learning from other Boards and sub-national work had been incorporated. It was confirmed that a national learning exercise had been commissioned and that local and external learning would be used. Members also questioned whether 73 schemes had spread investment too thinly and made benefits difficult to track. The Committee agreed that a more focused investment approach, with explicit benefits realisation, was appropriate.

The Committee approved the Winter Evaluation 2025/26 and Planning for 2026/27

4.3 2026-27 Operational Priorities: Delivery Assurance & Strategic Alignment

Ben Hannan explained an interim assurance approach linking the eight national operational priorities with existing NHS Lanarkshire plans and governance arrangements. The report was intended to answer four questions: the current position, whether delivery was moving in the right direction, the level of confidence, and where further action was required. This would be developed into a single

integrated organisational plan and performance framework aligned to Our Health Together.

Members welcomed the concise approach and approved it as a transitional method.

4.4 Sub-National Planning

Louise Long provided a verbal update on subnational and West of Scotland planning. Work was under way on common flow actions, planned care, a national orthopaedic plan and the further development of the MyCare platform. Weekly sub-national discussions were continuing, although fuller staff-side participation was required before detailed workforce and clinical models could be progressed confidently.

Members queried about the absence of staff-side involvement and whether this had delayed progress. It was explained that detailed service and workforce models could not be developed safely without trade union involvement. National discussions had been affected by non-attendance of trade union representatives at a planned national evaluation meeting. The meeting noted that this had slowed implementation and that further national engagement was required.

Katharina Kasper advised that the Board would be briefed promptly following the anticipated national announcement, rather than waiting until the scheduled Board meeting.

The Committee accepted the update and took moderate assurance from it

4.5 Strategic Partnership between Glasgow Caledonian University, the University of Glasgow and NHS Lanarkshire

Ian Hunter updated informed the Committee on a proposal to establish a new medical education pathway with Glasgow Caledonian University (GCU) and The University of Glasgow (UOG). UOG would allocate 30 medical places to applicants undertaking an initial Bachelor of Medical Sciences at GCU before progressing to the UOG medical curriculum. NHS Lanarkshire would provide the clinical placements and early clinical skills input, creating a pathway from school engagement through undergraduate education and potentially into foundation and long-term careers in Lanarkshire.

Members welcomed the workforce, recruitment, reputation, education and research opportunities. Scrutiny focused on maintaining a strong student experience at GCU; extending multidisciplinary learning across nursing and allied health professions, using the partnership as a catalyst for research and widening access for Lanarkshire pupils from schools with historically low entry to medicine.

A member asked whether progression from the Bachelor of Medical Sciences to medicine would be guaranteed. It was confirmed that students who successfully completed the degree would progress automatically, subject to the final regulatory approvals of the programme. Members also asked that the impact of widening-access activity, including NextGen and summer schools, be evaluated. The Committee heard that data was available and that further work with local schools was planned.

The Committee approved Strategic Partnership between Glasgow Caledonian University, the University of Glasgow and NHS Lanarkshire.

5 Performance & Delivery:

5.1 Integrated Quality & Performance Report July 2026

Ben Hannan presented the first iteration of the redesigned Integrated Performance and Quality Report (IPQR). The report moved from point-in-time red, amber and green judgements toward statistical process control and clearer analysis of whether systems were improving, stable or incapable of consistently meeting the required standard. Measures had also been mapped to the four outcomes within Our Health Together.

It was acknowledged that improvement actions required further development. Some were specific about accountability, timescale and impact, while others still described activity. Future reports would sharpen the link between the data, action, expected effect and evidence of change, and would use the same information to support management at CMT, divisional and programme levels.

Members welcomed the new format but queried how it should be interpreted. Using Stage 2 complaints as an example, a member questioned how qualitative improvement activity should be reconciled with a quantitative timeliness target. Analysis showed performance within expected limits but not reliably at target, and that assurance should consider whether improvement controls and activity were appropriate and not simply whether every point had met the target. Additional work would make this clearer in the guidance and would strengthen timeliness actions.

Members also highlighted that delayed discharge numbers could potentially tell different stories. A reduction in duration might not be visible if only the number of delayed patients was shown. A deeper dive analysis of delayed discharge and the new integrated discharge hubs was underway, and a future report would be provided on this.

It was suggested that population health metrics should be explicitly cross-referenced, whether within the IPQR or through a complementary report. The Committee also requested clearer end dates for actions described as ongoing and that the areas in the lower part of the matrix should have a column for assurance to show if intervention was required.

The Committee took moderate assurance from the report and endorsed its continued development.

5.2 Population Health Highlight Report

Josephine Pravinkumar presented the Population Health Highlight Report. It brought together key matters previously considered through public health governance, including the community planning partnership event, whole-system action on inequalities and socioeconomic determinants, preparation for the Good Food Nation plan, tackling poverty, Marmot-related work and future tobacco reporting.

Members discussed the need to move from activity reporting towards clear outcome trajectories, while recognising the longer timescales associated with population health improvement. It was noted that a Board Seminar would consider the population health organisation self-assessment and help shape future reporting. North and South Lanarkshire partnership activity, including early years, prevention investment and locality work, would inform the developing approach.

The Committee took moderate assurance from the report and endorsed its continuing development.

5.2d Framework Metrics Update

Josephine Pravinkumar updated the Committee on the emerging suite of population health metrics. Twenty-five measures had been identified, one of which, sickness absence, was already reported through the IPQR. The remaining measures would be aligned to the most suitable reporting route and frequency, with some included regularly in the IPQR and others reported annually. Work with the University of Strathclyde would support longer-term modelling of life expectancy and healthy life expectancy.

Members requested clearer narrative for areas where NHS Lanarkshire was an outlier, including the actions being taken and the expected timeframe for improvement.

The Committee noted that work was continuing on the public health information platform and approved the proposed direction of the metrics framework.

5.3 Planned Care Update

Arwel Williams reported substantial improvement in long waits since March 2025. Outpatient waits were ahead of trajectory, with an expectation of eliminating waits over 52 weeks by the end of September or October, subject to validation and clinical exceptions. Treatment Time Guarantee performance was tracking slightly better than the original trajectory but was not yet on a path to zero. Endoscopy required process improvement and imaging remained particularly constrained by capacity and lower-than-expected non-recurring funding.

The report described extensive administrative and clinical validation, active clinical referral triage and patient-initiated review. Members were advised that recorded uptake required data-quality improvement because some activity occurred without being consistently captured. Variation between specialties was expected, but comparison with the national position would help identify where more work was required.

Members commended the improvement in 52, and 78-week waits and asked why the report stated that there was no specific workforce update. It was explained that no material workforce change had altered the planned care position; existing additional sessions, external provision and independent-sector activity was already reflected. The matter would also be followed through Staff Governance.

Members explored whether sub-national planning could unlock available theatre capacity elsewhere in the West. The limiting factor was often workforce rather than physical capacity. Work was underway to quantify the regional orthopaedic gap and examine different staffing and operating models. Although NHS Lanarkshire was making intensive use of its available theatres it was likely that mutual aid would be required nationally to make improvements for pressured areas such as orthopaedics and gynaecology.

Katharina Kasper requested that the Executive Team be explicit about what would be required to deliver zero waits by 31 March, including where additional finance would not be sufficient because of workforce, capacity or time constraints. This was important in anticipation of national challenges to trajectories that did not reach zero. Productivity-enhancing business cases should continue to be developed even where immediate affordability was uncertain, so that opportunities could be acted on when funding became available.

The Committee took moderate assurance from the Planned Care Update.

5.4 Unscheduled Care Update Report

Arwel Williams explained that there was continued pressure in unscheduled care. June performance against the four-hour standard remained below target, with the data showing common-cause variation rather than sustained improvement. High occupancy, flow constraints, variation between sites and staffing pressures remained as central challenges.

The report included activity through the Flow Navigation Centre, non-conveyance by the Scottish Ambulance Service, and work to schedule minor injury and ambulatory care arrivals through alternative pathways rather than Emergency Departments. A significant redesign of care for older people, focused on rehabilitation and reduced length of stay, was also being developed for a future Board seminar. Joint work with the Ambulance Service was intended to improve handover times and clarify shared responsibilities for escalation and discharge.

Members reflected on observations from a recent Emergency Department visit, including ambulance queues, the effectiveness of triage and the requirement to reassess patients after long waits. They questioned whether successful diversion of simpler cases could make Emergency Department performance appear worse because the remaining case mix was more complex. It was agreed that reporting should explain performance in the context of the totality of demand and patient outcomes, while preserving accurate attribution of activity.

Members asked whether frequent attenders were being assessed holistically across Emergency Departments, Hospital at Home and community services. The Committee heard that North and South locality pilots would test a more responsive frailty and admission-avoidance approach. Previous multidisciplinary case-management work with high-resource users had improved both health and wider social outcomes, but sustainable funding had been a challenge. Members asked that effective models be revisited through the transformation programme.

The Committee recognised the commitment and professionalism of frontline teams. However, it remained clear that the national flow plan and local 100-day plan would

need to translate quickly into measurable interventions, with rapid evaluation and wider rollout where tests of change proved effective.

The Committee took limited assurance from the unscheduled Care Update report.

6 Forward Look

6.1 Any Other Competent Business:

There was no other competent business raised.

6.2 Risks and Reflections

No new risks were noted.

6.3 Date and Time of Next Meeting

The next meeting is scheduled for 28th October 2026 at 10:00am Meeting Room 10, Kirklands.