Report for Mr Mike Nesbitt

Minister of Health

On

The Belfast Health and Social Care Trust

By

Dr Jennifer Hill & Mr Peter McBride

Private and Confidential when submitted but cleared by the Minister for publication

Index

A. Background / Approach / Context

B. Seven areas of work

Area 1 - An overview of the effectiveness of Belfast Trust's response to the DCO Partners report on Cardiac Surgery including its action plan.

Area 2 - An assessment of the degree to which the issues of poor culture and behaviours identified within Cardiac Surgery extend to the rest of the organisation, and an assessment of the efficacy of the management of these.

Area 3 - An analysis of any trends that may appear in relation to disciplinary investigations, grievances, referrals to professional bodies and legal actions by the workforce against the Belfast Trust.

Area 4 - An assessment of the effectiveness of, and staff confidence in, the mechanisms within the trust through which staff can raise concerns, including whistleblowing, and the degree to which these are welcomed and processed appropriately.

Area 5 - An assessment of the extant processes in place within BHSCT for Board level oversight and challenge.

Area 6 - An assessment of the extant processes in place within BHSCT for clinical governance.

Area 7 - An assessment of the extant processes in place within BHSCT for medical leadership.

C. List of recommendations

D. Appendices

Part A

Background

Belfast Health and Social Care Trust (BHSCT) is the largest integrated health and social care trust in the UK. It serves a population of 340,000 people in the greater Belfast area and is the centre for the majority of regional specialisms for Northern Ireland. It has a staff complement of over 20,000 employees and an annual budget of £1.4 Billion.[1]

In 2024 the Department of Health (DOH) through the Strategic Planning and Performance Group (SPPG) and the Public Health Agency (PHA), commissioned DCO Partners to undertake an independent review of Cardiac Surgery in The Belfast Trust. The report published in April 2025 indicated serious concern about a number of issues, including culture, in the Cardiac Surgery Unit.

In response in June 2025, The Minister of Health Mr Mike Nesbitt, raised Belfast Trust to Level 5 of the Support and Intervention Framework (SIF), the highest level. In his ministerial statement Mr Nesbitt said:

"A decision to escalate any HSC organisation to the highest level in the SIF framework is taken by myself as Minister with advice from senior officials. As Members will be aware, the Independent Review into the Cardiac Surgery service was commissioned by SPPG and PHA in 2024 to assess the impact of ongoing team issues on the safety and quality of the service. The publication of the report and the serious information it contained clearly underscored the need to increase the level of escalation."[2]

As a core component of this intervention, Mr Nesbitt put in place external support for the trust alongside enhanced departmental accountability measures. We, Mr Peter McBride and Dr Jennifer Hill, were commissioned as external experts to provide support to the Belfast Trust as they formulated their response to the DCO report on Cardiac Surgery, and to report to The Minister on broader issues for improvement and assurance across the whole of the trust. Our terms of reference can be found in appendices 1 and 2.

[1] https://belfasttrust.hscni.net/about/
[2] https://www.health-ni.gov.uk/sites/default/files/2025-06/doh-wms-05-06-2025.pdf

Approach

The approach to this work involved a combination of interconnected elements:

- The analysis of documentation including a variety of internal and external reports, policies and protocols.
- The proactive identification of, and engagement with, relevant individuals identified as having experience and knowledge to inform this process.
- An outreach to all staff, affording them the opportunity to directly inform this process.
- The opportunity for all staff to provide responses to high level questionnaires specifically focused on raising concerns.

In the course of this work, we had over 370 engagements with staff, some of these were with individuals, and some of them with groups. They were drawn from across a broad cross-section of the organisation. These included senior leaders with both medical and administrative responsibilities, Chairs of Division, Clinical Directors, Consultants and other medical and clinical staff. Our interviews also included a wide range of allied health professionals, administrative and support staff from across multiple departments and sites. We were also contacted by and met with a number of individuals who had either left the trust to go to work in other trusts, or who had retired. Anyone who indicated a desire to have an input into this process was provided with the opportunity to do so. We spoke also with other organisations such as the Unions, PCC, NIPSO, RQIA, PHA/SPPG and NIMDTA. We visited a number of clinical areas and governance meetings. Some staff were sought out and approached to provide us with interviews, others independently approached us when they heard about the work, and others approached us upon receiving information and an invitation to participate.

On 9th July 2025, an email invitation was sent to all staff explaining the work and offering them the opportunity to be involved. The next step was the offer of completion of a high-level questionnaire focused on their views on raising concerns, and the opportunity to indicate that they would be interested in further involvement. The Belfast Trust commissioned a video invitation for this work and broadcast this extensively throughout the organisation on all available staff computers. The Trust accompanied this with offers of engagement with those who might not have had access to IT equipment. The Belfast Trust put extensive effort into ensuring that all of their staff knew about the work, and that the trust encouraged them to be involved.

The survey component of this process closed on 22nd August 2025 by which time 3,429 people had responded, 710 indicating that they wanted further input into the process. The detailed responses are discussed in the body of the report. The 710 individuals who had requested further involvement were subsequently contacted with the opportunity to provide more detailed information about their circumstances, and with the offer of direct

engagement to discuss their experiences. Of those who responded, a further 70 indicated their desire for an individual interview, with 129 indicating their willingness to participate in online or in person group interviews.

Context

The intention of The Minister in instigating this work, and our intention as external experts is to provide support and constructive recommendations to The Belfast Trust as it endeavours to respond to the specific challenges raised by the DCO Partners report into Cardiac Surgery, as well as the broader challenges we have identified. However, it would be wrong of us not to make explicit our recognition of the complex and difficult context in which the Belfast Trust, and indeed all healthcare providers are currently operating. When we speak of culture, we recognise that there are multiple factors, many that are external to the organisation and outside of its control, that contribute to the components of its culture.

The Belfast Trust is a large complex organisation, delivering a diverse range of highly specialised services in a context of significant resource challenges, and significant public and political scrutiny. The health system in Northern Ireland is under extreme, and some would say, impossible pressure, and unfortunately it is frontline staff who face the brunt of the consequences of this impossible challenge. Any such organisation will inevitably have examples of behaviours and actions that fall short of its expectations and standards. The focus of this work is not to bring unrealistic scrutiny to the challenges of managing over 20,000 staff, but rather to ensure that the processes, behaviours and managerial approaches are aligned to ensure that when behaviours do fall short of what is expected, the organisation is willing to and capable of responding robustly and appropriately.

Through this process we have heard some staff relate extremely distressing accounts of how they have been treated, and how unfairly and badly they feel the organisation has dealt with them. Our role is to ensure that we honour those testimonies and reflect this feedback in the recommendations that we make. In tandem, we must balance this with the recognition that there are also multiple examples of excellent behaviours and actions, and of areas in which, through intentional intervention, The Trust has successfully improved a situation. Trying to balance these demands is not straightforward, however reflecting accurately in this report what we have heard and seen will hopefully allow others, as well as us, to draw helpful conclusions about how best to move forward.

Part B

Area of work 1

An overview of the effectiveness of Belfast Trust's response to the DCO Partners report on Cardiac Surgery including its action plan.

The DCO partners report included 15 recommendations for the Trust related to clinical safety and patient outcomes, culture and civility, raising concerns and trust governance. There was an immediate acceptance of the findings of the report by the senior leadership team, but it took several weeks before the oversight group and its reporting groups could be satisfactorily established with terms of reference and clear objectives. A CEO led Cardiac Surgery Steering Group has overseen work within task and finish groups covering (a) culture and civility (led by the HR and OD director), (b) raising concerns (led by the HR and OD director), (c) governance and assurance (led by the Medical Director (MD)) and (d) cardiac surgery (led by the Director and Chair of division) with two sub-groups of the Cardiac Surgery workstream to address patient safety and governance, and culture, communication and support.

There has been significant effort by the Trust to engage with all staff groups, the trade unions and patient representatives as well as attempts to communicate about the work with the wider cardiac team through 'townhalls' and newsletters.

We have noticed that the senior management team has tended to move to short term actions, particularly within the culture and civility, and raising concerns task and finish steering groups rather than taking time to engage and consider the next steps. Work within the Governance and Assurance task and finish group has progressed.

In terms of the cardiac team, the cardiac surgical Consultants have continued to question the conclusions and validity of the DCO Partners report. Despite this, and through the workings of the patient safety workstream of the cardiac surgical task and finish group, with the support of the interim Vascular Surgical Clinical Director, and Steve Livesey, retired Cardiac Surgeon / co-author of the DCO report, and the new Patient Safety and Clinical Governance lead in Cardiac Surgery, governance processes within cardiac surgery have become more robust and a functional face to face mortality and morbidity meeting is in place, and reported to 'feel safe' by several members of the team.

After extensive discussion, the appointment of an external Consultant Cardiac surgeon as interim Cardiac Surgery Clinical Director (CD) for 6 months has been progressed, and an individual is due to commence in post in early October 2025. There has been agreement that this individual will have rapid access to the new CEO for support and advice. The appointment of the external CD will need to be accompanied by clear expectations of behaviours, and attendance at the Trust's civility training and departmental governance meetings for all Consultant Cardiac Surgeons.

An externally validated monthly safety report to include cardiac team outcomes and complications, and analysis of deaths on the waiting list as per comparable cardiac units is still in development. A quarterly cardiac surgery governance board report is also in development. The team is now expected to review and discuss individual Consultant surgeon outcomes and complications as part of their regular governance meetings.

Our ongoing concern is that, after individual meetings with each of the Cardiac surgeons, the interim CD and the management team, we concluded that there is a fundamental breakdown in relationships between some of the Consultant Cardiac surgeons, there is little trust between them, and consequently there is an ongoing risk to service delivery and patient safety.

Conclusions

The Trust has made good progress with elements of the action plan in response to the DCO Partners report. There is still significant risk associated with the dysfunctional team dynamics within the Cardiac surgical team.

Recommendations

The Belfast Trust must monitor the Cardiac Surgery Consultant team relationships and their impact on service delivery and patient safety in Cardiac surgery

In order to achieve this:

The CEO should formally review the impact of the Cardiac Surgery Consultant team relationships on service delivery and patient safety at 3 and 6 months with the interim Cardiac CD.

Part B

Area of work 2

An assessment of the degree to which the issues of poor culture and behaviours identified within Cardiac Surgery extend to the rest of the organisation, and an assessment of the efficacy of the management of these.

In any healthcare organisation of over 20,000 staff there will be teams with challenging interpersonal relationships and difficult individuals with inappropriate behaviours. In The Belfast Trust we have heard directly from leaders and staff about behaviours that fall short of what the organisation expressly expects, and we have heard about the distress and pain that this causes. The nature of this sort of review is that those narratives will be the dominant ones, but they are not the only ones. Whilst the findings of the DCO report have been very disappointing to many within The Trust, it has also emboldened others to speak up because it has demonstrated action being taken when concerns have been raised. There are some that we spoke with who had no direct experience of these sorts of behaviours, however everyone we spoke with recognised that they existed within the Trust and accepted that there was a pressing need to deal with them.

In relation to the very concerning behaviour and culture described in the DCO Partners report, we have heard of similar examples that are historic, and current examples in which The Trust is directly intervening. The efficacy of the management of poor culture and behaviour will be discussed in significant depth in the rest of the report.

Conclusions

The challenge for the Belfast Trust is to ensure that all staff experience an authentic alignment between its values and the behaviours of managers and staff on the ground. Our assessment would be that, at the moment, in many parts of the Trust, those factors are out of alignment, and that the senior leaders are in the early stages of recognising this and formulating plans to deal with it. The appointment of a new Chief Executive affords a superb opportunity to reset this dynamic and send a clear message to staff about the intended culture of the organisation going forward.

Recommendations

The Belfast Trust must ensure that The Board has clear visibility of areas within the organisation in which there are significant ongoing conflicts, with associated assessments of risk and oversight of the interventions and their effectiveness.

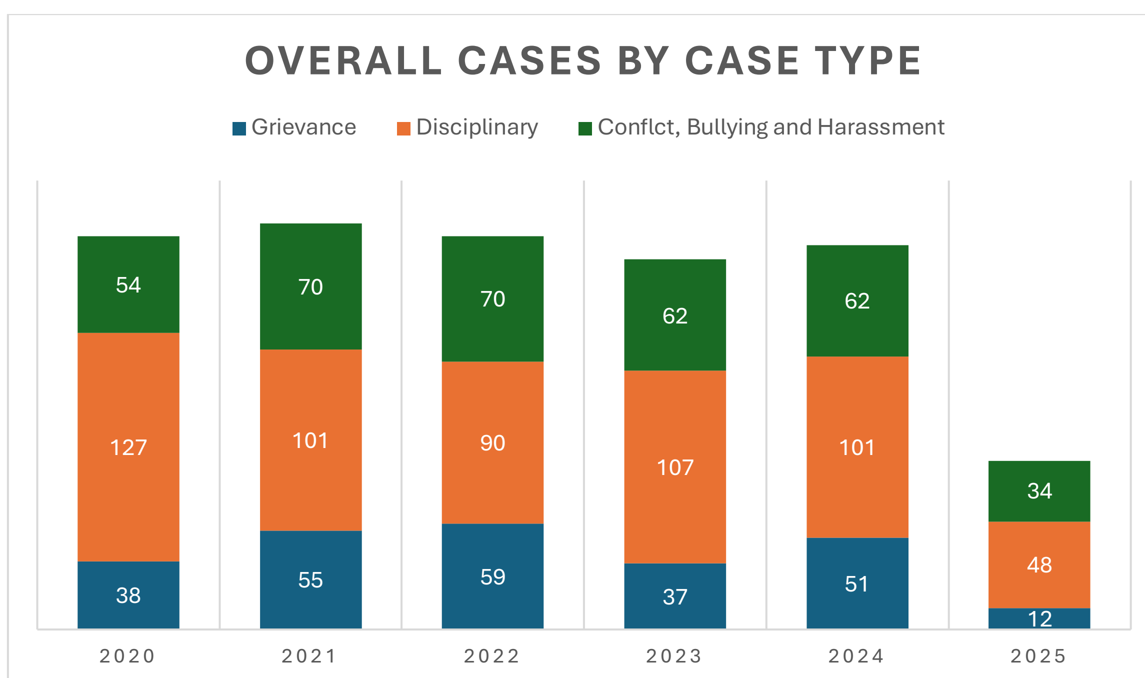
Part B

Area of work 3

An analysis of any trends that may appear in relation to disciplinary investigations, grievances, referrals to professional bodies and legal actions by the workforce against the Belfast Trust.

The data provided by the Belfast Trust shows that the rates of grievances, disciplinary and Conflict, Bullying & Harassment cases have remained steady over the past 5 years. The data for 2025 is not yet complete. See Fig. 1

Fig. 1



It should be noted that these data do not include processes relating to Medical staff and data for Maintaining High Professional Standard (MHPS) investigations are not included in these numbers.

In relation to disciplinary processes specifically for medical staff, we were told that there were over 100 case files open relating to concerns about Doctors in the Trust in 2022, although not all of these would have progressed to a formal investigation. The most recent available data demonstrate that this situation appears to have changed with numbers reducing to 1 Doctor under the MHPS process, 16 Open Cases and 7 Doctors with practice restrictions as of September 2025. See Fig. 2 and Fig. 3

Fig. 2

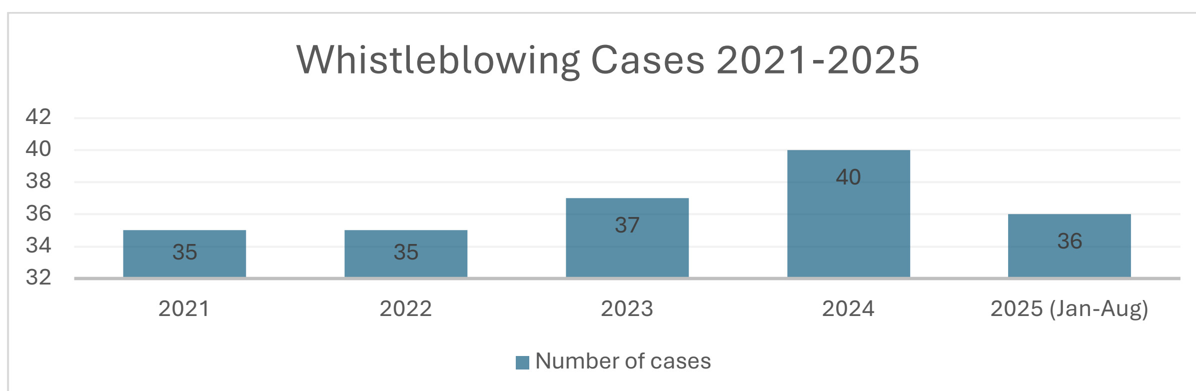
Data from September 2025 report to Board Fig.3

Fig.3

Category	**Number of Doctors**
Under MHPS Process	1
Concerns Being Reviewed / Open Cases	16
With Practice Restrictions	7

In relation to the specific issue of whistleblowing, the data received from the Belfast Trust shows an increase over the past five years. See Fig.4

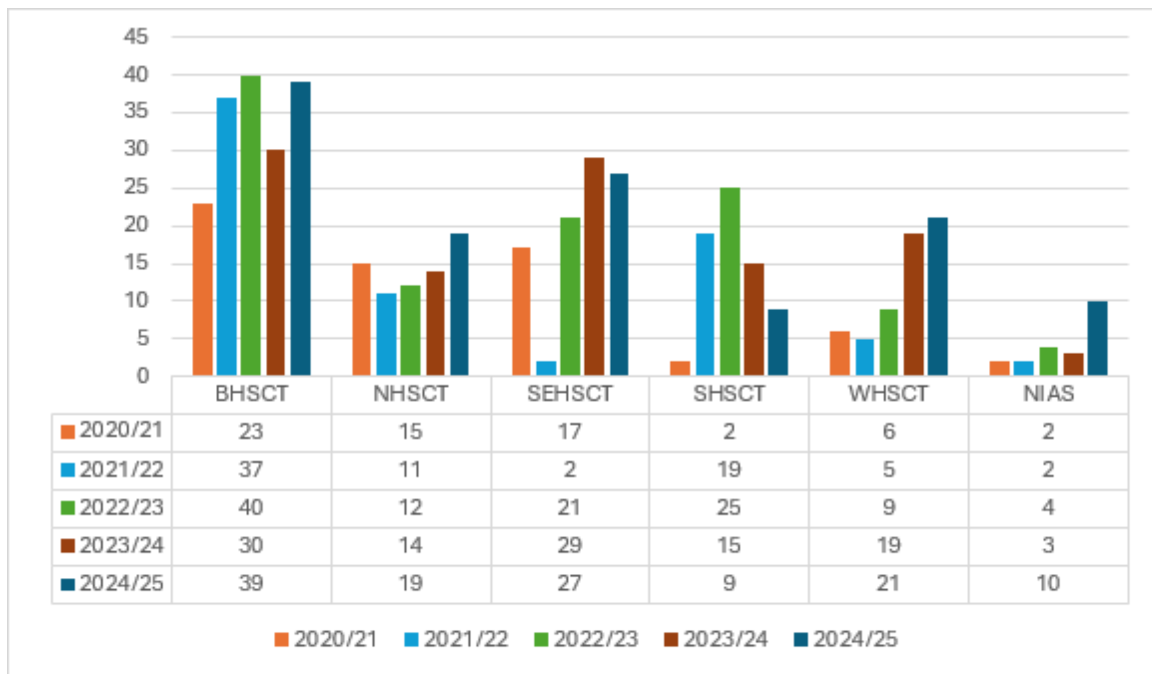
Fig. 4



The commentary from the trust indicates that it is expected that the total for 2025 will exceed previous years. The attitude of staff towards whistleblowing is discussed at length in this review, and it may be possible that the visibility that whistleblowing has received through the response to the DCO Partners report has increased staff confidence in raising concerns in this way.

The regional data for whistleblowing shows that The Belfast Trust is broadly in line with other trusts, with a steady increase over the past five years. See Fig.5

Fig.5



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS
2020/21	23	15	17	2	6	2
2021/22	37	11	2	19	5	2
2022/23	40	12	21	25	9	4
2023/24	30	14	29	15	19	3
2024/25	39	19	27	9	21	10

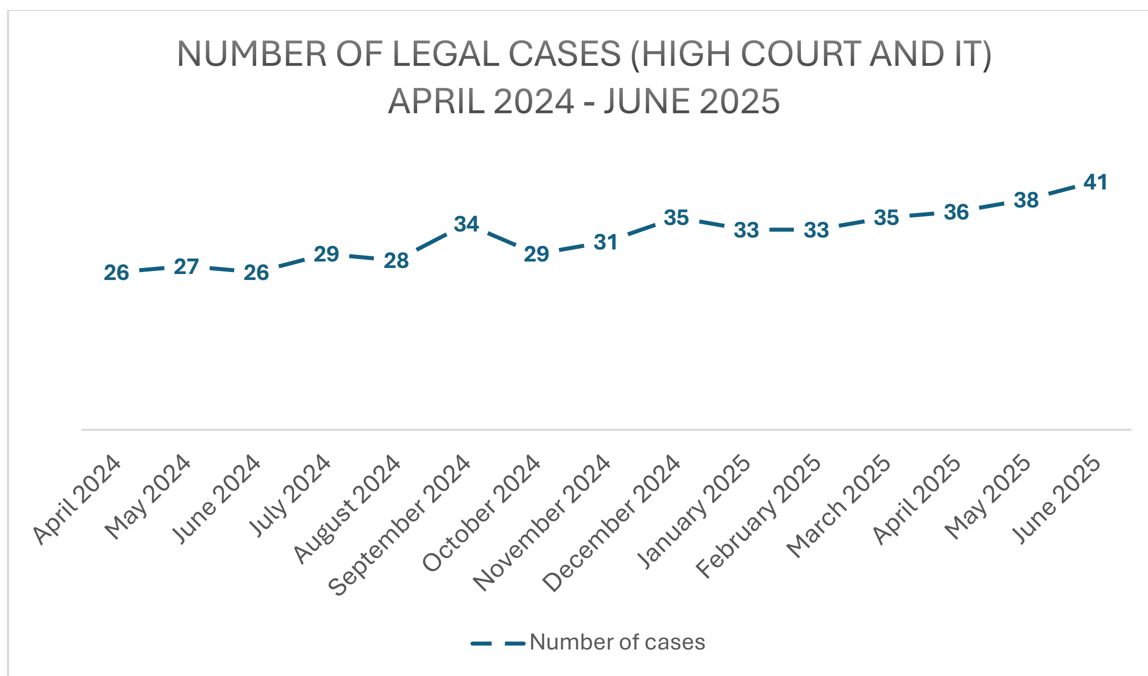
The ratio of whistleblowing numbers to total staff numbers allows for direct comparison between Trusts.

	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT
2025 Workforce	19038	10288	10453	9644	10330
24/25 WB Numbers	39	19	9	27	21
	0.20%	**0.18%**	**0.09%**	**0.28%**	**0.20%**

It is important to note that it is not clear if all of the trusts measure their whistleblowing data in the same way, and so it would be important to seek further clarification before drawing definitive conclusions from this.

In relation to legal actions taken by staff against The Trust, the following data was provided by the Belfast Trust. See Fig.6, Fig.7 and Fig.8

Fig.6



This shows a steady increase in legal claims against the Trust over the past year. When compared to previous years the data shows an increase year on year, apart from 2022 to 2023.

Fig.7

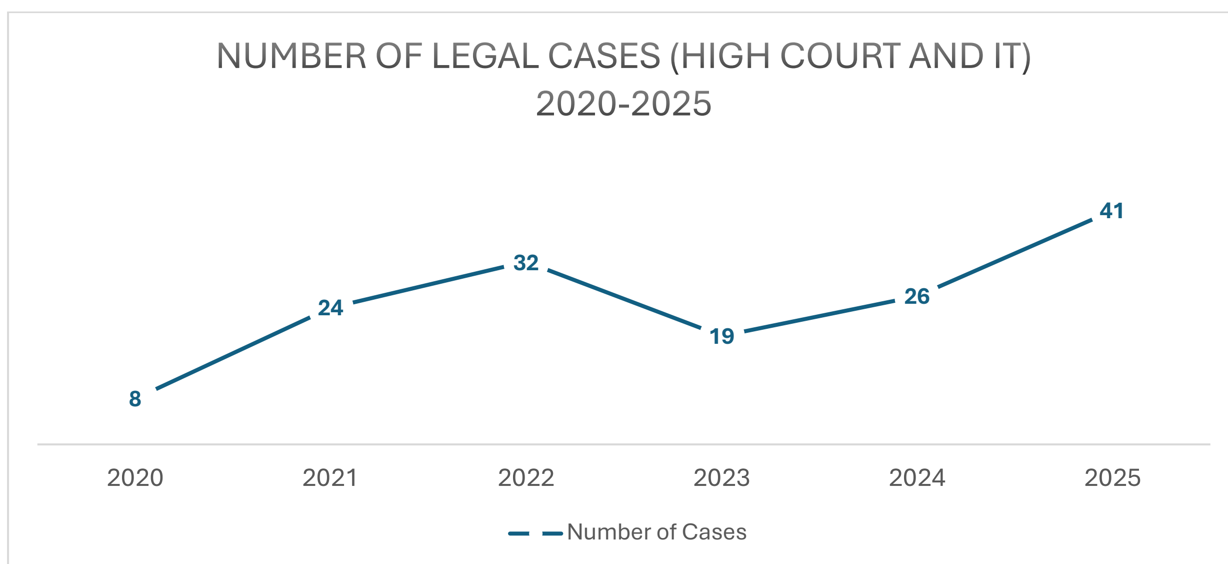
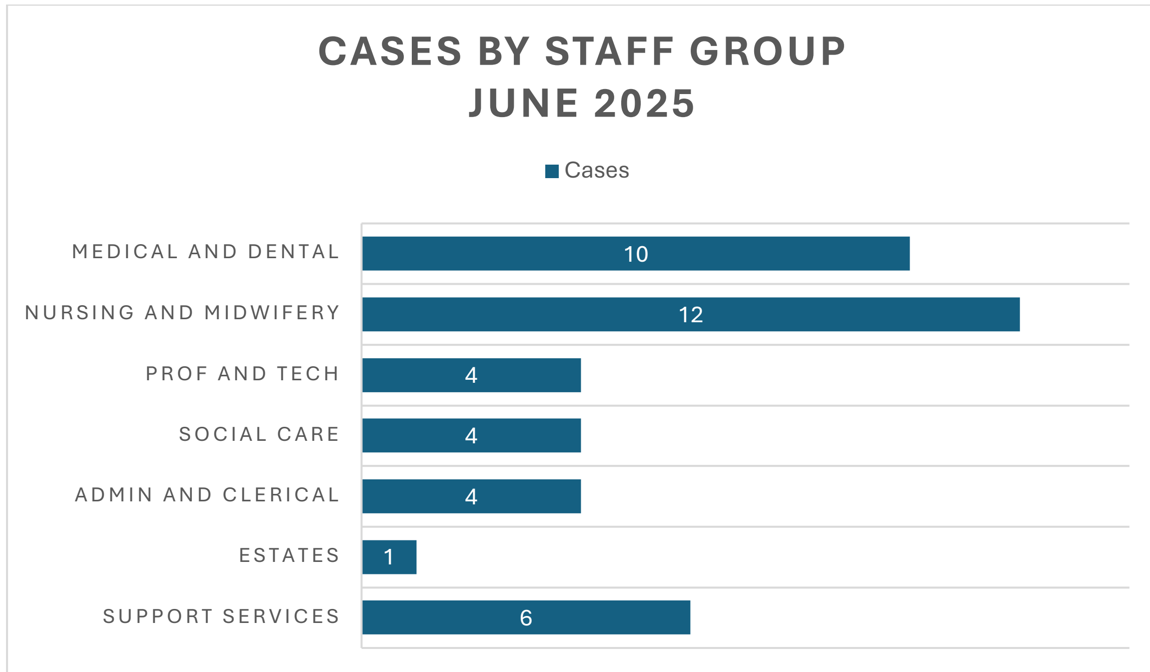


Fig. 8



Conclusions

The rates of grievances, disciplinary and conflict, bullying and harassment cases have remained steady over the past 5 years. Whistleblowing, in line with other regional Trusts with the exception of the SHSCT, has shown a steady rise over the same period.

Legal claims against the Trust have shown an increase over the last five years, and the majority of these are coming from Nursing & Midwifery and Medical & Dental staff. The narrative of excessive 'weaponisation of MHPS' against Doctors is declining, and the numbers would support this narrative.

The trust has undertaken extensive surveys with its staff which have shown some improvement in critical areas. The interpretation and application of the intelligence gained through analysis of this data is an essential component of monitoring progress going forward.

Recommendations

Not applicable

Part B

Area of work 4

An assessment of the effectiveness of, and staff confidence in, the mechanisms within the trust through which staff can raise concerns, including whistleblowing, and the degree to which these are welcomed and processed appropriately.

(a) Initial questionnaire

Of the c.20,000 staff in the Belfast Trust, 3429 responded to the initial questionnaire – a response rate of around 17%. Feedback from interviews with some staff indicated a low level of trust in the anonymity of the Belfast Trust's own organisational staff survey with a consequent unwillingness to participate. The supplementary data from this survey may provide additional insights to that organisational staff survey data.

Initial Questionnaire Responses from 3,429 staff, 17% of BHSCT Staff

Question	Yes	No
Are you aware that your organisation has a whistleblowing policy?	3,182 (92.8%)	247 (7.20%)
Do you know where to find information about your organisation's whistleblowing policy and process?	2,559 (74.63%)	870 (25.37%)
Do you feel confident about reporting a concern or misconduct without fear of retaliation?	1,190 (34.70%)	2,239 (65.30%)
Do you believe the Belfast Trust would treat concerns that you might raise with the appropriate confidentiality?	1,321 (38.52)	2,108 (61.48%)
If you witnessed inappropriate behaviour in your team or department, would you feel encouraged and supported to speak up, or to raise a formal concern?	1,627 (47.45%)	1,802 (52.55%)
Have you ever experienced or witnessed inappropriate behaviour that you felt should be reported?	2,119 (61.8%)	1,310 (38.20%)
Did you report the behaviour you witnessed?	704 (20.53%)	2,725 (79.47%)

The reason for not reporting an incident you witnessed:	Number of individuals
Fear of retaliation.	377 (25.39%)
Lack of trust in confidentiality.	154 (10.37%)
Unclear or complicated reporting procedures.	15 (1.01%)
Belief that nothing will change.	535 (36.03%)
Cultural norms or peer pressure (i.e. fear of being labelled a troublemaker).	320 (21.55%)
None of the above.	84 (5.66%)

Degree of confidence you feel that concerns raised through the whistleblowing system are managed appropriately and effectively?	
Extremely confident.	134 (3.91%)
Very confident.	517 (15.08%)
Only slightly confident.	1,454 (42.40%)
Not at all confident.	1,310 (38.20%)
Not answered.	14 (0.41%)

(b) Second detailed questionnaire

Of the 3,429 people who responded to our anonymous survey, 710 indicated that they would like to follow this up with further information and provided their email addresses to allow direct contact. When contacted, 138 of these individuals were prepared to provide more detailed information about their experiences.

Staff Grade (not all disclosed)	Numbers
Medical/Dental	29
AfC Bands 2-4	5
AfC Bands 5-7	32
AfC Bands 8a-8b	18
AfC Bands 8c-8d	2

Type of concern raised (staff could choose multiple):	Numbers
Witnessed behaviours that had not been formally addressed by the organisation.	91
Raised concerns through a formal process but believe that the organisation has not taken action.	33
Experienced what they believed to be the misuse of the whistleblowing/raising concerns processes.	44
Witnessed behaviours that presented a risk to patient safety and that formal concerns that were raised were not acted upon.	52

When asked to describe the nature of the concerns that they raised, the main themes respondents described were of bullying and harassment, a toxic working environment, the misuse of power and processes, unprofessional conduct and disregard for policies, and patient and staff safety risks being ignored.

When asked for more detail about what happened when concerns were raised the feedback is summarised below:

Theme	Consequences
Ignored Concerns	Reports through various channels not followed up
Harassment/Retaliation	Whisper campaigns, threats, isolation, disciplinary action
Failure of Accountability	Senior staff deny, deflect, or delay action
Mental Health Harm	Work-related stress, burnout, suicidal thoughts
Broken Whistleblowing System	Investigations incomplete or misdirected
Process Abuse	Grievances and risk assessments delayed or ignored
Bias and Discrimination	Misogyny, sectarianism, silencing women and minorities
Rewarding Bad Behaviour	Offending individuals promoted or paid off

(c) External review of policies and processes for whistleblowing

Parallel to the process seeking staff views on raising concerns within the Belfast Trust, a high-level review of the Trust's whistleblowing policy was commissioned. An external consultant with expertise in governance was asked to undertake a review of the policies, and to speak with the whistleblowing manager.

The key findings from this report are:

Governance & Structure

- Whistleblowing responsibilities have shifted over time: from the Medical Directorate (pre-2022) to the Chief Executive's Office (2022), and to Human Resources by 2024.
- The Whistleblowing Manager post (Band 8a) operates without administrative support. A proposed new HR post (Band 8b) may take on related duties, creating further uncertainty.

Culture & Relationships

- There is evidence of strained relations and poor trust between those managing whistleblowing and senior leadership.
- Reports of tension, poor communication, blurred roles and possible "taking sides," undermining staff confidence in the system.

Policy & Procedure

- Multiple, sometimes conflicting policies in circulation (Oct 2023 vs. Oct 2024/Apr 2025 versions).
- Confusion exists over responsibilities, especially for managers, the role of a proposed "Raising Concerns Operational Group," and how concerns about the Chief Executive should be handled.

- Potential conflicts of interest if managers from the area under scrutiny sit on decision-making groups.

Training, Monitoring & Reporting

- Training provision is unclear; consistent organisation-wide training is needed for all staff, line managers, and designated whistleblowing advocates.
- Reporting to senior management, the Audit Committee and the Board appears ad hoc. Regular analysis and inclusion in annual reports, as recommended by NIAO guidance, is lacking.

Conclusions & Recommendations from the independent whistleblowing review

- There is "confusion and disarray" in the Trust's whistleblowing governance, culture and processes.
- BHSCT should pause further structural changes until a comprehensive, independent review is completed.
- Improvements needed include stable governance arrangements, clear policy alignment with the regional model, robust training, regular Board-level reporting, and leadership commitment to a culture where staff feel safe to raise concerns.

Whilst this high-level review highlights significant weaknesses, it is limited in scope and falls short of a full investigation. Nevertheless, it recommends a more thorough, organisation-wide examination before further reforms proceed.

Conclusions drawn from the Questionnaire data and external review of whistleblowing policies.

It must be acknowledged that for the majority of patients BHSCT delivers excellent care and the staff we have met through this work came across as committed, caring and capable people. It seems reasonable to assume that the 3,429 staff members who chose to respond to the initial survey did so because they wanted their experiences to be heard. It also seems reasonable to assume that as the majority of them had raised or wanted to raise concerns, their experiences of the process of doing so are therefore extremely important and relevant as 'experts by experience' of these processes.

There is understandable anxiety about the conclusions that will be drawn from our work, and some perceived defensiveness because of the otherwise outstanding work and reputation of the Trust. The purpose of this exercise is not to diminish this, but to provide additional intelligence from the experience of the significant number of staff who have raised concerns, so that improvements can be made.

(a) Culture around "Raising Concerns"

There is extensive evidence that demonstrates the link between patient safety and staff feeling able to speak up about their concerns. The focus of the survey component of this work and of the interviews, was on the culture within The Belfast Trust in relation to raising concerns. Of those who took part, 62% reported witnessing behaviours that they thought should be reported, but only 20% formally reported their concerns. The feedback from the surveys and face-to-face interviews would indicate that there is a systemic lack of trust across the organisation in the processes that are available for staff to raise concerns with descriptions of poor communication, inconsistent HR advice and application of processes, becoming the object of counter accusations as a consequence of raising a concern, processes taking excessive time, unclear outcomes, and an unwillingness to challenge unacceptable behaviors.

(b) Confidence in the Human Resources (HR) function.

There was a consistent message from those we spoke with about a lack of confidence in the HR function within The Trust. This was expressed as experiences of inconsistent advice, inconsistency in the application of formal processes, and specifically a lack of medical HR expertise for those involved in disciplinary issues with doctors. As with most large complex organisations, there are likely to be some unrealistic expectations of HR, however the criticisms were consistent and almost all staff we spoke to expressed a similar lack of confidence in the support they received from HR. It would be reasonable to conclude that the lack of confidence in HR is a critical component of the culture of mistrust in the systems to raise concerns.

(c) Confidence in the Medical HR function

We repeatedly heard a narrative of lack of trust in medical HR processes and specifically from Consultants about a historical 'weaponisation of MHPS' with an ongoing fear of raising concerns. One group of Consultants stated that they had only felt safe to raise concerns as a group rather than as individual Consultants for fear of being put into a disciplinary or an MHPS process as retaliation. There has been significant attention paid to this by the Medical Director and his team over the past year and several CDs and Chairs reported that the fear of disciplinary action has reduced, and that there has been a move from a punitive to a more supportive approach from the MD office. The creation of a regular Responsible Officer Advisory Group (ROAG) meeting allowing Chairs / CDs to meet to discuss concerns about medical staff with the MD office and HR team has been welcomed and appreciated. Despite the acknowledged reduction in Consultants involved in HR processes as described by some medical staff, there remains a sense of significant 'hurt', a mistrust of HR, and ongoing references to a previously extremely punitive environment. There was a widespread narrative, including from CDs, of difficulty

accessing helpful and consistent medical HR advice. Disciplinary investigations are led by service managers and CDs with a description of variable and remote medical HR advice and support. In discussion with a broad range of internal and external stakeholders there was a view that the Medical HR model and level of support and expertise in BHSCT is different than in other trusts in NI and was a significant factor in the lack of trust expressed by staff in the processes by which they could safely raise concerns.

(d) Whistleblowing

There is widespread confusion about whistleblowing. It would appear that because of low levels of trust in other mechanisms to raise concerns, or because of the ability or willingness of managers to challenge inappropriate behaviour, staff consider that escalating issues to whistleblowing status is the only option. Unfortunately, this seems to result in frustration when the criteria that define whistleblowing are not met. There is significant confusion around staff expectation of feedback and protection of their anonymity through protected disclosure leading to low levels of confidence from those we spoke with that the organisation is serious about dealing with inappropriate behaviours.

(e) Dealing with legacy issues

Many of the staff we spoke with described experiences dating back over years, and a significant component of their frustration was their belief that the Trust is unable or unwilling to deal with their issues, to reach conclusions and take definitive action. Many medical staff described a shift from a punitive past culture, specifically in relation to MHPS processes, but the significant legacy of hurt and mistrust persists and there is a belief that it needs to be addressed.

Recommendations

The Belfast Trust should commit to the development of a comprehensive 5 year "People and Culture" strategy.

In order to achieve this the trust should:

- Engage in a meaningful engagement/listening exercise that includes all staff in setting out the ambition of the People and Culture strategy
- Communicate widely to staff that the People and Culture strategy will be co-designed and co-produced with them, agree a mechanism to 'deal with the past', and set up the structures within the organisation that facilitate involvement and engagement

- Devise meaningful accountability processes that reflect the central importance of the People and Culture strategy to the success of the organisation:
    - Create a NED chaired People and Culture Board Sub- Committee.
    - a Ensure that a reporting template provides updates to the Board from the People and Culture subcommittee to the board concerning people issues as a standing agenda item
    - Devise metrics to monitor “culture” within the organisation. RQIA’s “Being Human” document may be helpful.
- Create staff engagement groups throughout the organisation to feed “soft intelligence” into formal People and Culture reports
- Incorporate a clear plan to build capacity among those with management responsibilities to support them to manage and challenge inappropriate behaviours.

The Belfast Trust should review its Human Resource function considering structure, capacity and resourcing.

In order to achieve this the trust should:

- Undertake a formal analysis of need based on the aspirations of the People and Culture strategy and the appropriate prioritisation of people issues
- Ensure that Human Resources is properly equipped with expertise and resources to undertake its function
- Evaluate the need for Medical HR expertise, and ensure that HR has meaningful oversight of all “people issues” involving Medical staff including active involvement with the application of MHPS
- Ensure that there is clear accountability for people issues at senior executive level to the board

The Belfast Trust should review, clarify and improve the mechanisms for staff to raise concerns.

In order to achieve this the trust should:

- Incorporate this as a central enabling tenet of the People and Culture Strategy
- Review and update all policies and procedures relevant to raising concerns – grievance raising, disciplinary procedures, conflict bully and harassment and whistleblowing

- Provide clarification to staff on the circumstances in which whistleblowing is appropriate, and the external organisations they can approach if they do not trust internal processes.
- As part of the People and Culture strategy embed "Listening to staff as a cultural norm in the Belfast Trust"
- Clarify the responsibility of line managers to listen to and to respond to staff who raise concerns.
- Introduce 360 review of managers as a standard part of annual appraisals, and ensure that staff views are actively sought and provided without fear of identification or negative repercussions

The Department of Health should introduce regional services that provide independent mechanisms for staff to raise concerns.

- A regional Freedom to Speak UP service should be developed. A local version of this was also recommended in the DCO Partners report. A Freedom to Speak up service should incorporate an independent regional component alongside embedded resources within each trust throughout the region. This should be aligned to the current Patient Safety and Quality initiatives.
- A regional whistleblowing service focused specifically on the Health Service should be developed. While each of the trusts should maintain, improve and develop their internal whistleblowing capacity, because of the lack of trust expressed by many staff in this there should also be access to an independent regional service. Models of good practice exist elsewhere in the UK. In Scotland such a service resides in the national public service ombudsman's office.

Part B

Area of work 5

An assessment of the extant processes in place within BHSCT for Board level oversight and challenge.

BHSCT is a large and complex organisation. The Trust Executive Group has sixteen members with five executive directors (of whom all bar one are in interim positions). This is large for an executive team. There are 5 service directorates overseen by 7 directors, and 14 Divisional Chairs (senior medical leaders). Many of the Directors (and their co-directors) are in interim roles. The seven Directors who are members of the Trust Executive Group have both responsibility and accountability for their services. This brings inherent conflict of interest and the potential for impairment of robust challenge.

Most executive teams of comparable sized UK healthcare organisations would comprise a Chief Executive Officer (CEO), Chief Finance Officer, Chief Medical Officer, Chief Nursing Officer, Chief People Officer and Chief Operating Officer.

The Board is consequently very large with the potential for over 25 people to be in attendance when all members of the Executive team and non-executive directors are present. This is likely to impair constructive discussion and debate.

The Assurance sub-committee of the Board has a huge remit with agendas covering people, quality, risk and performance. It meets four times a year with a packed agenda. It receives quarterly reports from its six steering groups, and the data presented are extensive. This inevitably minimises the time available for the committee to discuss and have oversight of the quality of care being delivered in the organisation.

Most large healthcare organisations have monthly Board sub-committees for People, Quality (and safety), Finance and Performance, and Audit (See Appendix 3). The Executive MD has developed a revised Board committee structure through the Governance sub-group of the Cardiac oversight group (part of the DCO report action plan). The proposal to create a Quality and Safety Board sub-committee aligns with the Integrated Governance Board Assurance framework document recently drafted by the DOH, and viewed in draft as part of our work.

Based on a comprehensive review of Board papers and reports, it was difficult to identify strategic priorities and discussion, and the focus over the last 12 months appears to have been significantly on operational challenges.

Reports from some steering groups to the Assurance committee appeared to consist simply of lists of issues without any prioritisation or clarity about whether they were being shared for information, assurance or escalation. Actions did not consistently have timelines for completion or update.

There are a large number of groups reporting into the steering groups of the Assurance committee and review and rationalisation of these groups with clear terms of reference, and annual workplans is underway and likely to standardise processes (see appendix 4 for proposed reporting groups for quality and safety).

The Quality (and Safety) Board sub-committee, chaired by a non-executive director (NED), should have a clear workplan of reports covering the key elements of quality (effectiveness, safety, and patient experience), with formal updates in the form of highlight reports from Executive led committees for Quality and Safety, Social Care, Health and Safety, and Patient Experience. Reporting templates from each Executive committee and reporting groups to the Executive Committee would enable the committee members to differentiate between what is being shared for information, assurance, or escalated for action (see Appendix 5 for proposed reporting template).

The Board Assurance Framework (BAF) and its principal risks appear more operational than strategic and do not appear to be related to the strategic objectives of the BHSCT. While the BAF is an organisation-wide risk document, responsibility for it sits with the MD rather than the CEO. The BAF is presented at a private meeting of the Board after review in the Assurance committee.

The Board does not appear to have discussed and agreed an overall risk appetite statement or a risk appetite for each principal risk in the BAF. It would be usual for the BAF to be reviewed at an Audit committee of the Board, and good practice for it to be discussed at a Public board meeting.

Corporate and quality (healthcare) governance is the responsibility of the MD and overseen by a co-director in his team. In our experience, it is unusual to have these grouped together as the responsibility of one individual and the oversight of corporate governance warrants review.

Board papers are not published in a timely manner on the external facing website (on 1st October 2025 the latest available public board minutes were those from the January 2025 meeting). The papers are not labelled with a standard naming convention which makes them difficult to access.

Conclusions

The Board size, its sub-committee structure and reporting, and the format of the Board Assurance Framework make it challenging for the Board to identify the most important strategic challenges and remain strategic in its focus. The Executive team is large, and its Directors hold both responsibility and accountability for their services.

Recommendations

The Belfast Trust should review its Board structure, membership, reporting and consider a programme of Board development

In order to achieve this:

- The CEO should review and consider reduction in size of the Executive team
- There should be a review of the Board sub-committee structure and meeting frequency, specifically to ensure that there is a monthly meeting of the Quality and Safety Board sub-committee and templated highlight reports from its Executive led reporting committees.
- There should be a review and rationalisation of reporting groups into a new Quality and Safety Executive committee.
- The board assurance framework (BAF) should be reviewed and revised to ensure that it links to the principal strategic risks of the organisation.
- There should be a review of the responsibility for and oversight of corporate governance.
- The Board should commence a programme of externally supported development, specifically to revise the BAF, and address risk appetite and board assurance and challenge.
- There should be timely publication of accessibly named board papers on the public facing website to demonstrate transparency.

Part B

Area of work 6

An assessment of the extant processes in place within BHSCT for Clinical Governance

There is a comprehensive governance framework document which outlines the expectations of directorate and divisional teams. There are daily governance meetings in every service and a daily call with the on-call executive director which allows rapid and timely escalation of safety and operational issues from services. This level of organisational responsiveness is very impressive.

Weekly divisional governance meetings ensure that there is oversight of new incidents, complaints and safety alerts, and monitoring of progress on complaint responses and incident reports. These meetings feed into a weekly organisation wide governance call, where these is a review of new serious adverse incidents (SAI) and significant complaints, and results in a very detailed weekly report. This level of scrutiny is impressive, but very time consuming and there may be opportunities to streamline processes and reduce workload for the governance teams.

Despite the level of attention to real time governance there are a very large number of unfinished serious adverse incident reports (over 100 unfinished at the time of writing), resulting in a significant delay to learning, and untimely reporting to patients and families.

An updated regional patient safety framework has been subject to consultation by the Department of Health as a replacement for the Regional SAI process. The resultant delay to changing to a new patient safety framework akin to the NHSE Patient Safety Incident Response Framework, means that a significant amount of time is being spent by staff undertaking detailed investigations and writing lengthy reports. The identification of and sharing of learning from serious incident investigations is limited by the large number of overdue reports.

The Trust declares a mean of 14 SAIs per month. Staff reported that these are often selected based on the level of harm to a patient rather than potential learning for the organisation or wider health system. Several staff described a lack of clarity about what constituted an SAI despite a policy being in place. There is perceived to be pressure from the SPPG / Department of Health and from patients and families to undertake detailed serious incident investigations when learning may be relatively minimal. A lengthy and detailed monthly SAI report is produced by the central governance team and details the numbers and types of incidents and the status of reports in each division. Consideration of how such a report could be automated would be advisable.

There is limited participation in national benchmarking audits which, perhaps unhelpfully, are not externally mandated by the Department of Health. There did not

appear to be regular reporting of outcomes from national audits, nor reporting of changes in outcomes over time to the Assurance Committee of the Board. We were told that participation in national audits is significantly limited by legal constraints related to data sharing.

A NICE guideline report describes the completeness of reviews of new guidance but does not report on deviations from NICE guidance or audits to confirm adherence to guidance.

There is a longstanding pilot of a regional medical examiner system which operates Monday to Friday during working hours and does not include community deaths. There are a significant number of overdue mortality reviews (over 900 in November 2024) with resultant delays in learning and incident reporting. It was not clear how the themes identified from inquests, claims, Mortality and Morbidity discussions, and serious incident reports are identified and lead to focussed quality improvement work. There is no requirement for a learning from deaths report to be presented to the Board.

Conclusions

There are very timely and responsive governance processes within the Trust, which ensures that quality and/or services issues are rapidly identified, escalated and actioned, and should be commended. However, this results in a very significant amount of work to deal with the wealth of resultant data and there is likely to be value in reviewing the comprehensive governance reporting and streamlining processes to allow focus on concluding overdue SAI reports, and analysing the data, particularly from deaths, to identify learning for improvement .

The learning associated with the current patient safety framework and perceived pressure to report and investigate incidents should be helped by the move to a new patient safety framework for NI and discussion of SAI threshold with the Department of Health.

There is little / no comparative audit data being reported to the Board or its sub-committees and the lack of external mandating of audit is not helpful in this regard.

Recommendations

The Belfast Trust should review and streamline its governance reporting and improve the reporting of outcomes

Specifically

- The Trust should consider whether review of its comprehensive governance reporting could release time for analysis of data for improvement and reporting of outcomes
- The Trust should discuss and review the threshold for declaring a serious incident with the Department of Health

- The Trust should ensure that there is regular reporting of benchmarked national audit data to the Quality and Safety committee of the Board
- The Trust should introduce a quarterly learning from deaths Board report bringing together all sources of learning from deaths.

The Department of Health should revise policies in relation to patient safety, mortality and audit

The Department of Health should introduce an updated patient safety framework akin to the NHSE Patient Safety Incident Response framework within the next 6 months.

The Department of Health should introduce a 24/7 regional medical examiner service to ensure review of all deaths and require a quarterly learning from deaths report to the Board.

The Department of Health should mandate Trusts to participate in benchmarked national audit.

The Department of Health should expedite changes to the law to facilitate data sharing as soon as feasible.

Part B

Area of work 7

An assessment of the extant processes in place within BHSCT for Medical Leadership.

There are 7 Directors and 14 Divisional Chairs across the 5 service Directorates in the BHSCT with a triumvirate leadership model of (Medical) Chair / Co-director and Divisional Nurse. Chairs are responsible for overseeing job planning, appraisal, and performance of their Medical staff as well as quality and safety within their divisions. Chairs are line managed by the MD and report to a Director. There are around 50 speciality or service Clinical Directors (CDs) and Patient Safety and Clinical Governance (PSCG) leads within services.

A comprehensive leadership programme for Chairs and CDs has been developed and there now needs to be consideration of how this can be offered to aspiring clinical leaders (CDs / PSCG leads / Chairs) before taking on these roles. We were told that Chair and CD posts are appointed for 3 years and extended by 2 years with mutual agreement. This is not clearly specified in job descriptions and consequently results in some very long serving chairs and CDs. There is a highly valued weekly senior medical leadership (SML) meeting between the MD team and Chairs of Division. There is no appraisal or coaching for Chairs / CDs in their leadership roles, which would be good practice.

Chairs have responsibility for Divisions of very different sizes and complexity and yet responsibility payments and time allocated for the roles are the same.

The Chairs and CDs do not meet regularly with, and therefore have opportunities, to influence the decision making of the Executive team. The CDs described a ‘ceiling’ beneath the Chairs and were concerned that their voices are not heard. CDs described little opportunity for cross divisional working between departments, CDs or Chairs on issues of mutual relevance.

Conclusions

The senior medical leaders in the organisation are well supported by their Directors and the MD team, but there are limited opportunities for them to influence strategic decision making by the Executive team and to work across services in the Trust. Consideration should be given to providing training for aspiring Medical leaders, appraising them in their leadership roles and adhering to documented tenure for the posts. Time and resourcing of the roles is equal despite differing size and complexity of responsibilities.

Recommendations

The Trust should strengthen its medical leadership

In order to achieve this the Trust should :

- Ensure that there are regular face to face meetings between CDs, Chairs and the Executive team.
- Ensure that there is annual appraisal of Divisional Chairs and CDs in their leadership roles.
- Consider an offer of coaching to Chairs / CDs in their roles.
- Review time and resource allocation for CDs and Chairs.
- Consider how aspiring leaders can access training and development before taking on leadership roles.
- Ensure that Chair and CD roles are time limited.

Part C

List of recommendations

1. **The Belfast Trust should monitor the Cardiac Surgery Consultant team relationships and their impact on service delivery and patient safety in Cardiac surgery**

   In order to achieve this:

   The CEO should formally review the impact of the Cardiac Surgery Consultant team relationships on service delivery and patient safety at 3 and 6 months with the interim Cardiac CD.

2. **The Belfast Trust must ensure that The Board has clear visibility of areas within the organisation in which there are significant ongoing conflicts, with associated assessments of risk and oversight of the interventions and their effectiveness.**

3. **The Belfast Trust should commit to the development of a comprehensive 5 year "People and Culture" strategy.**

   In order to achieve this the trust should:

   - Engage in a meaningful engagement/listening exercise that includes all staff in setting out the ambition of the People and Culture strategy.
   - Communicate widely to staff that the People and Culture strategy will be co-designed and co-produced with them, agree a mechanism to 'deal with the past', and set up the structures within the organisation that facilitate involvement and engagement.
   - Devise meaningful accountability processes that reflect the central importance of the People and Culture strategy to the success of the organisation:
     - Create a NED chaired People and Culture Board Sub- Committee.
     - Ensure that a reporting template provides updates to the Board. from the People and Culture subcommittee to the board concerning people issues as a standing agenda item.
     - Devise metrics to monitor "culture" within the organisation. RQIA's "Being Human" document may be helpful.
   - Create staff engagement groups throughout the organisation to feed "soft intelligence" into formal People and Culture reports.

- Incorporate a clear plan to build capacity among those with management responsibilities to support them to manage and challenge inappropriate behaviours.

4. **The Belfast Trust should review its Human Resource function considering structure, capacity and resourcing.**

   In order to achieve this the trust should:

   - Undertake a formal analysis of need based on the aspirations of the People and Culture strategy and the appropriate prioritisation of people issues.
   - Ensure that Human Resources is properly equipped with expertise and resources to undertake its function.
   - Evaluate the need for Medical HR expertise and ensure that HR has meaningful oversight of all "people issues" involving Medical staff including active involvement with the application of MHPS.
   - Ensure that there is clear accountability for people issues at senior executive level to the board.

5. **The Belfast Trust should review, clarify and improve the mechanisms for staff to raise concerns.**

   In order to achieve this the Trust should:

   - Incorporate this as a central enabling tenet of the People and Culture Strategy.
   - Review and update all policies and procedures relevant to raising concerns – grievance raising, disciplinary procedures, conflict bully and harassment and whistleblowing.
   - Provide clarification to staff on the circumstances in which whistleblowing is appropriate, and the external organisations they can approach if they do not trust internal processes.
   - As part of the People and Culture strategy embed "Listening to staff as a cultural norm in the Belfast Trust"
   - Clarify the responsibility of line managers to listen to and to respond to staff who raise concerns.
   - Introduce 360 review of managers as a standard part of annual appraisals and ensure that staff views are actively sought and provided without fear of identification or negative repercussions.

6. **The Department of Health should introduce regional services that provide independent mechanisms for staff to raise concerns.**

    - A regional Freedom to Speak UP service should be developed. A local version of this was also recommended in the DCO Partners report. A Freedom to Speak up service should incorporate an independent regional component alongside embedded resources within each trust throughout the region. This should be aligned to the current Patient Safety and Quality initiatives.
    - A regional whistleblowing service focused specifically on the Health Service should be developed. While each of the trusts should maintain, improve and develop their internal whistleblowing capacity, because of the lack of trust expressed by many staff in this there should also be access to an independent regional service. Models of good practice exist elsewhere in the UK. In Scotland such a service resides in the national public service ombudsman's office.

7. **The Belfast Trust should review its Board structure, membership, reporting and consider a programme of Board development**

    In order to achieve this:

    - The CEO should review and consider reduction in size of the Executive team.
    - There should be a review of the Board sub-committee structure and meeting frequency, specifically to ensure that there is a monthly meeting of the Quality and Safety Board sub-committee and templated highlight reports from its Executive led reporting committees.
    - There should be a review and rationalisation of reporting groups into a new Quality and Safety Executive committee.
    - The board assurance framework (BAF) should be reviewed and revised to ensure that it links to the principal strategic risks of the organisation
    - There should be a review of the responsibility for and oversight of corporate governance.
    - The Board should commence a programme of externally supported development, specifically to revise the BAF, and address risk appetite and board assurance and challenge.
    - There should be timely publication of accessibly named board papers on the public facing website to demonstrate transparency.

8. **The Belfast Trust should review and streamline its governance reporting and improve the reporting of outcomes**

   In order to achieve this the Trust should:

   - Consider whether review of its comprehensive governance reporting could release time for analysis of data for improvement and reporting of outcomes.
   - Discuss and review the threshold for declaring a serious incident with the Department of Health.
   - Ensure that there is regular reporting of benchmarked national audit data to the Quality and Safety committee of the Board.
   - Introduce a quarterly learning from deaths Board report bringing together all sources of learning from deaths.

9. **The Department of Health should review policies in relation to patient safety, mortality and audit**

   - The Department of Health should introduce an updated patient safety framework akin to the NHSE patient safety and incident response framework within the next 6 months.
   - The Department of Health should introduce a 24/7 regional medical examiner service to ensure review of all deaths and require a quarterly learning from deaths report to the Board.
   - The Department of Health should mandate Trusts to participate in benchmarked national audit.
   - The Department of Health should expedite changes to the law to facilitate data sharing as soon as feasible.

10. **The Trust should strengthen its medical leadership**

    In order to achieve this the Trust should :

    - Ensure that there are regular face to face meetings between CDs, Chairs and the Executive team.
    - Ensure that there is annual appraisal of Divisional Chairs and CDs in their leadership roles.
    - Consider providing an offer of coaching to Chairs / CDs in their roles.
    - Review time and resource allocation for CDs and Chairs.
    - Consider how aspiring leaders can access training and development before taking on leadership roles.
    - Ensure that Chair and CD roles are time limited.

Part D

Appendices

Appendix 1

Peter McBride Level 5 SIF intervention BHSCT

TERMS OF REFERENCE

1. To assess how widespread are the issues of poor culture and behaviours within the Belfast Health and Social Care Trust (BHSCT);
2. To examine and report on any trends regarding disciplinary investigations, grievances, referrals to professional bodies, legal actions by workforce against BHSCT;
3. To evaluate the efficacy of the management of poor culture and behaviours;
4. To assess the effectiveness of, and staff confidence in, the BHSCT “whistleblowing” and other reporting processes, whereby the workforce can raise concerns regarding culture and behaviour, with specific reference to whether there is evidence employees’ concerns are welcomed by management and processed appropriately;
5. To make recommendations to the Minister of Health regarding remedial actions;
6. To keep under review BHSCT’s Implementation / Action Plan arising from the recommendations of the DCO report into Cardiac Surgery;
7. Mr McBride will operate with the full authority of the Minister of Health, with the unfettered right to advise and quality assure, among others, the BHSCT Oversight Group and the DoH Accountability and Assurance Group.

To accomplish the above, Mr McBride is expected to consult widely, including: BHSCT staff; trade union representatives; professional bodies and; patients / service users (aided in the latter category by the Patient Client Council (PCC)).

This work should be progressed at pace, ideally with outcomes by September 2025. The ToR should allow for flexibility, permitting Mr McBride to liaise with the Minister of Health for necessary amendments in light of and emerging information.

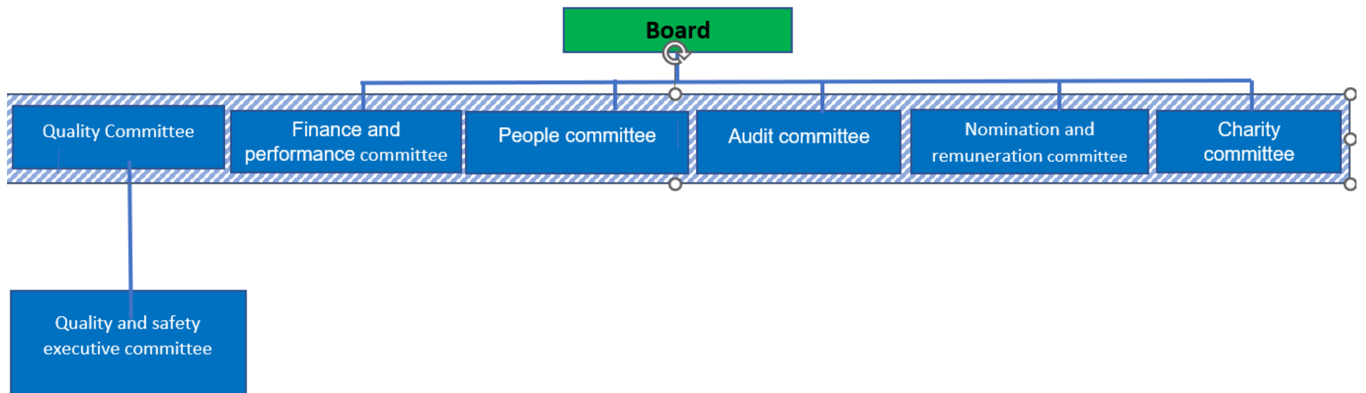
Appendix 2.

Terms of reference for Dr Jennifer Hill

CONSTITUTION	Dr Jennifer Hill has been asked by the Permanent Secretary to assess and make recommendations on the improvement of clinical governance and medical leadership processes and oversight from 'floor to board'. This follows the DCO report into Cardiac Surgery service, however the work is not limited to this area of service and should consider issues across the BHSCT and corporately.
PURPOSE	To assess, consider and provide advice and assurances on both the processes and application of clinical governance and medical leadership and the related elements of the associated Action Plan for the BHSCT.
MEMBERSHIP	Dr Jennifer Hill will work with the internal Oversight Group within BHSCT to provide supportive challenge to the delivery of their Action Plan and provide an assessment of progress through the Accountability and Assurance Group to the Minister.
SCOPE	Provide a constructively challenging but supportive review within the following key areas: • Discuss and consider the related DCO findings and recommendations with regards to the BHSCT's action plan. • Consider the extant processes in place within BHSCT (floor to Board) for clinical governance, medical leadership and Board level oversight and challenge. • Engage with staff of the BHSCT as necessary. • To provide independent assessment and support to the Accountability and Assurance Group on related actions and progress demonstrated for both Cardiac Surgery and the BHSCT corporately. • Provide a report of findings and recommendations.

Appendix 3.

New Structure for Board and associated committees BHSCT



Appendix 4

Tier 1 Groups
Tier 2 Groups
Tier 3 Groups

New Structure for Quality committee and reporting

Audit Committee
Quality Committee
Tier 2 Groups have a reporting line to exec group through Exec Chairs

Risk Management Executive Committee
Quality and Safety Executive Committee
Mental Health Steering Executive Committee
Pt Experience and Engagement Executive Committee
Social Care executive committee
Health and Safety Executive Committee

Risk Validation Group
Outcomes review Group (audit / NICE)
Medicines Safety Committee
MCA and DOLS Group
Patient Experience and Engagement Group
Asbestos Management Group
EOL Strategy Group
Nutrition Steering Group
Dementia Group
Children, Young People Transition Group
Decontamination Group
Medical Sharps Group
Deteriorating Patient Group
Organ Donation Group
Trust Fire Safety Liaison Group
Hospital Transfusion Group
Infection control group
Violence and Aggression Working Group
Radiation Safety Steering Group
Water Quality Steering Group
Ventilation Meeting
IG Committee
Pressure Ulcer Group
Safer Procedure Group
Mortality Governance Group
Safeguarding Committee
Med Devices Management Group
Strategic Falls Group
Medicines Management and Therapeutics
SAI Group
Thrombosis Committee

1

Appendix 5.

Meeting Assurance Report
to the Click or tap here to enter text. **held on**
Click or tap to enter a date.

Committee / Group Name	Click or tap here to enter text.
Date of Meeting	Click or tap to enter a date.
Chair	Click or tap here to enter text.
Lead Officer	Click or tap here to enter text.
Meeting Administrator	Click or tap here to enter text.

Purpose

The purpose of this report is to provide in summary an update on the key discussions, outcomes and escalations of the above meeting.

Agenda items covered at the meeting [Bullet list agenda items]
• Click or tap here to enter text.
Documents approved [State if approval/ratification required from another Committee/Group]
Click or tap here to enter text.
Important issues discussed / matters requiring attention such as new risks, new assurance, progress with actions to close gaps in control or assurance and potential areas of non-compliance [Identify as above and describe any actions and next steps agreed]
Click or tap here to enter text.
Items referred / escalated to another Committee or Group [Identify the name of the receiving forum and detail the recommendation made]
Click or tap here to enter text.
Any other matters to highlight
Click or tap here to enter text.

Recommendation

The Committee / Group is asked to **RECEIVE and DISCUSS** the update provided and respond to any specific points raised within the report.