Meeting Note

DATE: Tuesday, 21 April 2026
TIME: 1:00 pm – 3:30 pm (extended to 4pm)
VENUE: The Law Society of Northern Ireland, Belfast

Present	**Members & Partners** • **BHSCT**: Jennifer Welsh, Chief Executive; Patricia Gordon, Vice Chair (sub for Stuart Elborn), Olga O'Neill, Director of Nursing. • **NIAS**: Michelle Larmour, Chair; Phelim Quinn, Non-Executive Director; Seamus Mullen, Director of Planning & Performance (sub for Maxine Paterson) • **NHSCT**: Carol Diffin, Vice Chair (sub for Anne O'Reilly); Gillian Traub, Director of Operations (sub for Suzanne Pullins), Stevie Lennon, Director of Finance. • **SEHSCT**; Kevin McMahon, Non-Executive Director (sub for Jonathan Patton); Roisin Coulter, Chief Executive; Prof Stephen Kirk, Medical Director • **SHSCT**; Eileen Mullan, Chair (Meeting Chair); Steve Spoerry, Chief Executive; Colm McCafferty, Director of Children, Young People and Women's Services. • **WHSCT**; Tom Frawley, Chair; Karen Hargan, Chief Executive Designate, Teresa Molloy, Director of Planning and Performance • **Partners**: Aidan Dawson, Chief Executive, PHA; Karen Bailey, Chief Executive, BSO;
In attendance	Helen Moore, Director of Planning, Performance & Improvement, SEHSCT; Len Richards, External Advisor, WYAAT Provider Collaboratives; Dean Sullivan, Regional Co-ordination Centre (RCC); Dr Julia Simon, Consultant, NICON; Elaine Wilson, Director Planning, Performance and Informatics, SHSCT Programme Leads: Julia Fitzhenry; Gráinne Harte. Secretariat: Heather Moorhead, NICON; Elly McGinn, NICON.
Apologies	Anne O'Reilly, Chair, NHSCT; Suzanne Pullins, Interim Chief Executive, NHSCT; Maxine Paterson, Chief Executive, NIAS; Jonathan Patton, Chair, SEHSCT; Stuart Elborn, Chair, BHSCT; Tracey McCaig, COO, SPPG

Item	Discussion Summary	*Actions*
1.	**Nomination of Chair** The Committee considered the nomination of a substantive Chair for the Committee in Common, in line with previous discussions and Trust Board processes. Michelle Larmour on behalf of the HSC Trust Chairs proposed the nomination of Ms Eileen Mullan as Chair of the CiC, with Roisin Coulter formally seconding the proposal. The Committee agreed the nomination	
2.	**Chair's Welcome and Apologies** The Chair opened the meeting and welcomed members, deputies and attendees to the Committee in Common. The Chair congratulated Karen Hargan on her appointment as Chief Executive of the Western Trust with effect from 1 May 2026.	

3	**Chair's Update** The Committee received the Chair's written update, summarising progress against the CiC action log, provider collaborative reporting, governance arrangements and communications activity. The Chair reported that most actions are now at "propose to close" stage, with the remainder progressing as planned. Updated Terms of Reference and the Charter have been submitted to Trust Boards, programme brief and report card templates are in place, and a CiC visual identity has been agreed. The update noted work to profile the CiC at the Northern Ireland Leadership and Governance Conference, development of the CiC logo and "Working as One" strapline, and ongoing engagement with Trust Boards on governance alignment and reporting. No questions or comments were raised.	
4	**Declarations of Interest** The Chair invited members to declare any actual or potential conflicts of interest. No declarations were made.	
5	**Previous Meeting Notes (17 February 2026)** The Committee noted that the meeting notes for 17 February 2026 had been circulated in advance and pre-approved, subject to correction of the spelling of Jennifer Welsh's name. No further amendments were required.	*CiC Secretariat to action correction and ensure the final version is retained on file.*
6	**Matters Arising** The Committee reviewed the CiC Action Log and agreed the ten actions were now ready to close, including those relating to approval of the Terms of Reference and Charter, development of standardised communications and reporting templates, the CiC visual identity and forward planning for this meeting. The action log is appended to these notes detailing those actions that are closed closing and remain active.	*CiC Secretariat to update the log accordingly.*
6.1	**Mandatory Training** Committee received a brief update from Roisin Coulter on work to standardise mandatory and statutory training across Trusts. Roisin reported that a draft core mandatory training framework has been developed and discussed with Directors of HR, and that this will support a more consistent approach to requirements and reporting. She noted that further work is required on two elements to ensure alignment and that it will be important to demonstrate clear benefits for staff and services from the standardisation work. Roisin confirmed that this work will link with wider HR "passporting" activity and that Heads of HR will continue to refine the framework, with a further update to be brought back to a future CiC meeting.	*Mandatory Training report card to be issued following the meeting.*

7	**Communication and Engagement** The Committee received an update from Julia Fitzhenry and Gráinne Harte on the emerging communications and engagement framework for the CiC. The framework sets out objectives, key audiences and next steps, including alignment with Trust communications, use of the new logo and strapline, and development of consistent messaging on the role and impact of the CiC and provider collaboratives. In discussion, members emphasised the need to prioritise internal communications to Trust Boards, senior leadership groups, clinical and professional networks and system partners (SPPG, PHA, Department) to ensure clarity of purpose and consistent reporting on CiC programmes. Roisin Coulter asked about messaging to the public; Tom Frawley highlighted the importance of communications remaining clearly owned by the six Trusts; and several members stressed the need for a clear stakeholder map and alignment with existing clinical networks to avoid conflicting narratives. Len Richards advised that the Committee in Common in WYAAT did not have a public facing communication campaign given the publics assumptions that all Trusts already work collaboratively and instead listed their CiC within each Trusts websites and other materials, rather than being standalone. The Committee agreed: • the need for a CiC communications and engagement plan, including stakeholder mapping and a stakeholder engagement plan. • that CiC Programme Leads would engage with Trusts Heads of Communications • further work to be undertaken with Trusts through Chief Executives on the detailed approach	*Programme Leads and Secretariat to refine the communications and engagement framework, including stakeholder mapping and an outline plan, and bring a short update back to a future CiC meeting for endorsement.*
8	**System Financial Position** In the absence of Tracey McCaig COO SPPG, the Committee received a verbal update on the system financial position from Aidan Dawson, drawing on the latest SPPG and Departmental discussions. Aidan advised that the Permanent Secretary is required to secure around 6% savings across HSC in 2026/27, that SPPG has written to Trusts asking for schemes to be categorised, and that no decisions have yet been taken on higher-impact proposals. He noted that, even if 6% savings are achieved, there will remain a significant system deficit and unresolved issues around pay and the Real Living Wage. In discussion, Steve Spoerry highlighted that Trusts are awaiting clarity on how to proceed with the savings programme and that delay compresses the time available to deliver schemes.	

	Jennifer Welsh and Stevie Lennon reflected that some Trusts have made more progress than others in reducing deficits and that the longer decisions are deferred, the more difficult the required savings will become. Karen Hargan raised concerns about the risk of industrial action if pay uplifts are not funded, noting that this would both distract from and increase the cost of achieving savings. Aidan stressed that 6% savings "must come" in-year and that there is a need for collective working across the wider public sector, not only health. The Committee noted that Chief Executives and Directors of Finance will continue to lead this work directly and that, at this stage, no specific decisions or additional actions were required from the CiC beyond maintaining oversight of any implications for provider collaboratives	
9	**Provider Collaborative Updates**	
9.1	**Enhanced Care** The Committee received an update from Gillian Traub on the Enhanced Care Provider Collaborative. Members noted that around 200 patients remain delayed in acute settings awaiting care-home placement, with approximately 50 requiring dementia-specific beds, and that a regional ceiling of affordability is now being applied across all Programmes of Care. A regional Expression of Interest has generated offers of 246 beds, with 118 under detailed discussion. Michelle Larmour recognised the efforts made and the importance of this work in supporting flow, referencing the recent Leadership and Governance conference which showcased good practice in dementia care in NHSCT. Gillian Traub emphasised that there is still substantial work to do; Tom Frawley described the programme as an impressive early step and stressed the need for this progress to be visible in Trust committee structures.	Enhanced Care updates should be shared through relevant Trust Board committee structures to support wider understanding of the provider collaborative, progress and impact
9.2.	**Gynaecology Elective Care** The Committee received an update from Roisin Coulter on the Gynaecology Elective Care Provider Collaborative. The update described two main strands of work: standardising service delivery models across Trusts and addressing capacity and demand. Members noted that the collaborative has delivered substantial reductions in the longest waits since September 2025, with outpatient waits over three years reduced from around 13,650 to approximately 2,100 and inpatient/day case waits over three years reduced from around 1,380 to under 200.	

	Roisin highlighted that progress has at times been "clunky", as this was the first CiC-sponsored collaborative and operates in a space where multiple parallel programmes and governance routes already exist. She noted that work on developing endometriosis hubs had been taken forward outside the CiC and reflected that this type of service development should ideally come through the collaborative first. Roisin observed, however, that the move to a single business case across all Trusts for the first standardisation priority that the Provider collaborative have take forward; gynaecology enhanced red flag triage represents an important step towards alignment and the need for provider autonomy and freedom to act within the elective care framework, with DoH, SPPG and Chief Executives working together to enable the collaborative to operate as a single provider voice. In discussion, Helen Moore noted strong commissioner engagement whilst emphasising that this remains a different way of working for all including SPPG, which is used to seeking separate Trust responses. Dean Sullivan observed that a key challenge is realigning commissioners to work with collaboratives instead of their "business as usual" approach. Steve Spoerry suggested that Trusts should be alert to responding collectively to commissioner asks; Roisin confirmed that, wherever possible, Trusts already seek to provide a single system response.	
9.3	**Candidate Passporting** The Committee received an update from Karen Hargan on the work previously described as "candidate passporting" for post-employment checks (PECs). Karen reported that analysis of recent recruitment rounds shows that approximately 30–40% of PECs relate to candidates who move between Trusts rather than joining from outside the system. The group had therefore explored whether a passport-style approach would materially reduce duplication and time. Karen explained that, although a more streamlined approach had been in place for around eight years, a recent decision by RQIA, reflecting the legislative basis within which it operates, has effectively required that approach to be reversed. This has created significant constraints, particularly in relation to Access NI checks, and is expected to increase cost and complexity across all healthcare providers unless legislation is amended. Karen noted that extensive discussions are underway with colleagues in the Department, RQIA and Trusts to understand the full implications and options. In light of this, and taking legal and HR advice into account, the group was not proposing to pursue a formal PEC "passport" at this stage. Instead, its focus will be on improving consistency and timeliness of PEC processes across Trusts, including shared templates and expectations, and will align with the wider Time to Fill (TTF) work on recruitment timelines. Karen	*TTF group, via Karen Hargan, to continue work on PEC process consistency (templates/timelines) and bring back an update once the position with RQIA and associated legislative issues is clearer.* *Karen Hargan to link in with WYAAT*

	noted that she had already connected with Len Richards to understand learning from WYAAT's successful collaboratives on Staff Portability and would link in again with colleagues there to explore what aspects might be transferable to the NI context, and how change can happen. This may require changes to legislation. She indicated that, once a final position with RQIA is reached, she will update the CiC to advise what support might be required to unblock any remaining regulatory constraints.	
9.4	**Regional Agency Reduction / ARIG** The Committee received an update from Karen Hargan on the Regional Agency Reduction Implementation Group (ARIG). Karen reported continued progress in reducing off-framework agency usage and costs, supported by implementation of the new medical and dental framework and work to align doctors to framework rates across Trusts. She noted that this is challenging where it involves moving existing staff down from higher legacy rates, but that progress is being made and a further update will follow the next regional meeting. Karen advised that Trusts are working through risk assessments and mitigation plans in relation to agency reduction and highlighted the importance of maintaining service safety and continuity as rates are standardised. She also referenced work to understand and address variation in the use of SaaS doctors and to ensure that workforce planning and vulnerable specialties workstreams are aligned with ARIG. In discussion, Steve Spoerry emphasised the need to balance reducing agency spend with the risk of losing staff from fragile services, and expressed concern that, without a clearer system view of vulnerable specialties, cost reductions could inadvertently destabilise care. Tom Frawley noted that, given the scale of the 6% savings requirement, it is inevitable that some changes will be painful and stressed the importance of a frank, system-wide discussion about where the greatest vulnerabilities lie before services reach a tipping point. Patricia Gordon supported the view that the CiC should use ARIG learning to inform this wider conversation on protecting priority services.	*ARIG and the vulnerable specialties workstream leads to bring back a consolidated view of priority vulnerable services, drawing on ARIG data and psychiatry/haematology work, to support a system-wide discussion at a future CiC.* *Karen Hargan agreed to bring back to the next CiC meeting an update on how implementation of the new medical and dental framework is working in practice*
9.5	**Regional Coordination Centre** The Committee received an update from Dean Sullivan on the Regional Coordination Centre (RCC). The paper set out the RCC's role as a regional mechanism for operational oversight of unscheduled care, hosted by NIAS and jointly funded by the six Trusts, with a current annual cost of around £850k reducing to about £650k in 2026/27 following changes to operating hours. It	

	described the RCC's core functions in providing a single version of the truth on escalation across all acute sites, leading regional work on ambulance handovers and alternative pathways, and supporting Trusts through data and analysis. In response to a request from the CiC at a previous meeting, the paper also presented a quantitative analysis comparing system performance across four measures – patients leaving ED without treatment, ED 12-hour performance, total ED time for admitted patients, and ambulance handovers exceeding three hours – for the two years prior to and the two years following the RCC's establishment, sourced from SPPG management information. The Committee welcomed the quantitative analysis of performance provided in the paper. The quantitative analysis showed that, across all four measures examined, the previously worsening trajectory had been arrested and in some areas partially reversed since the RCC's establishment, with actual performance in 2024 and 2025 consistently better than the pre-RCC trend would have projected. Members noted that, while causality could not be attributed to any single intervention within a complex system, the analysis was consistent with improved coordination and earlier intervention. Roisin Coulter noted the benefit of the RCC's central coordination function in taking pressure away from local frontline Trust staff, the value of the regional data sources developed by the RCC, and the impact of its service improvement support to Trusts. Jennifer Welsh echoed these comments, noting the substantial improvement in collaboration across Trusts that the RCC had facilitated. Teresa Molloy acknowledged the operational oversight role and confirmed WHSCT's participation in RCC arrangements but noted that the ability to support WHSCT though diverts to other hospitals differs from elsewhere and the ability to avail of system working is not as significant as with other Trusts. She advised that DoPPs see the RCC dashboard as an interim measure, due to data quality issues on discharge information, and stressed the need to return to strong local dashboards, and an automated regional dashboard from encompass, referencing the regional data collation as having a significant overhead in local operational teams. Teresa emphasised the need for a clear exit strategy, so the system is not permanently reliant on the RCC. Phelim Quinn queried why the paper focused on handovers exceeding three hours when the agreed aim is a two-hour standard and questioned how the analysis would look if the two-hour metric were used. Michelle Larmour welcomed the more detailed paper but, referencing earlier governance and priorities discussions, noted that the RCC still sits as a discrete cost. She stressed that if the	*Dean Sullivan to re-engage with SPPG to adjust data to better reflect the two-hour standard.*

	CiC is to consider RCC as part of its governance and infrastructure conversations, it must be clear about RCC's future role and expectations. Michelle expressed concern that arguments around "removing burden from staff" would not be persuasive to the public at this level of spend and stated she was not currently seeing material benefit commensurate with the cost, warning that if the trajectory continues, organisations will struggle to operate within available resources. Dean Sullivan agreed on the importance of data evolution in due course as Encompass develops. But for now, the USC data developed by the RCC with Trusts are in many cases the only reliable sources at regional level. On the two-hour versus three-hour handover issue, Dean explained that three-hour data was what SPPG had provided; he committed to rerun the analysis with two-hour data when available. [Note, subsequent to the meeting the two-hour data has been obtained: it shows a deterioration in two-hour performance in 2023 and 2024, followed by stabilisation and slight improvement in 2025.] Dean acknowledged that the paper does not seek to fully capture the breadth of work undertaken by the RCC, for example around handover performance and the access it has created for NIAS to data on alternative pathways and engagement with commissioners, and in relation to the planning for Release to Rescue. He indicated he would be happy to provide additional briefing at future CiC meetings if helpful. Dean acknowledged that the funding of the RCC was significant and it would be important that the function continues to deliver benefits regionally and locally for Trusts in responding to USC pressures. Gillian Traub commented that RCC-facilitated discussions between NIAS and Trusts had been helpful in understanding flow and data, and that this has demonstrated value. Seamus Mullen added that the RCC-supported fortnightly meetings with Trusts in relation to ambulance handovers are a relatively recent but useful development, providing consistency across sites, with senior leaders present and expected to take forward agreed actions. He noted that the data underpinning this work existed within NIAS systems, but that the RCC has analysed and presented it in a more usable way. Michelle Larmour asked whether encompass would address some of the data issues. Olga O'Neill, referencing her involvement from the start of the RCC, noted that a key benefit has been that Trusts now "speak the same language", with a shared interpretation of data that was not present previously. She stated that encompass can provide data, but that SPPG has already found encompass data difficult to use because it continuously changes, whereas RCC provides a single point of truth. Olga emphasised that interpretation of data in the context	*Chief Executives to consider the future role, scope and operating model of the RCC (including how the model evolves as system data infrastructure matures, and clearer impact measures) and update the CiC at a future meeting*

	of wider system pressures will remain critical, regardless of platform. Karen Hargan observed that, while WHSCT does not receive the same level of direct output as some others, the "critical friend" role the RCC provides is very useful. The Committee agreed that there is a need to continue to look carefully at the role and expectations of the RCC in line with the system needs now and into the future. The Chair noted that the type of data collated by the RCC should have been more readily accessible across the system and that it should not have required this level of effort to achieve a coherent picture.	
9.6	**Virtual Wards** The Committee received an update from Jennifer Welsh on the emerging Virtual Wards collaborative in BHSCT. Members noted that a regional oversight group and encompass build group have now been established, with the first build meeting held on 16 April 2026, and that the current intention is to admit the first virtual ward patients in Belfast Trust by September 2026, subject to successful design and testing. The update confirmed that pilots are being planned in both Belfast and at least one rural Trust, reflecting the Committee's previous request that the model be tested across different geographies. In discussion, colleagues welcomed the potential of virtual wards to support flow, reduce length of stay and improve patient experience, but emphasised the need for a coherent regional operating model, clear governance, and a minimum data set that allows the CiC and Trust Boards to see whether the anticipated benefits are being realised. Members also linked the virtual wards work to the broader financial and Reset context, noting that decisions about scaling will need to be grounded in evidence of impact and affordability, and that early pilots should be used to refine assumptions and inform future planning. The first Provider Collaborative for the Virtual Wards Oversight Group will be held in May 2026, and the Oversight Group will work to consider the rural pilot(s).	
10.	**Provider Collaboratives- under consideration**	
10.1	**Psychiatry** Helen Moore provided a brief overview on the potential areas of work that a Psychiatry provider collaborative could work on. These had been identified in follow up meetings held since CIC meeting in February with both DOH lead and SPPG leads, noting that new leadership arrangements at SPPG. DOPPS and Mental health directors have met on 13 April and scoping work on-going.	*Formal Provider Collaborative to be established Programme Brief and Report Card to*

10.2	Members recognised psychiatry as a fragile specialty with significant workforce pressures and emphasised that any model will need to be built on robust data about demand, current service configuration and the balance of substantive, training and locum posts. In discussion, colleagues reflected on learning from other collaboratives, including the need for clear senior sponsorship, early clinical engagement and a realistic view of the time and capacity required to progress collaborative work alongside existing pressures. Psychiatry will move to a formal provider collaborative model, with a paper to Chief Executives, identification of a sponsoring Chief Executive and development of a Programme Brief to be brought to next CiC.	*be prepared for next CiC*
	Haematology Helen Moore noted that further work on a potential Haematology PC is underway following the February agreement that an update would come back to CiC once the new leadership team was in place and initial scoping completed. Members reiterated that haematology is a high-risk area with regional workforce and resilience challenges, and that any future proposal must clearly set out the system-wide implications, including on smaller sites and on training. In discussion, colleagues emphasised the need for outputs from this work to align with the broader agency reduction discussions, ensuring that provider collaborative solutions are coherent with work on fragile specialties and urgent care.	*Report on Haematology to be provided to the June CiC Meeting as per matters arising log.*
11.	**Meeting Closure**	
	The Chair thanked members, deputies and attendees for their full engagement in what had been a substantive workshop and meeting. The Committee confirmed its support for two additional CiC meetings in June and December. Secretariat asked to confirm the proposed date of 23 June does not conflict with the SLG meeting before issuing formal invites. Reminder of further meeting dates: • **23 June 2026**, 1:00 p.m. – 3:30 p.m., via MS Teams • **18 August 2026**, 1:00 p.m. – 3:30 p.m., venue: NHSCT • **20 October 2026**, 1:00 p.m. – 3:30 p.m., venue: BHSCT • **Date TBC - December 2026**, TBA	