

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

Minutes of a Public Meeting of the South Eastern Health & Social Care Trust Board held on Wednesday 27 May 2026 at 2.30pm in the QIIC Hub, Trust Headquarters, Ulster Hospital, Dundonald

PRESENT: Mr J Patton, Chair of Trust Board (**JP**)

Ms R Coulter, Chief Executive (E) (**RC**)

Mrs V Cleland, Interim Director of Primary Care & Older People's Services (**VC**)
Mr K Donaghy, Non-Executive Director (**KD**)
Mrs R Gibbs, Director of Adult Services & Healthcare in Prison (**RG**)
Mr R Havlin, Non-Executive Director (**RH**)
Mrs S Henderson, Non-Executive Director (**SH**)
Professor S Kirk, Medical Director (E) (**SK**)
Mrs H Moore, Director of Planning, Performance & Informatics (**HM**)
Ms S McCauley, Non-Executive Director (**SMcC**)
Mr B McFetridge, Director of Surgery, Elective Care, Maternity & Paediatrics (**BMcF**)
Mr N McKinley, Non-Executive Director (**NMcK**)
Mr K McMahon, Non-Executive Director (**KMcM**)
Mr M Neil, Director of Unscheduled Care, Medicine & Cancer (**MN**)
Mrs A Quirk, Non-Executive Director (**AQ**)
Professor D Robinson, Deputy Chief Executive, Executive Director of Nursing, Midwifery & AHPs and Director of Support Services (E) (**DR**)
Ms M-L Sloan, Director of Children's Services & Executive Director of Social Work (E) (**MLS**)
Mrs C Smyth, Director of People & Organisational Development (**CS**)
Ms W Thompson, Deputy Chief Executive, Director of Finance, Contracts & Estates (E) (**WT**)

'E' denotes Executive Director

IN Mrs R Sutherland, Chair, Patient & Client Council (PCC) (presentation only) (**RS**)

ATTENDANCE: Mrs M McNally, Assistant Director, Risk Management & Governance/Board Secretary (**MMcN**)
Ms J Loughrey, Head of Communications (**JL**)
MS Teams AI function (minutes)

OPENING REMARKS

The Chair (JP) welcomed everyone in attendance and advised the meeting would be recorded for minute-taking purposes.

PRESENTATION: PEOPLE TO PARTNERS – DEVELOPING A UNIQUE APPROACH FOR NORTHERN IRELAND (PATIENT & CLIENT COUNCIL)

Mrs Sutherland (RS) as Chair of the Patient Client Council (PCC) presented on a proposal for a strategic cultural shift towards partnership with the public highlighting the need for a collaborative cross-government framework and inviting Board support.

Statutory Functions and Transformation: **RS** explained the PCC's five statutory functions noting that advocacy has been the most recognised but emphasising the importance of public engagement and research. **RS** described the transformation of PCC's complaints handling using trauma-informed practice and mediation which reduced formal complaints from 85% to 58% and demonstrated cost savings.

Case for Change and Public Disconnection: **RS** cited a YouGov survey showing 51% of the public felt disconnected from health and social care, and 48% felt their actions would not impact their care, underscoring the need to harness citizen agency and improve trust in public institutions.

People to Partners Initiative: The PCC's 'People to Partners' initiative was discussed, aiming for a whole-system strategic shift to partnership with the public. **RS** described the October roundtable and its report, advocating for shared power, responsibility, and systematic engagement across health and social care.

Recommendations and Board Engagement: **RS** requested board support for developing a Northern Ireland-specific collaborative strategic framework noting its inclusion in recent planning guidance and rising PCC public awareness. **RS** encouraged Members to connect with PCC, join its membership scheme and utilise its representative council structure.

Discussion and Questions: Members asked about trauma-informed practice in complaints, immediate versus strategic public engagement, compatibility with the Being Human Initiative, community planning, political challenges, and the need for joined-up communication. **RS** responded with examples, economic arguments, calls for coordinated action and open dialogue.

Following discussion, **JP** recorded thanks to **RS** for taking the time to attend Trust Board and engage with Members on PCC's important advocacy work on behalf of patients and the public.

1.0 APOLOGIES

None received.

2.0 DECLARATIONS OF POTENTIAL CONFLICTS OF INTEREST

None declared.

3.0 CHAIR'S BUSINESS

Noted (**SET60&61/26**).

4.0 CHIEF EXECUTIVE'S BUSINESS

RC confirmed the recent successful opening of Redwoods Children's Home on 8 May 2026 with Minister Nesbitt in attendance to meet the team. **RC** also highlighted Foster Care Fortnight and the recent Family Fun Day celebrating Adoption and Fostering at Newtownards Airport which hosted over 100 families. **RC** concluded by welcoming the recent visit by His Majesty King Charles to Ards Allotments - at which SET has a plot - with our Staff Health and Well-Being Co-Ordinator present for the engagement.

5.0 MINUTE OF PREVIOUS MEETING HELD ON 25 MARCH 2026

Approved without further amendment.

6.0 MATTERS ARISING

Noted (**SET/62/26**) there being three items – two of which had been actioned and one carried forward relating to the Quality & Innovation Presentation from the previous meeting. At **JP**'s request, Members agreed this should be actioned for the next meeting.

7.0 ITEMS FOR DECISION

7.1 BOARD ASSURANCE FRAMEWORK (BAF) RISK DOCUMENT & CORPORATE RISK REGISTER (CRR) 2025/26 YEAR-END POSITION & 2026/27 OPENING POSITION

SK presented the tabled Report (**SET/63/26**) summarising its content. Following discussion, **JP** sought and obtained approval for the 2025/26 Year-End Position and the 2026/27 Opening Position.

7.2 ANNUAL REPORT: DISCHARGE OF DELEGATED STATUTORY FUNCTIONS & CORPORATE PARENTING 2025/26

MLS presented the tabled Report (**SET/64/26**) summarising detailing workforce, data and service delivery challenges across social care, mental health, disability, children's services and fostering.

Workforce Recruitment & Retention: **MLS** reported significant challenges in recruiting and retaining social workers with regional strategies and dedicated roles being implemented. **RH** asked if there was any data regarding the reasons or barriers in terms of attracting applicants. **MLS** explained there was a workforce strategy in place with DoH analysing the challenges in relation to recruitment – one of which being an ageing workforce profile. **MLS** added working patterns were a challenge but there was also an opportunity within that to be creative. Following a query from **KMcM**, Members agreed there should be a review of the current workforce transfer policy to enable easier staff movement and reduce barriers.

Data Collection and System Limitations: **SMcC** asked how the delay in implementing Encompass within Children's Services was being mitigated. **MLS** advised manual data collection had been introduced to compensate for system build limitations affecting data robustness, particularly in tracking Unallocated Cases and statutory functions with ongoing regional subgroup efforts to resolve these issues.

Mental Health and Disability Services: **MLS** stated SET faces insufficient staffing and high volumes of deprivation of liberty referrals, but has improved triage and reduced unauthorised cases. Physical and learning disability services struggle with placement shortages, prompting local and regional plans and recruitment of transition workers.

Children's Services & Fostering: **MLS** reported Children's Services had seen a 47.9% improvement in Unallocated Cases, a shift to a service delivery model and increased family support. Fostering remains challenging due to kinship preferences and assessment times but creative recruitment campaigns and increased short break provision have been implemented.

Statutory Visits & System Integration: NMCK asked what plans are in place to ensure SET can avoid any LAC not being seen by their social worker within the statutory timescales. MLS outlined a number of measures being taken including Delegated Statutory Functions being exercised to Band 5 roles and team restructuring had improved statutory visits though absence and sickness impacted continuity. Encompass system limitations require dual recording, with ongoing efforts to improve regional data integration.

Following consideration, JP sought and obtained approval for the tabled Report.

7.3 TERMS OF REFERENCE: PATIENT SAFETY & QUALITY COMMITTEE

NMCK presented the tabled Terms of Reference (SET/65/26) explaining GAC would shortly be stood down with its remit subsumed into a new Patient Safety & Quality Committee (PSQC). NMCK explained the new PSQC would be the Board's principal forum for oversight and assurance on patient safety, quality of care and continuous improvement across clinical and social care services.

Following discussion, JP sought and obtained approval for the draft Terms of Reference as tabled subject to a minor typographical amendment on Page 8.

7.4 TERMS OF REFERENCE: PEOPLE & CULTURE COMMITTEE

AQ presented the tabled Terms of Reference (SET/66/26) and recommended approval. JP advised Members that he had asked Mrs Henderson to move from the Committee to serve on the Charitable Funds Committee so the membership as stated would need to be amended which was agreed. Following discussion, JP sought and obtained approval as requested.

7.5 TERMS OF REFERENCE: AUDIT COMMITTEE

SH presented the tabled Terms of Reference (SET/67/26) and recommended approval highlighting two amendments from the previous version agreed by Trust Board. Following discussion, JP sought and obtained approval.

8.0 ITEMS FOR DISCUSSION

8.1 INTEGRATED PERFORMANCE MONITORING REPORT

HM presented the tabled 2025/26 Year End Report (SET/68/26) and Month 1 2026/27 Report (SET/69/26) summarising performance information before addressing hospital performance, cancer targets, ED pressures, outpatient waiting times as well as AHP services before outlining causes and mitigations. BMcF highlighting a significant reduction in patients waiting over four years for elective care due to exceptional funding during 2025/26 while also highlighting sustainability measures, validation processes and regional collaboration.

Funding and Impact: HM stated SET secured £9 million in funding to target patients waiting over four years for outpatient, day case, and inpatient procedures, resulting in reductions of 50%, 55% and 65.5% respectively.

Validation and Clinical Activity: **HM** highlighted robust admin and clinical validation accounted for 40% of reductions with nearly 90,000 patients were seen or treated during the period, with ongoing additions to the waiting list.

Regional Day Procedure Centre (DPU): **BMcF** explained LVH DPU had processed 10,633 day cases including over 4,500 theatre cases and 6,000 endoscopies and colonoscopies – all contributing to overall performance.

Sustainability and Future Planning: **HM** advised that, with no indication of continued funding, the long waiting group has been re-established to creatively manage clinic and theatre time, continue validation and explore patient-initiated follow-up to maintain progress.

NMcK asked why there did not appear to be a target for 12 hours breaches and **HM** explained how every month there is a measure against a system metric which varies. **SMcC** referred to Page 18 and the Cancer 62 day target before asking for further information on what issues were causing delays within pathology. **MN** advised testing goes to BHSCCT where turnaround time had stretched adding this has been flagged with SPPG.

Strategic Collaboration: **RC** emphasised the importance of sharing positive outcomes with political parties and regional partners, advocating for greater collaboration and partnership with the private sector to sustain improvements.

8.2 FINANCIAL POSITION

WT presented the tabled Report (**SET/70/26**) for Month 12 2025/26.

Break-Even and Savings: **WT** stated SET had achieved break-even due to £28.8 million in non-recurrent deficit funding and achievement of £34m of recurrent savings.

8.3 SUPPORT & INTERVENTION FRAMEWORK (SIF) UPDATE

HM presented the tabled Report (**SET/71/26**) confirming SET had been escalated to SIF Level 4 in respect of ED waiting times and ambulance handovers before detailing improvement plans for ambulance handover delays and ED patient flow, governance structures, metrics as well as community service challenges, with extensive discussion on sustainability and regional issues. **HM** also explained actions in support of the introduction of the 'Release to Rescue Protocol' and daily monitoring of performance.

Governance and Action Planning: **HM** outlined that enhanced governance arrangements had been established, including a new steering group, hospital and community flow oversight with collaboration with SPPG and NIAS supported by external expertise and weekly reporting. **RH** asked when the first meeting of the SPPG Assurance Board would be held and **HM** replied this would likely to be next month. **KMcM** asked if there was a target for NIAS in respect of 'See and Treat, Hear and Treat' and **HM** replied this is part of the SOBS programme on which we meet bi-weekly with NIAS. **SMcC** asked for sight of the Terms of Reference for the Assurance Board and detail as to when in the reporting cycle Members would be asked to review performance data. **HM** replied SET had not

yet received a Terms of Reference and the timing of data reporting would depend on what SPPG required in support of the Assurance Board but this will be confirmed once known.

Metrics and Operational Measures: NMCK asked what were the key metrics being used in relation to 12 hour breaches which could provide assurance that while this is a slow but persistent approach it is turning around something highly complex. MN explained key metrics include ambulance handover times, 12-hour breaches, early discharge rates, and clinical capacity in ED with business intelligence tools used for real-time monitoring and targeted interventions. SH noted the total number of NIAS handover had consistently crept up in recent weeks and asked how improvement could be maintained in this context. SH also asked how staff were managing with the implications of the NIAS protocol.

Community Services and Discharge Challenges: KMCM asked if there was an understanding of what might be missing within Community Services in order to support this effort. VC described challenges in care home placements, dementia beds, and patient refusals to leave hospital, with mitigation strategies such as hospital at home, remote monitoring, advanced care planning, and collaboration with NIAS and technology partners. Following discussion, Members requested the Community Services locality plan be shared detailing mitigations for care home placement and Hospital at Home.

Staff Experience and Sustainability: SH noted the total number of NIAS handover had consistently crept up in recent weeks and asked how improvement could be maintained in this context. SH also asked how staff were managing with the implications of the new NIAS protocol. MN advised staff across hospital and community services were adapted to new ways of working, with ongoing support and engagement to ensure sustainability and maintain improvements amid increased NIAS arrivals and operational pressures.

8.4 COMMITTEE IN COMMON (CiC) UPDATE

RC presented the tabled Report (SET/72/26) highlighting progress being made in respect of formal collaboration across HSC Trusts including on agreeing shared priorities, learning from other regions as well as recognising the importance of avoiding duplication. RC recorded thanks for the support of Ms Eileen Mullen (Chair of the Southern HSC Trust and Chair of CiC) and the importance of ongoing feedback to the Board.

Collaboration and Progress: RC explained the CiC had agreed to table all papers at Public Board meeting in an effort to foster consistent approaches and formal collaboration across Trusts and provided a summary of the associated documents tabled under this item. Following discussion, Members suggested the CiC might wish to consider adding 'Engaging with the Public' as a theme.

8.5 RIGHT CARE RIGHT PERSON (RCRP) INITIATIVE

RG presented the tabled Report (SET/73/26) noting RCRP is a UK wide initiative designed to ensure those experiencing health or social care crisis – particularly in respect of mental health – are supported by the most appropriate statutory agency rather than defaulting to police involvement.

Implementation and Concerns: **RG** advised PSNI were in the process of implementing RCRP in Northern Ireland which would pose substantial challenges given differences in funding and approach compared to England. **RG** explained concerns raised by both NIAS and Mental Health Directors about the high likelihood of service gaps and increased risk in the absence of careful, phased implementation as well as strong cross-agency co-ordination.

SMcC asked who would make the assessment of those suffering a mental health crisis at home and if the PSNI would still attend. **RG** replied work was ongoing on identifying where each agency's statutory function begins and ends before noting a recent joint workshop which had been helpful in raising awareness around key risks.

8.6 NEIGHBOURHOOD HEALTH & WELLBEING MODEL

VC presented the tabled Report (**SET/74/26**) explaining the DoH Reset Plan was based around 3 pillars of Stabilisation, Reform & Delivery with a focus on prevention by shifting resource into neighbourhood health care. **VC** explained the new Neighbourhood Model was now progressing at pace before outlining a number of key issues with efforts to formalise community initiatives focused on consistency, governance and outcome measurement.

Workshops and Team Formation: **VC** advised new Integrated Neighbourhood Teams will operate within the GP Federation footprint with an average population of 115,000 in each area. **VC** stated SET has 4 GP Federations – Lisburn, Ards, North Down and Down with South Belfast Federation bordering the SET area before summarising the likely membership for each team. **VC** also fed back on recent regional workshops held to define next steps.

SH asked how Members could be assured that the Integrated Neighbourhood Teams would be fully integrated across primary care, secondary care and the community/voluntary sectors. **SH** also asked how would SET measure outcomes to ensure improvement of health & well-being. **VC** replied that moving forward it was not envisaged that this would SET but much more of an equal partnership across the board. **VC** stated the intention would be to build on existing governance structures to ensure the capture of what was being achieved and to identify the appropriate metrics moving forward.

8.7 THIS IS OUR HEALTH PROGRAMME

HM presented the tabled Report (**SET/75/26**) outlining a PHA co-ordinated initiative based on the success of the Wigan Deal where local authorities focused on establishing what was important to their citizens so services could be tailored to focus on their priorities. **HM** stated PHA had launched a survey between May and June 2026 to reach a regional target of 20,000 and the ask of Trusts was to support the programme within existing resource by releasing staff to carry out engagement sessions with patients, staff and the public as required.

JP asked if the target figure of 20,000 would be sufficient to capture the depth and scope required given NI's population is circa 2 million. **HM** stated her team had fed back areas where focus was required including connecting the Healthcare in Prison team with the initiative given they serve a hard to reach

group within society. **SH** asked about the role of the community and voluntary sector and **HM** provided further detail on the types of engagement mechanisms PHA were trialling including the use of board games to interact with the public as well as promoting the initiative through Community Planning Partnerships on which the community and voluntary sector are well-represented.

8.8 PEOPLE WORKFORCE 2025/26 YEAR END REPORT

CS presented the tabled Year-End Report (**SET/76/26**) covering workforce retention, flexible staffing costs, mandatory training and employee relations with discussion on agency use, appraisal rates and regional benchmarking. **CS** reported the figures in relation to the Management of Violence and Aggression had been included within the Report. **CS** also highlighted the timeliness of today's NIAO publication titled '*The Use of Temporary Nursing Staff in Northern Ireland*' which would be added to the External Report Register.

Retention and Agency Use: **CS** welcomed SET's high staff retention rate of 92.3% with ongoing efforts to reduce agency spend and reliance as well as regular monitoring through agency reduction groups. **KD** stated it was important to recognise the valuable contribution of agency staff within the workforce.

Benchmarking: At the request of **KMcM**, **CS** agreed to provide regional benchmarking data on staff retention rates to determine if SET is ahead or in line with other HSC Trusts. **SMcC** asked if SET might assess the impact on the Management of Violence and Aggression following the introduction of the body worn camera pilot within UHD ED and **CS** agreed to review the figures on an ongoing basis.

Mandatory Training: **CS** explained mandatory training has been a real focus of the People & Culture Committee over the past year with SET's position having improved with a focus on seven core areas and appraisal rates being targeted for improvement by Directorate supported by HR business partners. Following feedback from **KMcM**, Members agreed there should be a review of mandatory training terminology and frequency as part of the CiC's regional work which **RC** agreed she would be communicated to the CiC.

Appraisal Improvement Plan Monitoring: **KD** referred to the relatively low levels of completed appraisals across a number of Directors and Members requested EMT monitor directorate-level appraisal improvement plans and report progress to the People & Culture Committee.

Exit Interview Data Collection: In addition, Members agreed there was a need to ensure exit interview data is collected and analysed across all areas to understand reasons for staff leaving beyond retirement.

9.0 COMMITTEE BUSINESS

9.1 MINUTE: REMUNERATION COMMITTEE – 13 OCTOBER 2025

Noted (**SET/77/26**).

9.2 MINUTE: GOVERNANCE ASSURANCE COMMITTEE – 21 JANUARY 2026

Noted (SET/78/26).

9.3 MINUTE: PEOPLE & CULTURE COMMITTEE – 22 JANUARY 2026

Noted (SET/76/26).

9.4 MINUTE: AUDIT COMMITTEE – 5 FEBRUARY 2026

Noted (SET/76/26).

9.5 MINUTE: AUDIT COMMITTEE – 2 APRIL 2026

Noted (SET/76/26).

9.6 MINUTE: FINANCE & PERFORMANCE COMMITTEE – 23 FEBRUARY 2026

Noted (SET/76/26). RH advised there was discussion at the meeting on the need to escalate performance against the 4 hour and 12 hour Unscheduled Care targets but this had been superseded by the SIF escalation discussed earlier.

9.7 ANNUAL REPORT: AUDIT COMMITTEE 2025/26

Noted (SET/76/26). SH advised 15 Internal Audit reports were received during 2025/26 with several limited assurances but all recommendations due for implementation in 2025-26 were fully or partially completed and support planned for areas in the 2026-27 programme.

9.8 ANNUAL REPORT: GOVERNANCE ASSURANCE COMMITTEE 2025/26

Noted (SET/84/26).

9.9 ANNUAL REPORT: ADOPTION PANEL 2024/25

Noted (SET/85/26) with MLS recording her thanks to all panel members involved as making an invaluable contribution to this important area of work.

9.10 UPDATES FROM DESIGNATED NON-EXECUTIVE DIRECTORS

Members noted the tabled Reports from each designated Non-Executive Director (SET/86/26) with JP advising this was the first occasion a new written template had been used to record each Report which would be refined over time.

10.0 ITEMS FOR NOTING

10.1 REPORT ON THE USE OF THE COMMON SEAL

Noted (SET/87/26).

10.2 EXTERNAL REPORT REGISTER: RECENT ADDITIONS

Noted (**SET/88/26**) with **JP** explaining this was the first written Report for this agenda item negating the need to table each individual publication received.

10.3 TRUST BOARD REGISTER OF INTERESTS 2026/27

Noted (**SET/89/26**) with **JP** confirming the revised Register would be published online in due course.

10.4 HOSPITAL PARKING CHARGES BILL UPDATE

Noted (**SET/90/26**).

10.5 RURAL NEEDS MONITORING ANNUAL REPORT 2025/26: REVISED SUBMISSION ARRANGEMENTS

CS advised the aforementioned Annual Report would usually be tabled for decision by this Board meeting each year but following receipt of revised submission arrangements from DAERA the draft covering 2025/26 would be tabled at the Board meeting in September 2026.

10.6 WRITTEN QUESTIONS SUBMITTED TO TRUST BOARD

Noted (**SET/91/26**).

11.0 ANY OTHER BUSINESS

None.

12.0 DATE AND VENUE OF NEXT MEETING

JP advised the next Public meeting would be held on Wednesday 24 June 2026 at 2.30pm in the QIIC Hub, Trust Headquarters, Ulster Hospital, Dundonald before closing the meeting at 4.55pm.