

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

Minutes of an Extraordinary Public Meeting of the South Eastern Health & Social Care Trust Board held on Thursday 27 August 2026 at 2pm 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**) (*via MS Teams*)
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 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 ATTENDANCE: Mrs M McNally, Assistant Director, Risk Management & Governance/Board Secretary (**MMcN**)
Ms J Loughrey, Head of Communications (**JL**)
Mr S Martin, Board Assurance Manager (minutes)

OPENING REMARKS

The Chair (JP) welcomed everyone in attendance noting today's extraordinary meeting had been called to consider the implementation of proposed so-called Phase 2 measures in order to reduce the current projected 2026/27 budgetary deficit and to discuss the SIF Level 4 status as neither issue could wait until the next Board meeting scheduled for 30 September 2026.

JP extended a particular welcome to Ms Gillian Foley, Trade Union Chair, who was observing proceedings together with a number of her Trade Union colleagues before advising the meeting would be recorded for minute-taking purposes.

1.0 APOLOGIES

Mr N McKinley (Non-Executive Director).

2.0 DECLARATIONS OF POTENTIAL CONFLICTS OF INTEREST

None declared.

3.0 CHAIR'S BUSINESS

None.

4.0 CHIEF EXECUTIVE'S BUSINESS

None.

5.0 MINUTE OF PREVIOUS MEETING HELD ON 24 JUNE 2026

Approved subject to an agreed minor typographical amendment proposed by **SMcC**.

6.0 MATTERS ARISING

Noted (**SET/131/26**). **JP** noted 7 actions all of which are in train and or will be dealt with at September's meeting.

7.0 ITEMS FOR DECISION

7.1 FINANCIAL PLAN

RC summarised the current outlook facing HSCNI with Trusts working together to respond to DoH/SPPG's direction to deliver 4% savings this year as well as each of the next two financial years. **RC** stated the 4% had been removed from the Trust's opening indicative budget allocation following identification of an overall £800m gap in funding for DoH based on draft budget figures. **RC** commented that staff were best placed to inform how to make most efficient use of available resources adding EMT was in support of this year's Pay Award and hopeful this would be delivered following agreement of the NI budget. **RC** emphasised how challenging this will be to deliver for all HSC organisations and explained how the process to date for all Trusts had involved the identification of Phase 1 savings totalling £203m. **RC** stated these Phase 1 savings have been assessed as having Low impact on services and have moved into planning/delivery stage. **RC** continued that Phase 2 proposals are being considered by all Trust Boards today to agree plans to deliver a further £72m of savings in total. **RC** stated SET's approach remained on working in partnership regionally, acknowledging the immense efforts made by staff to date, supporting them in the delivery of all savings while continuing ongoing engagement efforts with colleagues, trade union and elected representatives.

WT then spoke to the tabled presentation (**SET/132/26**) outlining the various measures proposed as part of Phase 2 focusing on admin modernisation to harness the benefits of Encompass, vacancy control, diagnostic reform to streamline the use of labs, supplier optimisation, a move to the cessation of the use of agency staffing through stabilising our permanent workforce and the cessation of the UHD Phone First service. **WT** explained the Minister had

confirmed he was content for SET to proceed with the Phase 2 measures totalling £15.6m and confirmed relevant screening exercises had been attended to. On this basis, **WT** recommended approval of the proposed measures for implementation.

JP advised he had agreed to a written request for speaking rights from Ms Gillian Foley (**GF**) on behalf of Trade Union colleagues and invited GF to address the meeting. **GF** expressed UNISON's concerns with the proposals before the Board as they believe they would negatively impact patients, service users and the wider workforce. **GF** noted the plan represented only the first year of a projected 3 year cycle in what SET will be expected to cut spending so Trust Board must understand the combined effect that such cuts might have across multiple years on patients and service users particularly those experiencing health inequalities and on staff.

GF placed on record that Trade Unions was not satisfied SET had followed its obligations to consult effectively with them as staff representatives or with the public adding there were specific obligations to consult and negotiate with all recognised Trade Unions. **GF** requested full disclosure of all relevant information in relation to the proposals noting legal obligations to assess the impact of significant decisions and to consult appropriately.

GF stated UNISON were opposed to cuts that would damage the health of the public or negatively affect staff and stated there was no doubt political leaders must bear responsibility for public services not being funded based on need. **GF** emphasised there remained an obligation on Trust Board to push back against budgetary allocations that would not allow SET to meet its duty to provide services to the public. **GF** emphasised Trade Unions do not accept that where actions such as these are proposed to tackle budget shortfalls that they can enable effective reform. **GF** highlighted the proposals envisaged further reducing spending on agency staff and UNISON would continue to work alongside employers as well as DoH to reduce such spending with the aim of reinvesting into permanent posts and the non-agency workforce. **GF** stated they were concerned by any proposals to control vacancies or reduce recruitment activity and explained that, with services already overstretched and understaffed, controlling vacancies where they arise would negatively impact on morale and place staff who remain in post under even greater pressure. **GF** concluded by calling on Members not to agree to cuts in the budget as they will damage services as well as impact negatively on service users and staff.

RH asked what the level of consultation had been with Trade Unions and **CS** explained there had been a meeting yesterday prior to communication out to all staff which would be followed up by a further email to staff and a 'Keeping in the Loop' session scheduled for next week. **RH** sought to clarify if there had been any meetings prior to this week and **CS** replied there had been regular updates provided as part of scheduled JNCF meetings. **RC** stated communication and engagement was vital at all levels including with trade union colleagues so there are no surprises for staff, the public and elected representatives. **RC** referred to discussions through each Directorate staff forum, internal 'Keeping in the Loop' sessions with one scheduled for next Thursday, engagement at regional level between DoH and Trade Unions

centrally as well as elected representatives briefings with one due to be issued after today's meeting.

KMcM placed on record the Board had concerns about the impact on patient safety and emphasised Members' commitment to staff which he hoped would give some comfort to Trade Union representatives. **SMcC** stated that, as we are moving into Phase 2, it will become more difficult so asked for a clear engagement plan with scheduled meetings with Trade Unions so they are clear how SET intend to implement the proposals.

KD sought clarity from Trade Unions on when they have been engaged with on the equality screening process for Phase 2. **GF** advised she had seen the details as part of today's presentation but had not previously adding she assumed relevant documents would be made available after the meeting. **HM** outlined the process to date and emphasised they were living documents with **CS** advising equality screening documents were published quarterly on the Trust's website with the next round due soon though this set may fall into the next quarter after this one as they are subject to ongoing change.

HM advised Phase 1 equality screening would be published in line with the explained equality obligations and explained the difference between screening and assessment noting equality assessments are carried out if the screening articulates that, despite mitigating actions being taken, a S75 group is going to be affected and if a decision is made to continue this would lead to consideration if consultation was required. **HM** stated at that point equality assessment documents would be published as and when a public consultation commences. **JP** sought detail on the equality screening outcomes and **HM** advised they had been found to be of lower/minor impact. **SMcC** said it was important to engage consistently in two way feedback and asked that all relevant documents be provided to Trade Unions which **RC** agreed to take as an action.

AQ stated she welcomed the presence of Trade Union colleagues and asked what appetite and process was there for adjusting plans as we go along such as incorporating feedback from clinicians. **WT** advised this would remain part of SET's ongoing engagement which would remain focused on the how and the when with the latter usually the most important element. **AQ** stated this was great to hear as she was aware of previous discussions around risk, patient safety and the importance of listening to staff. **RC** stated these are the only significant areas approved to date noting some areas were already over-delivering so there was need to balance in advance of winter.

SH referred to SPPG's Planning Guidance objectives to not only make the required savings but that we are also tasked with delivering improvements in core business and asked which services are being targeted for improvement through these plans, what data is being used to drive the improvements and how will performance and impact be monitored before suggesting the Neighbourhood Model as an example. **WT** replied that the focus in Phase 2 measures on stabilising our workforce through a move to cease agency usage was a key element in improving services as SET will not be able to achieve what is being asked without a stable workforce. **WT** invited EMT colleagues to comment on improvement work within their areas.

BMcF referred to the diagnostic reform plans and provided detail on how this would be taken forward regionally. **RG** highlighted the Neighbourhood Model as well as Mental Health, Learning Disability and Dementia Services as key areas where SET had guided ideas regionally. **RG** reported on a significant decrease in dementia admissions and how changes at MAH resulted in an intensive support team at home being established within Learning Disability Services. **VC** outlined multiple new initiatives within PCOP including the Hospital at Home pathway and the Community Appointment Days (CAD) - the results of which had exceeding expectations.

MLS explained work was progressing on the Together for Families project supported regionally via £30m from the National Lottery and £29m from Transformation funding with SET focusing on the Edge of Care Service which was playing its part in a decrease in number of children entering residential care. **SH** stated it was encouraging to hear about these local examples adding it was important to not only focus on achieving savings but to also celebrate genuine transformation of services. **KMcM** welcomed the fresh funding available to support Together for Families before asking if the Minister's 'Shift Left' initiative would continue to be meaningfully driven given the budgetary pressures. **RC** stated the reality was frail elderly patients often do not want to leave home and she was passionate about exploring how resources can be shifted to support this work.

RC stated it was key to continue driving out savings and accelerate efficiencies arising from Encompass before referring to recent engagement with Airedale NHS Foundation Trust on how they supported over 500 care homes to significantly reduce conveyance to Hospital and subsequent hospital admissions which had reduced bed days as a good case study of how 'Shift Left' can be developed. **KMcM** asked for clarity on investment needed to build up the Neighbourhood Model and **WT** stated DoH/SPPG have not confirmed how the funding model will operate but there have been no reductions in Trust budgets to move funds to other parts of the system.

SMcC referred to the targeted review of high cost placements (HCPs) which presumably may impact the most vulnerable and asked what mitigations were there to ensure they are not disproportionately affected. **VC** explained HCPs had developed in recent years as a business model of advanced case which were now proving to be inflexible. **VC** advised her team were managing high workloads with comprehensive assessments of need needed for each individual to be continually reviewed adding there may be a reduction on some levels of care but this would be appropriate and Trust led. **SMcC** asked how this was being monitored and **VC** replied SET had a full list of those with a HCP. **JP** asked if there would be any impact on waiting lists and **BMcF** replied there was no direct link to elective activity but he remained mindful of indirect impact. **JP** asked what impact the removal of Phone First might have and **MN** replied the clinical team were supportive given the objective on implementing Phone First was to separate urgent and emergency had already been achieved through the opening of the Urgent Care Centre (UCC). **MN** added that, since the UCC had opened, Phone First was now – at times - an additional step in patients receiving timely care.

Following discussion, **JP** sought and obtained approval. **JP** stated this had not been without pain and was a situation Members would like not to be in but given HSCNI was currently spending circa £2m a day in excess of budget it was crucial to strive to be as efficient and effective as possible.

8.0 **ITEMS FOR ASSURANCE**

8.1 **SUPPORT & INTERVENTION FRAMEWORK (SIF) UPDATE**

HM introduced the tabled paper (**SET/133/26**) and provided an update.

RH welcomed the progress made and asked what process in particular had improved. **SK** replied there had been no single factor noting there has been much focus on the hospital's front and back doors but less on the elements in between. **SK** explained he were working across teams to use the acute medical unit as a funnel for all patients coming into UHD to improve 12 hr wait times as these were impacted by having non-designated ED beds. **SK** summarised ongoing engagement with clinical teams which had brought forward new ideas on how to update long-standing practices. **RH** also sought an update on the Release to Rescue initiative and **SK** replied it was a 'chicken and egg' indicator linked to ED capacity for which the upstream elements of patient flow working well remained crucial.

AQ noted SPPG's feedback and asked if they were fully aware of the challenges. **SK** replied SET was in the phase of readjusting the current system with **DR** adding SPPG were appreciative of SET's efforts evidenced by the improved position since February 2026 with performance currently sitting at 92% with the longest wait being over 5 hours. **AQ** stated it was positive to hear that changes were being led by staff rather than being done onto SET adding as changes are immersed into practice it was worthy of consideration how this could be communicated both internally and externally. **SMcC** asked about the number of ED staff absent and what more support could be offered. **SK** advised ill-health absence was long-term and colleagues were coping well in managing cover but consideration will be needed to clinical impact is maximised going forward.

JP noted ED attendances had not yet shifting significantly down and asked how do SET might further influence 'No' flow. **VC** explained how there was a twice daily NIAS conversation and SET was in the process of developing a single point of contact for NIAS so we would co-ordinate pathways to ensure patients receives the appropriate level of care. **VC** highlighted ongoing education and training to assist in decision-making. **MN** noted patients attending ED themselves had minimal correlation with ambulance handover performance but the number of admissions (DTAs) had significant impact and number of admissions being co-ordinated. **MN** stated ED attendance had been stable throughout the year and referred to recent feedback from DoH's 'This Is Our Health' initiative which found the public's top concern was access to general practice which linked to ED attendances.

JP referred to 12 hour waits and numbers waiting in excess of 2 hours before asking how SET could make further impact there given there must be an element of risk to patient safety. **MN** stated ED had been impacted by staff

absence but 11 Clinical Fellows had recently joined and stabilised the rota. **KMcM** commented on some of the positive numbers albeit NIAS attendances have gone up slightly. **KMcM** asked where did SPPG's current concerns lie given the plans just approved would see a further 20 beds taken down. **DR** replied SPPG remained concerned about the potential for escalation and SET's ability to sustain progress as winter approaches.

HM stated this had been subject of discussion over several months and it was recognised the system would benefit from a 'Health Needs Assessment' adding SET was focused on reducing length of stay by specialism not simply the headline rate.

9.0 ANY OTHER BUSINESS

None.

10.0 DATE AND VENUE OF NEXT MEETING

JP advised the next Public meeting would be held on Wednesday 30 September 2026 at 2.30pm in the QIIC Hub, Trust Headquarters, Ulster Hospital, Dundonald before closing the meeting at 3.29pm.