

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

Minutes of the Governance Assurance Committee Meeting held on Wednesday 29 April 2026 at 2pm in the Boardroom HQ and via Microsoft Teams

PRESENT:	Mr N McKinley, Non-Executive Director (Chair) Mr K Donaghy, Non-Executive Director Mrs A Quirk, Non-Executive Director Ms S McCauley, Non-Executive Mr K McMahon, Non-Executive Director Dr Robinson, Deputy Chief Executive, Executive Director of Nursing, Midwifery & AHPs, Director of Support Services Professor S Kirk, Medical Director Mrs Gibbs, Director of Adult Services & Healthcare in Prisons Mr B McFetridge, Director of Surgery, Elective Care, Maternity & Paediatrics Mr M Neil, Director of Unscheduled Care, Medicine & Cancer Mrs Cleland, Interim Director of Primary Care & Older People’s Services Mrs Moore, Director of Planning, Performance and Informatics Mrs M L Sloan, Director of Children’s Services & Executive Director of Social Work
IN ATTENDANCE:	Mrs M McNally, Assistant Director, Risk Management & Governance/Trust Board Secretary Mrs C Boyd, Emergency Planning & Systems Senior Manager Mrs T Glover, Risk Management & Governance Adviser (minute taker)
<u>CHAIRMAN’S OPENING REMARKS</u>	
Mr McKinley welcomed members to the meeting, including those attending remotely, and confirmed apologies as recorded. Members were thanked for their engagement and contributions, noting the volume and complexity of matters being overseen by the Committee. Mr McKinley confirmed that the meeting was quorate, and that he had received comments from Mrs Henderson in respect of the papers which will be addressed through the agenda.	
1.0	<u>APOLOGIES</u>
	Ms Coulter (Chief Executive), Mrs S Henderson, Non-Executive Director, Ms W Thompson, (Deputy Chief Executive, Director of Finance, Contracts & Estates) Mrs C Smyth, (Director of People & Organisational Development), Mr R Havlin, Non-Executive Director, Mr J Patton, Chair of Trust Board, Ms I Dullaghan (Assistant Director for Safe & Effective Care), Mrs V Walker, Head of Risk Management Advisory Services
2.0	<u>DECLARATION OF POTENTIAL CONFLICT OF INTERESTS WITH ANY BUSINESS ITEMS ON THE AGENDA</u>
	None declared.
3.0	<u>MINUTE OF MEETING HELD ON 21 January 2026</u>

	The minutes of the meeting held on 21 January 2026 were approved without further amendment.		
4.0	<u>MATTERS ARISING</u>		
	Members noted SET/GAC/28/26 with matters either completed or an updated provided, no further clarification was sought.		
5.0	<u>ITEMS FOR DISCUSSION</u>		
	5.1.(i)	<u>Risk Management Quarterly Report: Q4 2025/26</u>	
		Members received, for discussion, paper SET/GAC/29/26, with Mrs Boyd providing a brief synopsis of the key issues. Mrs Boyd presented the Risk Management Quarterly Report, highlighting 1,875 overdue incidents and 22 catastrophic incidents (18 deaths, three physical harm incidents and one natural cause), with the majority occurring within mental health services and prisons. 865 new complaints were recorded during the period, primarily within prison healthcare, with 961 complaints closed, 67% at stage one. The predominant learning themes remained consistent and related to communication, documentation, staff training and elements of clinical practice. During discussion, members raised concerns regarding overdue stage one complaints, noting that pressure within services was contributing to resistance to escalation. The Committee discussed the risk that delays increase the likelihood of escalation to stage two, Ombudsman investigation, political scrutiny and potential legal challenge. Mrs McNally confirmed that Ombudsman referrals had increased across the region and advised that the revised report would include a synopsis of learning and recommendations arising from closed cases. Mr McKinley welcomed the strengthening of the learning section within the report and highlighted that the recurring themes remained unchanged. Mrs McNally emphasised the importance of ensuring that learning not only be identified but demonstrably linked to improvement actions. It was confirmed that compliments data would be incorporated into future quarterly reports, commencing Quarter 1 2026/27. Mr Donaghy highlighted the increase in Healthcare in Prison (HiP) complaints. Mrs Gibbs advised that the increase reflected the new recording and reporting processes, rather than new or emerging issues, and outlined ongoing risks associated with prison overcrowding and staff safety. She confirmed that additional funding had been secured, the health mentor programme had been expanded, and that while many complaints were resolved at frontline level, escalation to the Departments of Justice and Health remained	MMcN

	ongoing due to environmental challenges. Mrs McNally referred to correspondence from Mrs Henderson on this issue and noted that NIPSO had confirmed HiP would not be treated as an exception under the Model Complaints Handling Procedure (MCHP). Mr Donaghy raised concerns regarding the prison working environment and queried whether any formal arrangements with justice partners were in place to improve conditions. Mrs Gibbs advised that violent incidents had reduced significantly over the past decade, with recent increases linked to rising prison population levels, and that the Department of Justice Permanent Secretary was working with the Minister of Justice on policing and justice decision-making. Mrs McNally advised that the Complaints Task and Finish Group had been stood down and replaced by a standing agenda item at the Governance Forum. A backlog of legacy complaints, largely pre-MCHP remained. Mr McKinley expressed concern regarding the volume of overdue complaints, both pre- and post-MCHP, and Professor Kirk noted that the complaints and SAI backlogs presented similar challenges. Mr McMahon expressed concern that while short-term delays may be understandable, a significant number of complaints remained outstanding beyond approximately nine days, with limited clarity on what actions or resources would unlock progress. It was acknowledged that many complaints require direct engagement with complainants and are therefore time-intensive. Members noted that prolonged delays increased the likelihood of complaints escalating to political, Ombudsman or legal challenge. Professor Kirk emphasised the need to better understand the specific constraints preventing progression, including workforce capacity within the complaints service and wider system pressures, and stressed that complaints and SAIs carry a particular negative impact on public confidence, warranting enhanced focus and prioritisation. Mr McMahon further challenged that current Board assurance on complaints does not constitute meaningful assurance, as it relies primarily on high-level performance data without sufficient detail to evidence grip, recovery or sustained improvement. He highlighted a sustained and growing cohort of complaints exceeding 50 days, with concern that further complaints were likely to drift into this category, and questioned whether delays reflected resourcing constraints, prioritisation issues, or unclear accountability, and what consequences existed for non-progression. Mrs Clelland highlighted significant pressures arising from understaffing within the complaints service. Mrs McNally outlined mitigating actions, including a weekly governance call and monthly EMT performance reporting. However, members expressed concern that attempting to address legacy backlogs while implementing new	
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		governance arrangements risked eroding organisational confidence and staff morale unless issues were demonstrably being closed.	
	5.1.(ii)	<u>SAI Backlog Overview</u>	
		Members received, for discussion, SET/GAC/30/26 Mrs Glover provided an update on the Serious Adverse Incident position. It was noted that the Trust had not met the March 2026 target set by the SPPG and that a revised staged trajectory had been agreed. This required a reduction in overdue SAIs to no more than 40 per cent by the end of May, 35 per cent by the end of July and 30 per cent by the end of September 2026. Members acknowledged the difficult position faced by services, given the need not only to reduce the existing backlog but also to prevent additional incidents from becoming overdue. The Committee expressed concern regarding the length and complexity of Level 1SAI reports, noting that current service requirements were contributing to delays and diverting clinical and managerial time away from improvement activity. There was strong consensus that reports needed to be proportionate, focused and written with families firmly in mind. Professor Kirk reiterated that families primarily wished to understand what had happened, what had been identified through the investigation, and what would change as a result, and that clarity in these areas was essential to maintaining trust. The Committee noted ongoing work to develop exemplary SAI report templates, including specific consideration of suicide-related cases, where achieving an appropriate, compassionate tone for families was recognised as particularly challenging. It was confirmed that additional support would be offered to directorates and Assistant Directors where required, including direct engagement if this would assist in progressing cases. Professor Kirk highlighted that prolonged delays in completing SAIs carried a significant risk of being perceived as concealment, regardless of intent, and could escalate concerns further. The Committee agreed that the current position regarding the SAI backlog, the revised trajectory, and the associated system-level risk should be escalated to Trust Board. This escalation was considered necessary in light of sustained delivery pressures, workforce constraints, and the potential regulatory and reputational implications for the organisation. Members considered it important that the Board maintained visibility of these issues and the mitigations in place. Mrs Quirk raised two linked questions spanning both the complaints process and SAIs. Firstly, while the quarterly report indicated that no new dominant themes had emerged during the reporting period, Ms Quirk queried whether it would be possible to understand what	

	elements of complaints and SAIs related specifically to maternity services, in order to correlate learning against the recommendations arising from the Renfrew Report. She further asked whether learning continued to be identified within other mandated areas where directives already exist, and how emerging themes in these areas were being addressed. Secondly, Ms Quirk reflected on the resourcing challenges outlined during discussion and questioned at what point a conscious decision would be taken to reallocate resources to address the backlog of complaints and SAIs, as opposed to accepting the risk of continued escalation and progression through Level 2, 3 and 4 on the SIF. She noted that there was no straightforward answer to this but highlighted the importance of understanding how such decisions were being considered. Professor Kirk advised that resource for complaints and SAI management sits primarily within directorates, and that it is considered appropriate for directorates to manage and deploy this resource, supported by the Risk Management Advisory Service. It was noted that local ownership is a key factor in sustaining learning and preventing recurrence, although it was acknowledged that there is not currently full visibility over the specific level of resource allocated within each directorate, and that this may be contributing to variability in progress. Professor Kirk emphasised that system failures are often multifactorial. It was acknowledged, however, that when incidents occur within maternity services, they are typically highly complex and of significant impact and therefore require particular focus. It was further noted that the emphasis of the Trust's approach is on simplifying reports and distilling salient learning, rather than detailed chronology, in order to ensure clarity on what actions are required to prevent recurrence. Mrs McNally confirmed that further work is planned, including a dedicated workshop, to review emerging learning and strengthen understanding of themes and improvement actions. Mr McFetridge advised that a SEMP directorate workshop would also be convened to support a detailed review of the current risk position, learning and mitigations, and to consider opportunities to rationalise risks where appropriate. Mrs Gibbs highlighted particular challenges associated with the SAI process within mental health services. It was noted that historic and ongoing underinvestment has resulted in sustained service pressures, with staff frequently required to undertake complex SAI investigations, often relating to suicide, alongside already stretched clinical workloads. Mrs Gibbs expressed frustration that the new Patient Safety Framework guidance had yet to be received, which early indications suggested that revised criteria around suicide and service engagement would change the number of reviews required. Mr McMahon reflected on previous discussions at Trust Board and within reports, noting consistent and recurring themes emerging	
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		across complaints and SAIs, particularly in relation to communication and documentation. He acknowledged that assurances had previously been provided that patients were not coming to harm; however, concern was expressed that the persistence of these themes indicated that sustainable change had not yet been fully embedded. While recognising the significant pressures faced within services, particular concern was raised that progressing within the SIF from Level 1 to Level 2 would not in itself deliver benefit and may further weaken the Trust's overall assurance position. It was noted that escalation elsewhere, including potential movement towards Level 4, would present additional challenge for the organisation. Discussion also highlighted concerns regarding proposed revised SPPG trajectories for overdue SAIs, including the risk of agreeing targets that may not be realistically achievable and the potential for further escalation within the SIF. Ms McCauley emphasised the importance of ensuring that assurance provided to SPPG accurately reflects both progress made and the material constraints faced by services. Members agreed to escalate both SAI and Complaint backlogs to Trust Board.	
	5.2	<u>Independent Inquiry Recommendations Implementation Oversight Meeting Group</u>	
		Members received, for discussion, (SET/GAC/31/26) Professor Kirk noted that there were no significant new updates in relation to national independent inquiries, with the summary of reports and recommendations set out within the paper table. Professor Kirk reported that, not all recommendations have been fully accepted by government. Locally, it was confirmed that 36 recommendations arising from the Neurology Inquiry have been implemented, with the exception of one outstanding issue relating to the definition of lone working. It was noted that the Trust has proposed a distinction between lone working and working alone, and while some procedural clarification remains outstanding, there is assurance that staff are not operating within unsafe lone-working arrangements, notwithstanding that some staff continue to work alone in defined contexts. Professor Kirk advised that the Urology Inquiry report, which was due for publication, had not yet been issued. It was noted that early intelligence suggests that the themes are likely to mirror those identified within the Neurology Inquiry, including poor team working, failures in communication, and lack of responsiveness to concerns, though this has yet to be formally confirmed. In relation to the Infected Blood Inquiry, Professor Kirk confirmed that the Trust continues to contribute to local review activity, including engagement by a Trust haematologist. It was noted that	

		some recommendations relating to blood and theatre practices are already implemented within the Trust, and therefore no material change to the Trust's position had been identified at this stage.	
	5.3	<u>Sharing the Learning – Identification of QI initiatives from SAls</u>	
		Members received, for discussion, (SET/GAC/32/26) Mrs McNally provided an overview of the thematic analysis of SAls. It was noted that consistent themes continued to emerge across services, notably communication failures, weaknesses in documentation, issues with recognition and escalation, and non-adherence to guidelines alongside broader system failures. Mrs McNally acknowledged the substantial work undertaken to identify these themes and noted that learning had been passed to the Quality Improvement Team. The Committee emphasised that assurance would ultimately depend on understanding how this learning was being translated into tangible improvement. Members requested further clarity regarding ownership of actions, the specific interventions planned, how priority areas would be selected, and how the impact of change would be measured and reported back to the Committee. The importance of closing the loop between learning and demonstrable improvement was strongly emphasised. Mrs McNally advised that a clearer section would be added to the quarterly report to set out the governance route for ownership of learning, including the role of the QI Team, consideration through the Sharing Learning Group, and escalation through the established governance reporting structure. It was agreed that clarifying accountability and reporting arrangements would support the Committee in gaining assurance that learning is being adopted and embedded.	MMcN
	5.4	<u>Integrated Governance Assurance Framework – Update</u>	
		Mrs McNally advised that the IGAF is subject to annual review and update. She was explained that the current version has not yet been published or re-uploaded to the Trust website, pending agreement on the Terms of Reference for the PSQC and the associated governance arrangements set out within the IGAF. Mrs McNally noted that, until formal approval is secured, the document cannot be finalised for publication. Mrs McNally further advised that the IGAF is also undergoing additional review of the 'Just Culture' section, to ensure alignment with the recently introduced Being Open Framework and the Human Factors framework, and to ensure consistency of language and intent across governance, safety and culture-related documentation. Mrs McNally described this work as necessary to ensure the Trust is "talking the same language" across its governance framework.	

5.5	<u>PPI Involvement Report Q3 2025-26</u>	
	Members received, for discussion, (SET/GAC/33/26) Dr Robinson explained that, following Trust Board feedback, the work had been taken forward through the Involvement and Experience Committee, with the aim of presenting information in a way that was more meaningful and accessible, while also reflecting experience across services rather than being limited solely to nursing and midwifery. Dr Robinson described collaborative work with teams to develop a dashboard approach, incorporating both involvement and experience data, including headline figures at directorate level. Members were advised that the dashboard had been received positively across directorates, providing improved visibility compared to previous reporting, while also prompting further discussion and enquiry. Attention was drawn to specific elements of the dashboard, including a section presenting Care Opinion stories, which offer insight into levels of criticality, ratings, response types and themes, alongside examples of improvement activity within directorates. It was noted that this element was particularly relevant to Trust Board discussion, including representation from members of the public, as it provides a clearer sense of lived experience. Mr Donaghy welcomed the work and highlighted the significant volume of positive feedback captured through Care Opinion, noting that despite ongoing pressures and constraints within services, levels of confidence and trust remained high. He emphasised the importance of finding more effective ways to promote and share positive experience and good news stories, both internally and through governance forums. Mr McKinley highlighted that this was not solely an issue of escalation, but of visibility and awareness at Trust Board level, and referenced previous discussions with the Chair regarding how best to promote this information. It was further noted that agreement had previously been reached on how different elements of the Nursing and Midwifery Experience Quarterly Report should be routed through governance committees, with relevant safety and quality metrics considered by appropriate forums, involvement and experience data reviewed through the relevant committee structures, and assurance ultimately provided through Trust Board sign-off. It was confirmed that any matters requiring escalation to Trust Board could be brought forward through this process.	
6.0	<u>ITEMS FOR APPROVAL</u>	

6.1	<u>Risk Registers</u>	
6.1.(i)	<u>BAF Risk Document/Corporate Risk Register Q4</u> Members received for approval, SET/GAC/34/26 with Mrs Glover providing a brief overview of the quarterly developments. It was noted that there had been no new risks added to or closed from the Board Assurance Framework during Quarter 4. The financial stability risk had achieved its target score, while all other BAF risks remained consistent with the previous quarter. Members noted that the assurance heat map had been extended to cover all BAF and Corporate Risk Register risks, in line with Internal Audit recommendation. It was acknowledged that directorates had experienced some difficulty completing the expanded heat map, given the additional requirements. Members nevertheless emphasised the importance of completing this work ahead of the May approval cycle, in order to provide a robust assurance position. Mr McMahon queried whether any issues arising from recent audit outturns required consideration for inclusion on the risk registers, noting that two specific elements had been highlighted in recent papers and discussion. Mrs McNally clarified that while these matters had not been explicitly proposed for inclusion on the BAF or CRR at this stage, she advised that further discussion would take place with Directorates to review this position, and that any changes arising would be communicated. Members discussed the importance of ensuring that issues associated with limited assurance are appropriately captured and cross-referenced within the Trust's risk architecture. Mrs McNally noted that relevant risks may already be reflected at DRR level, with escalation dependent on scope, impact and ownership, and that not all risks would necessarily require inclusion on the CRR. Mrs McNally agreed to cross-check to confirm whether the matters raised were adequately reflected within existing registers and, if necessary, escalated appropriately. The Committee further noted that two new corporate risks had been opened during the quarter, that one risk had reduced in score, and that seven directorate risks had been closed, leaving a total of 156 DRRs open risks at quarter end.	MMcN MMcN
6.1.2	<u>Directorate Risk Register - Schedule</u>	

		<u>Planning Performance and Informatics</u> Members received, for review, SET/GAC/35/26. Mrs Moore referenced PPI/PIC/01- Failure to meet Levels of performance identified through System Oversight Measures and advised that issues discussed align with findings from a recent internal audit, with further work underway to ensure appropriate risk wording, grading and assurance. Mrs Moore noted that the most significant risks relate to technology and telecommunications, within the broader context of cyber security, technical debt and service resilience, (PPI/ICT/68, PPI/ICT/99 & PPI/ICT/46). Learning from a recent ICT outage review in another Trust has prompted consideration of clearer separation of these risks, with work progressing on a regionally aligned basis. These risks are currently on the DRR, with escalation to the CRR or BAF to be considered through established governance processes. <u>Primary Care & Older People</u> Members received, for review, SET/GAC/36/26 Mrs Clelland advised that a recent review had identified several changes, including issues relating to system reporting capability and business access, and staffing pressures within specific services, notably podiatry. It was noted that several risks would be removed or updated, with some posts progressing through vacancy control as priority clinical roles, and active recruitment continuing in areas such as statutory home care. Ongoing concerns relating to finances PC/AHP/01 and Mental Capacity Act compliance PCOP/ALL/01 were noted, with actions in progress. Members were further advised that an interim solution has been agreed for the GP Out-of-Hours call-handling system, which is no longer fit for purpose, pending implementation of a replacement PCOP/OOH/01. <u>Surgery, Elective Care Maternity</u> Members received, for review, SET/GAC/37/26 Mr McFetridge confirmed that a workshop is planned with the Directorate team to review the register in detail, including opportunities to rationalise and combine risks where appropriate. Mr McFetridge referred to risk WACH/MAT/10 the absence of a dedicated elective caesarean section list, with work ongoing to address job planning and scheduling arrangements. It was noted risks relating to the capacity of the gynaecology assessment unit, where staffing and process improvements are expected to reduce risk. (WACH/Gynae/04) Mr McFetridge reported that the risk WACH/Gynae/03 associated with the termination of pregnancy service has been mitigated through successful recruitment, with improvement anticipated in the next quarter.	
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		Ongoing work was noted in relation to WACH/PHARM/05 chemotherapy prescribing, with mitigations in place through regional working and use of the JAC system. Mr McFetridge advised of emerging improvement within audiology services, with increased activity and backlog reduction following additional input, although demand pressures remain. (WACH/Audio/001) Mr McKinley welcomed the closure of the midwifery workforce risk, noting sustained improvement and positive recruitment outcomes, and acknowledged this as a significant achievement following a prolonged period of challenge. (WACH/MAT/04)	
	6.2 (i)	<u>Review of Terms of Reference</u>	
		Members received, for approval, SET/GAC/38/26 Mr McKinley introduced the revised Terms of Reference (ToR), outlining the background and context for the review. Mrs McNally reminded members that the revisions had been informed by Departmental direction, regional discussion, and comparative review of existing Trust committee structures. It was noted that this work aimed to strengthen assurance around patient safety and quality, while ensuring clarity of purpose within the Integrated Governance Assurance Framework. The Committee discussed the approach taken to revising the ToR, which included: • Cross-referencing existing committee responsibilities. • Identifying gaps in assurance coverage; and • Excluding high-level statements where no clear metric or assurance mechanism could be applied. Members noted the importance of avoiding duplication across committees, recognising organisational capacity constraints and the need for this committee to focus on meaningful assurance rather than operational detail. The intention to ensure that all areas within the ToR could be evidenced through proportionate, measurable indicators was emphasised. Members discussed the next phase of work required to embed the revised role of the Patient Safety Quality Committee. Mrs McNally advised that further work is underway to map specific metrics to each element of the ToR, identify which subordinate committee provides assurance, and determine where unresolved gaps may need to be escalated, and work has commenced with Ms Dullaghan to ensure both CGC and SQIC can provide the required assurance and metrics. Mrs McNally highlighted this approach would support clearer lines of sight for members, reduce repetition across governance forums, and enhance the quality of assurance reporting to the Trust Board.	

		Members welcomed this approach and agreed that the proposed metrics mapping would be brought back to a future meeting for consideration. Members approved the revised Terms of Reference for onward recommendation to the Trust Board for final approval. Future meetings will be convened under the Patient Safety Quality Committee structure, subject to Trust Board approval, with this meeting constituting the final meeting of the Governance Assurance Committee.	MMcN
	6.2 (ii)	<u>Programme of Work 2026/27 – Draft</u>	
		Members received, for approval, SET/GAC/39/26 Mrs McNally presented the draft Programme of Work for 2026–27 consideration. Members noted that the programme reflected the committee’s core functions and priorities, while recognising that some refinement may be required once the revised ToR and assurance framework are fully implemented. The Programme of Work was approved, noting that it may be reviewed and updated if necessary following implementation of the revised committee arrangements.	
	6.2 (iii)	<u>Annual Report of Board Committee Effectiveness</u>	
		Members received, for approval, SET/GAC/40/26 Mr McKinley referred to the Committee Effectiveness Report, thanking Mrs McNally for incorporating previous feedback. Members noted that the report provides an overview of committee activity and effectiveness and aligns with the standard approach used across Trust subcommittees, supporting consistency of reporting. The Committee approved the Effectiveness Report for onward progression.	
7.0	<u>SUBCOMMITTEE BUSINESS</u>		
	7.1	<u>Approved Minutes: Safety, Quality Improvement & Innovation Sub-Committee – 05 December 2025</u>	
		Noted (SET/GAC/41/26).	
	7.2	<u>SQIIC Sub Committee reports</u> (i) Action Plan position report as of 30 March 2026 (ii) SQIIC Sub-Committee Action Plan Updates Q4 2025/26 (iii) Action Plan position report for Action Plans 2026/27 (iv) SQIIC Report on NEW Sub-committee Action Plans 2026/27 (v) SQIIC Programme of Work 2026/27	

		Noted (SET/GAC/42-46/26).	
	7.3	<u>Approved Minutes: Corporate Governance Sub-Committee 14 January 2026</u>	
		Noted (SET/GAC/47/26)	
	7.4	<u>CGC Sub Committee reports</u> (i) Action Plan position report as of 31 March 2026 (ii) CGC Sub-Committee Action Plan Updates Q4 2025/26 (iii) Assurance Composite Report Summary 25-26 (iv) Programme of Work position report 25-26 (v) Position Report (as at end year 31 March 2026) (vi) CGC Programme of Work 2026/27 (vii) CGC Action Plan 2026/27	
		Noted (SET/GAC/48-54/26).	
	7.5	<u>Annual Report of Corporate Governance Committee Effectiveness 2025/26</u>	
		Noted (SET/GAC/55/26).	
	7.6	<u>Organisational Controls Assurance (End year position</u>	
		Noted (SET/GAC/56/26). Mrs McNally presented the end-year organisational controls assurance position. Members were reminded that controls assurance is reviewed on a mid-year and end-year basis, using structured criteria and supporting evidence. Members discussed the relationship between controls assurance and heat-map reporting, noting the importance of ensuring that risk ratings accurately reflect organisational position and are subject to appropriate challenge and review. The paper was noted, with no significant concerns raised at this stage.	
	7.7	<u>Issues for Information and Awareness from Sub Committees</u>	
		(i) DHIG - Cyber Programme - (SET/GAC/57/26) Mrs Moore provided an update on digital health, including ongoing cyber risk activity and the Windows 11 replacement programme. Members noted the complexity of the programme and its interdependencies across the organisation. (ii) DHIG - All third-party access to Encompass - (SET/GAC/58/26) Mrs Moore provided an update on third-party access to the Encompass system. Members noted the steps taken to establish a process for access management, while acknowledging limitations in capacity to carry out proactive auditing. It was recognised that this issue is not unique to the Trust and represents a regional and national challenge, requiring consistent handling and further discussion at programme board level	

8.0	<u>ITEMS FOR NOTING</u>		
	8.1	<u>Mental Capacity Act (NI) 2016 – update</u>	
		Noted (SET/GAC/59/26).	
	8.2	<u>Model Complaints Handling Process</u>	
		Noted (SET/GAC/60/26).	
	8.3	<u>Publication of Consultation Analysis Report – Regional Framework for Learning and Improvement from Patient Safety Incidents</u>	
		Noted (SET/GAC/61&62/26). Mrs McNally advised of recent response from the Department of Health regarding the new Patient Safety Framework. It was noted that the framework and associated documentation are still being finalised, taking account of consultation feedback, and have not yet been submitted for Ministerial consideration. Mrs McNally highlighted that a defined transition and implementation period is anticipated once the framework is finalised and confirmed, and that further updates will be brought to the Committee in due course.	
	8.4	<u>Learning from Medication Incidents</u>	
		Noted (SET/GAC/63/26).	
	8.5	<u>NIPSO – Quarterly Bulletin March 2026</u>	
		Noted (SET/GAC/64/26).	
	8.6	<u>Board Governance Self-Assessment Tool</u>	
		Noted (SET/GAC/65/26). Mrs McNally acknowledged receipt of correspondence regarding board governance assurance, including reference to the NIO governance checklist and the Board Governance Self-Assessment Tool. It was confirmed that assurance will continue to be provided through existing mechanisms, with any requirements overseen via the Audit Committee, avoiding duplication of effort. Members also noted that independent board governance reviews operate on a three-yearly cycle, with the last review undertaken in 2025.	
	8.7	<u>Internal Audit - Clinical Audit and Quality Assurance</u>	

		Noted (SET/GAC/66/26) . Mrs McNally provided an update confirming that a clinical audit action plan and governance oversight arrangements are now in place and are being monitored through the Audit Committee.	
	8.8	<u>IS Quarterly Report & Briefing paper</u>	
		Noted (SET/GAC/67&68/26) .	
	8.9	<u>Being Open Framework</u>	
		Noted (SET/GAC/69/26) .	
	8.10	<u>Covid Inquiry Update</u>	
		Noted (SET/GAC/70/26) .	
9.0	<u>ITEMS FOR ESCALATION TO TRUST BOARD</u>		
	Members agreed that the SAI backlog and Complaints backlog prior to the implementation of MCHP should be escalated for Board awareness and oversight.		
10.0	<u>ANY OTHER BUSINESS</u>		
	None.		
11.0	<u>DATE AND VENUE OF NEXT MEETING</u> Mr. McKinley thanked members and extended his appreciation to their teams for the wealth and detail of information provided to support the meeting. Mr McKinley confirmed that the next meeting will be held on Wednesday, 19 August 2026 at 2.00pm in the Innovation Centre QHC Hub and Microsoft Teams, Ulster Hospital, Dundonald, with the option for members to join via MS Teams, operating under the committee's new title, Patient Safety Quality Committee . The meeting was declared closed at 3.55pm.		