Southern Health and Social Care Trust

TOGETHER, IMPROVING CARE, TRANSFORMING LIVES

Minutes of Trust Board meeting held on Thursday, 28th May 2026 at 11.00 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT

Ms E Mullan, Chair (Left meeting at 1:00pm)
Mr S Spoerry, Interim Chief Executive (Left meeting at 1:00pm)
Mrs G Browne, Non-Executive Director
Mrs L Ensor, Non-Executive Director
Mr A Hughes, Non-Executive Director
Mr J Johnston, Non-Executive Director
Mr R Lynas, Non-Executive Director
Mr C Stewart, Non-Executive Director
Mrs M Corkey, Non-Executive Director
Dr S Austin, Executive Medical Director (Left meeting at 1:00pm)
Mrs C Marks, Executive Director of Finance, Procurement and Estates
Mrs G Hamilton, Executive Director of Nursing, Midwifery and Allied Health Professionals, Functional Support Services and IPC

IN ATTENDANCE

Ms E Wilson, Director of Planning, Performance and Informatics
Mr B Beattie, Director of Adult Community Services
Mrs T Mulholland, Assistant Director MUSC on behalf of Mrs D Burns and Mrs T Reid
Mrs V Toal, Director of Human Resources and Organisational Development
Mr D McClements, Interim Director of Surgery and Clinical Services
Mrs J McGall, Director Mental Health and Disability Services
Mrs D Murphy, Assistant Director CYPWS on behalf of Mr McCafferty
Mrs C McNally, Assistant Director of Primary Care (Item 8)
Mrs R Rogers, Head of Communications
Mr S Wallace, Head of Office (Minutes)

APOLOGIES

Mr C McCafferty, Deputy Chief Executive, Executive Director of Social Work / Director of Children, Young People and Women's Services
Mrs D Burns, Director of Operations, Adult and Community Services

Mrs T Reid, Director of Medicine and Unscheduled Care

1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed members and attendees to the meeting, including colleagues from the South Eastern Trust. Mr Jonathan Patton, Chair, and Mrs Martine McNally, Head of Office, The Chair also extended a welcome to members of staff in attendance, noting the value of their participation and inviting feedback at the conclusion of the meeting.

Apologies were noted from Mr Colm McCafferty, Mrs Debbie Burns, and Ms Trudy Reid. It was noted that Mrs Murphy was in attendance on behalf of Mr McCafferty, and Mrs Mulholland was in attendance on behalf of Mrs Burns and Ms Reid.

The Chair advised members that the Chief Executive, Medical Director, and the Chair would be required to leave the meeting at 13:00. It was confirmed that Mr Chris Stewart, Non-Executive Director, would assume the role of Chair for the remainder of the meeting, with Mrs Marks presenting items on behalf of the Chief Executive as required.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflicts of interest in relation to any matters on the agenda other than those previously recorded. No interests were declared.

3. CHAIR UPDATE

The Chair referred to the Chair update and took the paper as read. There were no questions or comments on the paper.

4. CHIEF EXECUTIVE UPDATE

The Chair introduced the Chief Executive's Report and invited Mr Spoerry to highlight any key issues arising.

Mr Spoerry advised that he would take the report as read, noting that it had been circulated to members in advance. He highlighted that, since the last

meeting, a number of reports had been published, with particular emphasis on the importance of ensuring that Board Committees receive external peer-led review reports relating to services.

Mr Spoerry noted that this represented an important area of organisational learning and supported strengthened governance and oversight.

In respect of other matters contained within the report, Mr Spoerry indicated that he was content to take the paper as read and invited any questions from members.

The Chair thanked Mr Spoerry for the report and invited comments from members. There were no further questions raised.

The Board noted the Chief Executive's Report.

5. MINUTES OF PREVIOUS MEETING HELD ON 26TH MARCH 2026

Minutes of the meeting held on 26th March were approved by the Board.

Minutes of 26th March 2026 were approved

6. MATTERS ARISING

The matters arising were noted by Board members.

Daisy Hill Hospital Simulation Suite

Members received an update in relation to the provision of simulation training facilities.
Mrs Marks reported that engagement had taken place with the simulation team, with input from Mrs Burns. A short-term solution had been identified to enable simulation activity to continue, with arrangements being progressed by Estates in collaboration with the clinical teams. It was noted that this interim solution would require a short period to become operational.

In addition, a longer-term solution is being developed, which will involve structural modification to an existing Trust building. It was acknowledged that this will require additional time to deliver; however, the simulation team expressed satisfaction with the proposed interim arrangements and the direction of travel.

Mr Spoerry added that the development of simulation facilities aligns with a wider strategic approach to strengthening the medical workforce. He advised that the Trust has recently approved a programme to reduce expenditure on agency and locum staff by converting a proportion of this spend into Clinical Fellow posts. This initiative is intended to support recruitment and retention of junior doctors, particularly in the context of limited access to formal training posts.

Mr Spoerry emphasised that investment in simulation training is integral to this approach, providing high-quality training opportunities to support workforce development, stabilise services in the short term, reduce reliance on locum staffing, and contribute to the longer-term consultant pipeline.

Members noted that the availability of high-quality simulation facilities is also a key factor in attracting and retaining staff and trainees within the Trust.

The Board welcomed the progress made and noted the update.

Restricted Procedures Audit

Mr McClements provided a verbal update in relation to the Restricted Procedures Audit, noting that this work sits within the wider Effective Use of Resources (EUR) policy framework. Mr McClements advised that the audit relates to procedures which are no longer commissioned by the Department of Health and, as such, require careful governance, monitoring, and communication both within the Trust and with primary care referrers.

He outlined that this work has been progressed on a regional basis through collaboration across the five Trusts over a period of approximately six months. While an initial request had been made for a retrospective audit, subsequent discussion at a regional level had shifted the focus towards prospective monitoring and analysis. Mr McClements reported that:

- Prospective reviews have been undertaken across a range of specialties within the Trust, including ENT, Urology, General Surgery, and Haematology;
- Clinical teams have confirmed that appropriate governance arrangements are in place and that decisions are being made in line with agreed policy and clinical criteria;
- Where procedures are identified as no longer commissioned, appropriate communication is issued to both patients and referring clinicians; and

- Waiting lists have been reviewed and updated in accordance with these criteria, with patients either retained where clinically appropriate or advised where procedures are no longer indicated.

It was noted that regional communications are being developed in collaboration with the Department of Health to support consistent messaging, particularly at the point of referral.

Mr McClements advised that further consideration will be given to undertaking retrospective analysis during 2026, although the current focus remains on ensuring robust prospective oversight. He confirmed that the Trust will continue to monitor activity on a routine basis going forward, with regular review through established governance arrangements.

The Board noted that the Trust is in a positive position with respect to compliance and oversight in this area and welcomed the continued regional approach.

7. COMMITTEE CHAIR REPORTS

i) Charitable Trust Funds Committee, 30th March 2026

Mr Lynas who chaired the Charitable Trust Funds Committee meeting on 30th March 2026 provided an update. Mr Lynas advised on the Trust's progress towards achieving Charitable Trust status. Mr Lynas advised that this transition will introduce a range of new responsibilities for the Board, reflecting its role in the governance and oversight of charitable activities. He noted that appropriate training will be provided to support Board members in discharging these responsibilities effectively.

Mr Lynas further indicated that, within an anticipated timeframe of 12 months, the Trust should be in a position to begin raising funds under the new charitable arrangements.

The Board noted the update and received it for assurance.

8. REGIONAL RESET PLAN – LEARNING FROM TRUST MANAGEMENT OF GP PRACTICES

Mr Beattie introduced Mrs McNally, Assistant Director of Primary Care, noting her responsibilities across a range of services interfacing directly with General

Practice, including Integrated Care Teams, community-based services and Multi-Disciplinary Teams in Primary Care (MDTPC) arrangements. It was noted that, more recently, these responsibilities had extended to the direct management of three GP practices.

By way of context, Mr Beattie advised that the Trust had not sought this responsibility, however had been requested by the Strategic Planning and Performance Group (SPPG) to assume oversight and management of three practices following the return of contracts by incumbent providers. He emphasised that, in the absence of Trust intervention, the practices were at significant risk of failure, with their populations potentially to be redistributed across neighbouring practices, creating further system pressure. The Trust had therefore "answered the call", with early indications demonstrating significant improvement in service performance compared to the pre-existing position.

Mr Beattie further highlighted the strategic relevance of the work, particularly in the context of the emerging neighbourhood model of care, noting that the experience would provide valuable insight into how services could be designed and delivered at neighbourhood level.

Mrs McNally outlined the operational context, advising that the Trust had taken over three practices at very short notice, with less than one week's lead-in time. She described the initial challenges, including workforce uncertainty, limited infrastructure and risks to continuity of care. Immediate priorities had focused on stabilising the practices, providing assurance to staff and patients and maintaining service continuity through clear "business as usual" messaging within local communities.

Mrs McNally reported that the Trust had implemented a structured approach to stabilisation and improvement, including:

- Establishing robust governance frameworks, processes and standard operating procedures;
- Supporting staff transfer to the Trust, with input from HR and Trade Union colleagues, alongside targeted training;
- Introducing consistent administrative systems and improving workflow management; and
- Enhancing visibility and engagement with local communities and stakeholders, including community pharmacies.

She observed that staff had responded positively to the clarity and structure provided and that the Trust's established governance and HR processes had been a key enabler of service stabilisation.

Mrs McNally highlighted a number of service improvements, including:

- Removal of restrictive telephone access arrangements and introduction of more flexible access throughout the day;
- Standardisation of appointment templates, with increased face-to-face capacity;
- Development of alternative access routes, recognising that patients may access care via GP, Emergency Department (ED) or Out-of-Hours services; and
- Expansion of MDTPC and social prescribing services to better meet patient need, particularly for frequent attenders.

It was noted that improving access to GP services had the potential to reduce demand on ED and Out-of-Hours services. Mrs McNally further outlined the significant analytical and improvement opportunities arising from Trust involvement, including access to GP data. This had enabled:

- Analysis of ED attendance patterns, including identification of frequent attenders and variation in referral practices;
- Identification of patients bypassing GP services and exploration of underlying causes;
- Delivery of targeted improvement initiatives, including a primary care heart failure audit; and
- Testing of the electronic frailty index within general practice.

Particular attention was drawn to the importance of accurate clinical coding, with Mrs McNally advising that a cohort of 739 patients within the practices had not been appropriately coded, limiting the ability to identify need and support early intervention.

Mrs McNally also described preventative initiatives, including outreach to patients aged over 75 who had not attended services, with a view to identifying unmet need and linking individuals to appropriate supports. In responding to queries from Mr Spoerry regarding the key differences from previous operating models, Mrs McNally highlighted:

- The Trust model does not operate on a profit-driven basis, enabling greater focus on patient care;

- GPs are released from administrative and managerial burdens, allowing them to focus on clinical work; and
- The application of consistent governance, HR processes, and standardised systems across practices.

Mr Spoerry reflected on the wider system benefits, noting the opportunity to better understand the interface between primary and secondary care, manage demand across services and develop exemplar models that could inform future system design. He emphasised that the approach aligned with the Trust's strategic direction and the development of neighbourhood-based care.

Mrs Corkey sought assurance on how learning would be disseminated. Mrs McNally confirmed that learning was being shared through established networks of Practice Managers and through MDTPC structures, supporting scale and spread across the system.

Mr Stewart commended the work as a significant achievement, noting that the Trust had not only prevented service collapse but had strengthened and improved delivery. They queried whether a more proactive approach should be taken to identify and support other practices at risk. Mrs McNally advised that while contracts are often subject to late-stage negotiation, the Trust had developed a replicable model and was well positioned to respond quickly and engage early where appropriate.

In response to further questions, Mrs McNally emphasised that sustainability had been achieved through:
- Strong governance frameworks and consistent processes;
- Effective administrative support to manage workflow; and
- Optimisation of GP time towards patient care rather than administrative functions.

Mrs Ensor queried the impact of changes to telephone access arrangements and the potential link to ED attendance. Mrs McNally acknowledged that while improvements in accessibility had been observed, formal metrics were not yet in place and would be developed. She confirmed that ED attendance patterns, including patients bypassing GP services, were being explored through data analysis.

Mr Johnston sought clarification on governance arrangements between Trust-managed and independent practices. Mrs McNally advised that variation exists

across all GP practices, with Trust-managed services operating under an alternative contractual model. This alternative contract is entitled an Alternative Provider of Medical Services (APMS) contract, compared to the more commonly known General Medical Services (GMS) contract. She noted that SPPG had already incorporated learning from the Trust's experience into its oversight processes. Mr Spoerry added that there would be further opportunity to influence future GP contractual arrangements through engagement with the Department of Health.

Mrs McGall welcomed the model, particularly in the context of the regional neighbourhood model and highlighted potential benefits for vulnerable groups, including individuals with learning disabilities and mental health needs. Mrs McNally agreed that there were clear opportunities to extend the approach to these populations, particularly through the MDTPC and neighbourhood working.

In concluding, Mrs McNally reiterated that, while unplanned, the Trust's involvement had provided significant opportunities to improve service delivery, enhance population health insight and inform future models of care.

The Chair thanked Mrs McNally and the team for an informative and uplifting presentation, commended the significant progress achieved in stabilising and improving the practices and noted the Board's interest in receiving further updates as the work develops.

9. COMMITTEE IN COMMON UPDATE

The Chair introduced the update on the Committee in Common and referred members to the suite of papers circulated, including forward plans, workshop summaries, action logs, and report cards relating to the range of provider collaboratives currently underway or in development.

The Chair emphasised the importance of ensuring full visibility and transparency of this work across all Trust Boards and Senior Leadership Teams. Directors were encouraged to actively brief their teams on the collaborative programmes in progress, noting the expectation that this work should be well understood across the organisation.

Reflecting on progress to date, the Chair advised that while the Committee in Common had been evolving over a number of years, there had been a

substantive shift over the past year. In particular, this was characterised by an increased willingness across the six Trusts to work collectively on service improvement, operational standardisation, and regional priorities aligned to the Reset Programme. The Committee in Common was highlighted as a key mechanism for progressing this agenda, with a core aim of reducing unwarranted variation in services and approaches across Northern Ireland.

Mr Spoerry endorsed this position and highlighted the emergence of a clear and increasingly coordinated programme of collaborative work, underpinned by a strong cooperative ethos. He noted that one of the initial priority areas was the stability of vulnerable specialties, with psychiatry identified as a key focus.

Mr Spoerry outlined that a programme of work was now underway in relation to psychiatry, supported by:

- Appointment of a Senior Responsible Owner (SRO);
- Engagement of clinical leadership from across Trusts, including representation from both well-resourced and more challenged organisations to ensure a balanced perspective;
- Support from the Chief Medical Officer's Clinical Advisor for Mental Health; and
- Involvement of the Royal College of Psychiatrists.

He advised that an initial phase of work was focused on gathering comparable data across Trusts to better understand variation in service provision and demand. It was noted that this represented an important step towards addressing longstanding systemic challenges within psychiatry services.

Mr Spoerry further reflected that, as collaborative working matures, there may be a point at which greater alignment of services requires organisations to consider trade-offs, including potential redistribution of activity or adjustments to local service provision. While this stage had not yet been reached, it was recognised as an important future consideration for the Committee in Common and for Trusts collectively.

In discussion, Mr Johnston referenced the Bengoa Report (2016) and its predominantly top-down approach to transformation. He contrasted this with the current model of collaborative working, which is more bottom-up in nature and led by Trusts working collectively to identify priorities and agree approaches. Mr Johnston highlighted the development of initiatives such as

virtual wards as an example of how this collaborative model may shape service design and resource allocation in practice.

Members noted that the collaborative approach provided an opportunity to explore alternative models of transformation, and to assess the relative merits of system-led versus locally driven approaches over time. It was also noted that this aligned with evolving thinking at Departmental level, with an increasing emphasis on coalition-building and collaborative leadership.

Further discussion referenced the development of virtual ward models, including opportunities for cross-Trust collaboration, evaluation, and adaptation to different population contexts, including rural settings. The potential role of digital enablers and integration with existing services, such as Hospital at Home, was also acknowledged.

The Board welcomed the progress made in strengthening regional collaboration, noting the increasing maturity of the programme of work and the opportunities it presents to improve service consistency, sustainability, and patient outcomes across the system.

The Board noted this item for information

10. PROFESSOR FRANK ATHERTON SUMMARY REPORT ON ISSUES RELATED TO NORTHERN IRELAND CERVICAL SCREENING PROGRAMME

The Chair introduced the item and referred members to the papers circulated, including the Ministerial statement dated 14 May and Professor Sir Frank Atherton's summary report on the cervical cytology screening programme.

Dr Austin advised that the report provided a comprehensive overview of a number of reviews undertaken in relation to cervical cytology over recent years. These included the Trust's own cytology review, the Royal College of Pathologists (RCPath) review, and other expert and regional assessments, including work undertaken within NHS England. The report set out how the findings from these various reviews aligned and provided an overarching summary of the programme.

Dr Austin confirmed that the recommendations arising from earlier reviews had been implemented by the Trust. He further noted that the screening programme

had undergone significant change over recent years, including the centralisation of laboratory services within Belfast Trust and the introduction of primary Human Papillomavirus (HPV) testing, representing a fundamental shift in screening methodology.

Notwithstanding these developments, Dr Austin emphasised that there remained opportunities for further learning arising from the most recent report. Work was therefore ongoing to review the findings in detail and to identify any additional actions required to further strengthen systems and processes within the Trust.

The Chair invited comments from members and also extended an invitation to those public attendees to contribute should they wish to do so.

In closing the item, the Chair, on behalf of the Board, reiterated a formal apology to all women and their families who had been impacted by the issues identified through the cervical screening reviews. The Chair acknowledged that the performance of the Trust at the time had not been acceptable and that the actions taken had not been sufficiently robust. This was recognised as an unacceptable failure in governance processes.

The Committee noted the report, the progress made in implementing recommendations, and the ongoing commitment to learning, improvement, and strengthening of governance arrangements in relation to the cervical screening programme.

11. RELEASE TO RESCUE PROGRAMME

The Chair introduced the item and welcomed Mr McNulty to the meeting under speaking rights. The Chair outlined the format for the discussion, with Mr McNulty invited to present first, followed by an update from Ms Wilson.

Mr McNulty thanked the Board for the opportunity to contribute and outlined the sustained pressures facing ambulance services and Emergency Departments, noting that these challenges had developed over a prolonged period and had continued to worsen despite previous attempts at improvement. He highlighted that ambulance handover targets had evolved over time but were now consistently being missed, resulting in significant loss of operational ambulance hours.

Mr McNulty described the situation as unacceptable, particularly where patients experience extended waits for ambulance response or prolonged delays outside Emergency Departments. He referenced the SDLP “Health Can’t Wait” report, which advocates for the introduction of a mandatory 45-minute (W45) ambulance handover standard. He advised that evidence from other settings indicated that such an approach could significantly reduce handover times and release ambulance capacity back into communities. While acknowledging the introduction of a two-hour maximum turnaround time as a positive step, Mr McNulty encouraged continued progress towards the 45-minute standard.

Ms Wilson provided an update on the implementation of the Release to Rescue programme, which had been introduced regionally on 27 April. She advised that the initial focus of the programme was to achieve ambulance turnaround within two hours, recognising this as an important interim step towards the longer-term ambition of achieving the 45-minute standard. Ms Wilson reported that:

- The Trust had made significant progress, with the majority of ambulances now being turned around well within the two-hour timeframe;
- Average turnaround times had improved markedly, with performance now approaching or within the 45-minute range in many instances; and
- Some apparent breaches within the reported data were attributable to recording and timing discrepancies, which were being addressed in collaboration with NIAS. Based on reviewed data, only a very small number of confirmed breaches had been identified.

Ms Wilson emphasised that the programme formed part of the wider Timely Care Programme, requiring a whole-system approach to patient flow. This includes ensuring that, where patients are admitted through Emergency Departments, corresponding movement is enabled within the hospital system to maintain capacity. She noted that delivery of the programme had required a significant operational effort across all services, including reconfiguration within Emergency Departments and the establishment of control room functions.

Ms Mulholland highlighted the substantial cultural shift achieved, noting that staff across teams had embraced the programme despite considerable operational pressures. She described strong levels of engagement and commitment from frontline teams and emphasised the importance of embedding these practices to ensure sustainability, with ongoing work to improve internal processes and reduce system inefficiencies.

Mr Spoerry commended staff for their leadership and delivery, noting the impact of the programme on inpatient wards, where increased demand had been absorbed to support patient flow. He advised that both hospital sites had recently undergone external peer-led review, with initial feedback confirming that the Trust's assessment of the underlying issues was accurate. He supported a phased approach to achieving the W45 standard, recognising the two-hour standard as an appropriate interim target.

In discussion, members considered performance data and patterns of activity, including pressures at weekends and holiday periods. Ms Wilson acknowledged that system pressures are typically higher at these times and that this remains an ongoing area of focus.

The Chair referenced recent correspondence from the Chair of the Northern Ireland Ambulance Service (NIAS) to the Minister, highlighting the impact of ambulance handover delays on service capacity and staff wellbeing. The Chair commended the progress achieved through the Release to Rescue programme, noting that it represented a significant improvement and a positive development for patients and the wider system.

The Chair further acknowledged that the improvements had implications for inpatient capacity, with increased demand on wards as flow improves through Emergency Departments. While recognising these challenges, the Chair emphasised that the programme should be regarded as a positive step forward, particularly in supporting timely ambulance response for patients in the community.

In conclusion, the Committee welcomed the progress made, noted the strong commitment demonstrated by staff, and acknowledged both the benefits achieved and the challenges associated with sustaining performance, particularly as the system approaches the winter period. The trajectory towards the 45-minute handover standard was supported as the longer-term ambition.

12. HOME CARE SERVICES

The Chair introduced the item and invited Mr McNulty to address the Board under speaking rights. Mr McNulty highlighted the critical importance of home care services, describing them as a "lifeline" for many families in enabling individuals to live independently within their own homes. He commended the

dedication of home care staff and the essential role they play in supporting patients and providing reassurance to families.

Mr McNulty advised that his office continues to receive regular representations from families concerned about reductions or withdrawal of care packages. He expressed concern that such changes may leave individuals with less support, with particular impact in rural communities, and sought assurance from the Trust that patients would continue to receive timely and high-quality home care provision.

In response to Mr McNultys comments, Mr Spoerry clarified that any reduction or removal of a home care package is undertaken following a formal reassessment of the individual's needs, in line with established professional practice. He noted that it is common for individuals' needs to change over time, particularly following discharge from hospital, as independence and confidence improve.

Mr Spoerry further advised that the Trust has recently enhanced its ability to collect and analyse data on home care delivery, particularly in relation to directly employed staff. This has identified cases where the duration of care visits is consistently lower than originally allocated. In such circumstances, and following verification of patterns over time, the allocated time may be adjusted accordingly. He emphasised that this approach does not reduce the level of care required by the service user, however it enables the Trust to utilise available capacity more effectively, including supporting those currently awaiting care packages.

Mr Beattie presented the report on home care services, noting that this area sits at the core of the Trust's "Community First" objective. He acknowledged the significant pressures facing social care services locally, regionally and nationally, as well as highlighting the impact of demographic change, with the over-75 population representing the fastest growing group within the Trust area. Mr Beattie provided an overview of current service provision, noting that:

- Approximately 4,550 individuals are currently in receipt of home care services;
- Around 60,000 hours of care are delivered weekly across the Trust area;
- The Trust delivers approximately 2.2 million visits annually, rising to over 5 million when independent sector provision is included; and

- Demand continues to exceed capacity, with approximately 697 individuals currently awaiting a home care package (a reduction from over 800 at year-end, representing a 15% improvement).

Mr Beattie acknowledged that unmet need remains a significant challenge. He noted that, where care cannot be immediately provided in the community, some individuals may be supported through alternative arrangements, including temporary placement in care homes, with the aim of returning them to home-based care as soon as possible.

Mr Beattie outlined the Trust's approach to addressing capacity and improving service delivery through its Modernising Home Care programme. This includes:

- Use of a live monitoring system to better align allocated care with actual delivery;
- Redistribution of unused capacity, based on evidence and consistent patterns, to support individuals awaiting services;
- A renewed focus on personalised care planning, moving away from standardised models towards more tailored, needs-based packages; and
- Engagement with over 500 staff to support a more enabling, independence-focused approach to assessment and care delivery.

He emphasised that the Trust does not reduce care below the level required to meet assessed need and noted that the Trust continues to provide a higher proportion of longer-duration care packages compared to regional peers, while also delaying fewer individuals awaiting services.

Looking forward, Mr Beattie advised that the Trust is progressing work to enhance oversight and consistency across independent sector providers, who currently deliver approximately 60% of home care provision. He indicated that achieving full alignment and transparency across this sector would require regional collaboration and is expected to be a multi-year programme.

The Chair sought further clarity on arrangements with independent sector providers, emphasising the importance of achieving comparable levels of transparency and assurance across all provision. Mr Beattie confirmed that this work is ongoing and that the region is planning to commence working on agreeing a new regional Home Care contract within an anticipated timeline of two to three years, to fully implement consistent systems and approaches.

Mr Johnston queried the potential role of digital solutions in improving service delivery and reducing delays. Mr Beattie confirmed that opportunities for greater use of digital approaches are being explored, while noting the importance of maintaining appropriate person-centred care. Mr McNulty acknowledged the scale of unmet need and highlighted the potential benefits of resolving delays for individuals awaiting home care packages, particularly those currently in care home settings. He noted that addressing this could support improved patient flow across the system and welcomed the Trust's efforts in this regard.

In concluding the item, the Chair thanked Mr McNulty for his contribution and commended staff for their ongoing work in a highly challenging service area. The Chair noted that the Trust had made measurable progress, particularly in reducing the waiting list and described this as a positive trajectory. However, she emphasised the need to sustain this progress and continue addressing underlying pressures, including demand growth and system capacity.

The Committee noted the report, the progress achieved to date and the ongoing work to modernise and strengthen home care services, while recognising the continuing challenges associated with unmet need and increasing demand.

13. DRAFT FINANCIAL PERFORMANCE REPORT – 12 MONTHS ENDED 31.03.26 – ST1254/31

Mrs Marks presented the Month 12 year-end position as at 31 March, noting that the figures reflected the initial draft position pending finalisation of the Annual Report and Accounts. She advised that the draft accounts had been reviewed by the Audit and Risk Assurance Committee (ARAC) earlier in the month, with a full briefing to be provided to the Board once the final accounts were available.

Mrs Marks reported that the Trust had achieved a break-even financial position at year-end of year, delivering a small surplus of £177k, representing 0.02% of the available revenue resource limit. She emphasised that this position remained subject to external audit review. She further noted that this had been achieved in the context of a highly challenging financial environment, supported by £28m of additional deficit funding from the Department of Health, alongside the successful delivery of a £43m savings target by the Trust.

In discussion, the Chair reflected on the position reached, noting that earlier in the year there had been uncertainty as to whether a break-even outturn would be achievable given the scale of the financial challenge. The Chair commended Mrs Marks and the wider Senior Leadershp Team and organisation for the collective effort required to deliver this outcome.

Mr Hughes and Mrs Browne also commended the Trust's financial performance, recognising the significant amount of work undertaken across Directorates and support services to achieve financial balance. It was noted that this represented a substantial organisational effort, including detailed financial management, performance oversight, and control measures.

The Chair further highlighted the importance of collective responsibility across the organisation, acknowledging that while the Director of Finance leads on financial matters, delivery of the financial position is dependent on the contribution of all Directorates. The Chair noted that the approach adopted over recent years, including strengthened organisational focus and collaborative working, had supported the achievement of this position.

In concluding, the Chair thanked Mrs Marks and asked that appreciation be extended to all staff involved in delivering the financial outturn. It was also noted that, notwithstanding this achievement, significant financial challenges remain for future years and sustained focus will be required.

The Board noted the draft year-end financial position and the achievement of a break-even outturn.

The Board approved the Financial Month 12 Report

14. OPENING FINANCIAL PLAN 2026-27 – ST1254/32

Mrs Marks presented the draft opening financial plan for 2026/27, noting that this remained subject to confirmation of the final allocation from the Department of Health. She advised that, in line with Standing Financial Instructions, the Board is required to approve a draft opening plan to enable budgets to be issued to Directors.

Mrs Marks highlighted that the Trust is now entering the third month of the financial year without a confirmed opening budget, creating a challenging planning environment. Notwithstanding this uncertainty, the draft plan has been developed based on the indicative allocation provided. She reported that the plan reflects:

- An opening recurrent deficit of £10.8m;
- Underlying cost pressures, including growth in high-cost cases; and
- £6.8m of non-recurrent savings delivered in 2025/26 which cannot be carried forward on a recurrent basis.

Mrs Marks advised that, in response to Department of Health planning guidance, the Trust had developed a savings plan for 2026/27, with Phase 1 identifying approximately £30m of low and medium impact savings. These proposals had been subject to engagement with the Senior Leadership Team and the Trust Board and are now in the process of implementation.

Mrs Marks emphasised that, whilst the plan reflects the indicative allocation and identified savings, the Trust is not currently in a position to confirm achievement of a break-even outturn. She noted several key risks, including:

- The potential requirement for further savings during the financial year;
- Continued upward demand for services; and
- The increasing difficulty of delivering additional efficiencies following the significant savings achieved in 2025/26.

She further advised that the savings programme is being progressed through the RISE Programme Board, with regular monitoring and oversight. External assurance is being provided through PA Consulting, who are currently stress-testing the savings plan to assess robustness and identify any further opportunities.

Mrs Marks also highlighted targeted workstreams to support delivery, including focused programmes addressing nursing agency expenditure, medical locum costs, and wider workforce controls, supported by designated Senior Responsible Owners.

In discussion, the Chair acknowledged the challenging position of developing a financial plan in the absence of a confirmed budget but emphasised the importance of proceeding with a clear plan to provide direction to Directorates.

Mr Hughes noted that the challenge was compounded by the requirement to plan part-way through the financial year and the absence of multi-year financial settlements. He reflected that this limits the organisation's ability to take longer-term strategic decisions and risks driving a focus on short-term cost control rather than transformational change.

Mrs Ensor sought assurance in relation to workforce health and wellbeing, noting the pressures arising from the financial and operational context. It was confirmed that this remains a key priority within the People Framework, with an established programme of work and oversight through the People and Culture Committee.

Mr Johnston emphasised the importance of broader public and stakeholder engagement regarding the financial context, noting the need for clear communication on the implications of funding constraints. The Chair supported this position and also highlighted the importance of consistent and transparent communication with staff, recognising both the pressures placed upon them and the importance of maintaining engagement and trust.

Mr Spoerry further noted the constraints associated with single-year budgets, particularly in limiting the Trust's ability to invest in transformation initiatives that could deliver longer-term efficiencies and improved outcomes.

In concluding, the Chair acknowledged the significant work undertaken to develop the plan in difficult circumstances and reiterated the importance of maintaining focus on both financial sustainability and service delivery.

The Board approved the draft opening financial plan to enable allocation of budgets to Directorates, noting the uncertainty pending Department of Health confirmation of the final funding position.

The Board approved the Draft Opening Financial Plan 2026/27

The Chief Executive, Medical Director, and the Chair left the meeting at 13:00. Mr Chris Stewart, Non-Executive Director, assumed the role of Chair for the remainder of the meeting, with Mrs Marks presenting items on behalf of the Chief Executive as required.

15. COMMITTEE CHAIR REPORTS

i) Audit and Risk Assurance Committee, 23rd April 2026 & 21st May 2026

Mrs Ensor provided an update on activity since the last Board meeting, noting that two Audit and Risk Assurance Committee (ARAC) meetings had been held and that the report presented was a consolidated summary of both.

Mrs Ensor highlighted that a key item of focus had been cyber security. The Committee had received a detailed update from Ms Wilson on progress against Internal Audit (IA) recommendations. This discussion had developed into a substantive "deep dive", which provided a high level of assurance to the Committee regarding progress and oversight in this area. Mrs Ensor further advised that five Internal Audit reports had been considered during the reporting period, all of which had been reviewed at the most recent meeting, ensuring that outstanding reports had now been fully addressed.

In addition, the Committee had reviewed both the draft Charitable Trust Fund Accounts and the Trust's draft Annual Report and Accounts, including associated queries regarding governance matters such as trustee appointments.

Mrs Ensor confirmed that there were no items requiring escalation to the Trust Board.

By way of clarification, Ms Wilson noted that a reference within the report to "EPIC utilisation" should instead refer to IT asset utilisation. It was emphasised that utilisation of EPIC itself remains high, and that the finding related specifically to the use of additional IT equipment associated with its rollout.

The Board noted the update from the Audit and Risk Assurance Committee.

ii) Patient Safety and Quality Committee, 14th May 2026

Mr Johnston provided an update on the newly reconstituted Patient Safety and Quality (PSQ) Committee, noting that the Committee had transitioned from the former governance committee and held its first meeting in this new form on 14 May.

Mr Johnston drew members' attention to Section 6 of the report, which outlines the Committee's remit and the adoption of model Terms of Reference issued by the Department of Health. He advised that, while these model Terms of Reference have been provisionally adopted, the Committee has identified concerns regarding their ability to fully encompass the breadth of the Committee's intended remit.

Mr Johnston confirmed that the Committee has agreed to undertake further work over the summer to review these arrangements in detail and to develop a considered response to the Department of Health. Subject to this, revised draft Terms of Reference will be brought back to the Board for consideration, likely in September or November.

The Chair thanked Mr Johnston for the update and invited comments from members. There being no further questions, the report was noted for assurance.

The Board confirmed that it was content to accept the report as assurance.

16. APPLICATION OF TRUST SEAL ST1254/33

Mrs Marks presented nine applications for Trust Seal, these were approved.

The Board approved the Application of the Trust Seal

17. STANDING ORDERS INCLUDING RESERVATION AND DELEGATION OF POWERS – ST1254/34

Mr Stewart asked the Board for approval of the revised Standing Orders including Reservation and Delegation of Powers

The Board approved the Standing Orders including Reservation and Delegation of Powers

18. SCHEDULE OF BOARD REPORTING 1ST SEPTEMBER 2026 – 31ST AUGUST 2027 – ST1254/35

Mr Stewart asked the Board for approval of the schedule of Board reporting for 2026/27.

The Board approved the Schedule of Reporting for 2026/27

19. ANY OTHER NOTIFIED BUSINESS

Mr Stewart noted that this meeting marked Mr Beattie's final Trust Board meeting ahead of his retirement.

On behalf of the Board, the Mr Stewart expressed sincere appreciation for Mr Beattie's significant contribution over many years. It was noted that his work had consistently reflected a strong commitment to the principles of person-centred care, with a clear focus on the needs of service users, staff, and the wider community.

Mr Stewart highlighted the depth and quality of Mr Beattie's contribution to the Trust Board, commending both the calibre of his professional advice and the insight he brought to discussions. His leadership, values-driven approach, and ability to balance strategic oversight with a clear focus on individuals were recognised as key strengths.

Members noted that Mr Beattie's contribution had been both highly effective and widely respected across the organisation, and that his input had been a valued element of Board deliberations.

On behalf of all members, Mr Stewart thanked Mr Beattie for his dedication and achievements and extended best wishes for a long, healthy, and enjoyable retirement.

The date of the next meeting will be Thursday, 25th June 2026 at 10.30 a.m.

PAPERS FOR INFORMATION

Members noted the following agenda items for information purposes.

a. Charitable Trust Funds Committee

- Minutes of meeting held 30th March 2026

b. Patient Safety and Quality Committee

- Minutes of meeting held on 14th May 2026

c. Audit and Risk Assurance Committee

- Minutes of meeting held on 23rd April 2026
- Minutes of meeting held on 21st May 2026

d. Chair and Non-Executive Directors Engagement

e. Southern Health and Social Care Highlights

f. Chief Executives Engagement for Trust Board

g. Board Member Declarations of Interest