

**Minutes of a Meeting of the Finance and Performance
Committee held on Thursday, 10th September 2026 at 09.30
a.m. in the Committee Room, Trust HQ, Craigavon**

PRESENT:

Mr A Hughes, Non-Executive Director (Chair)
Mrs L Ensor, Non-Executive Director
Mrs G Browne, Non-Executive Director
Mr S Spoerry, Interim Chief Executive
Mrs E Wilson, Director of Planning, Performance and Informatics
Mrs C Marks, Executive Director of Finance, Procurement and Estates
Mrs G. Hamilton, Executive Director of Nursing.

IN ATTENDANCE:

Mr C McCafferty, Executive Director of Social Work / Director of Children and Young People's Services (Item 6)
Mrs D Livingstone, Assistant Director Performance Improvement
Mrs S Barr, EQUIP Project Manager (Item 17)
Mrs S Hanna, Assistant Director, Informatics
Dr D Gormley, Deputy Medical Director
Mr D McClements, Interim Director Surgery and
Mrs S Glenny, Patient Access Service Manager
Mrs L Lappin, Assistant Director for Surgical and Outpatients
Mrs S Wallace, Head of Office
Mrs R Montgomery, Senior Project Manager

APOLOGIES

Mrs D Burns, Director of Operations

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and accepted apologies on behalf of Debbie Burns, noting that Heather Trouton was attending in her place.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any conflict of interests in relation to items on the agenda. None were noted.

3. CHAIR'S BUSINESS

The Chair reminded members that an additional Committee meeting will be held on 9 October 2026 to consider four focused deep-dive topics. Presentations should be concise and structured to allow time for Committee discussion and challenge.

4. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 18th June 2026 were taken as read and approved.

5. MATTERS ARISING FROM PREVIOUS MEETING

The Committee noted that one action had been completed and closed. The remaining action related to the provision of further information on the use of DACs in future financial reporting. Mrs Marks agreed to include the additional analysis in the report to the next meeting.

STANDING REPORTS

6. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the report and reminded the Committee that children's social work services had operated under business continuity arrangements for approximately three and a half years because of significant workforce pressures. Unallocated cases had peaked at approximately 400 at the beginning of 2024 and had reduced to approximately 252 at the end of the reporting quarter, with further improvement reported by the end of August 2026.

Workforce measures included the introduction of Band 5 Senior Support Officer roles and investment, at Trust risk, in Open University training places beyond the two places funded by the Department. Nine staff were due to commence the programme in September 2026. In addition, 26 newly qualified social workers were expected to take up posts across children's services, with most anticipated to be in post by the end of October.

The Committee noted that these developments should support further stabilisation, although referral activity remained very high at approximately 1,100 referrals each month.

The number of children in care had stabilised at approximately 670 to 690, following several years of annual growth. Unallocated cases within children in care had reduced to 33 by the end of August. Pressure remained particularly acute in children with disabilities services because of increased demand, including growth in autism referrals and post-assessment support requirements. A temporary increase in unallocated family intervention cases was linked to the cessation of a non-recurrent early-intervention service and the return of funding to substantive social work posts.

In response to the Chair's enquiry regarding the internal audit of safeguarding and unallocated cases, Mr McCafferty confirmed that the audit had concluded that child protection services were safe at the time of review. All eight recommendations have been implemented, evidenced and accepted by BSO. The Committee also noted that the Trust had the lowest rate of children in care per 10,000 child population across the five Trusts despite having the highest birth rate. This was attributed, in part, to established early-intervention and family-support arrangements.

Mr McCafferty advised that significant time-limited funding had been secured for the Together for Families project. While this represented an important opportunity to strengthen early-intervention support, the absence of recurrent funding beyond the programme period remained a material risk. Members also discussed arrangements for unaccompanied asylum-seeking children and noted that regional rotational arrangements were in place. Sickness absence across children's services remained a concern and reflected the wider Trust trend, with workforce availability further affected by the difficulty of securing temporary cover.

The Committee welcomed the continued reduction in unallocated cases and asked that the progress and commitment of staff be acknowledged.

7. CAPITAL ALLOCATION PLAN

Mrs Wilson presented the capital update. The Trust had received a capital allocation of £14.6m, the majority of which was ring-fenced for specified projects. Of the £4.9m general capital allocation, £4.6m had been allocated across medical equipment, estates, digital and fleet priorities.

The Trust had submitted a capital monitoring-round bid to the Department, focused on inescapable pressures, organisational risks and schemes capable of delivery within the financial year. The highest priority was funding for the robotic-assisted surgery system. Funding had been identified from charitable funds and general capital to allow the Trust to proceed, but departmental support would release those resources for other essential capital priorities.

The Committee expressed significant concern regarding the Trust's position within the draft ten-year capital investment plan. Members noted the limited provision for Southern Trust priorities, including the absence of identified investment for mental health and social care and the later scheduling of acute and primary care developments. Funding for the Daisy Hill Hospital fire evacuation works was welcomed, but members considered the overall distribution insufficient, particularly in the context of the Trust's reported £40m equity gap.

The Committee supported a strong formal response to the consultation. This would seek clarity on the assessment criteria, scoring methodology and prioritisation process; set out the Trust's unmet infrastructure requirements; and distinguish appropriately between replacement schemes and developments requiring additional revenue. Mr Spoerry confirmed that the Trust would pursue the matter actively and consider further engagement if the formal response did not secure an appropriate outcome.

The Committee also noted that operational capital requirements were not always progressing consistently through the established prioritisation routes. Continued communication and training were under way to ensure that directorates used the relevant capital subgroups and that priorities were assessed systematically.

ACTION: Mrs Wilson to ensure that the Trust's response to the draft ten-year capital plan addresses the criteria and scoring methodology, the Southern Trust's equity position and the full range of unmet service and infrastructure priorities.

8. CONSOLIDATED PERFORMANCE REPORT

Mrs Livingstone presented the Consolidated Performance Report and identified three amendments: the RAG status column was to be removed from the confidence-level table; the triage table headings were to read "compliant" and "non-compliant"; and the psychological therapies target in the SOMS assessment was to read 13 weeks rather than nine weeks.

Despite significant demand, workforce and capacity pressures, the overall position demonstrated gradual improvement in several strategically important areas. Confidence in SOMS reporting had improved, with high-confidence indicators increasing from 33 to 44 and low-confidence indicators reducing from 36 to 18. The Support and Intervention Framework profile remained stable, with no level 4 or level 5 escalations.

Urgent and emergency care performance had improved following implementation of Release to Rescue. At the end of July, 97% of ambulance handovers at Craigavon Area Hospital and 100% at Daisy Hill Hospital were completed within two hours, against the monitored standard of two hours and 15 minutes. Patients waiting more than 12 hours in Emergency Departments had reduced by 11%, equating to 1,141 fewer patients than in the comparable period, with three consecutive months of improvement recorded. Members noted, however, that renewed operational pressure could affect the position.

Elective recovery had also progressed. The inpatient and day-case waiting list had reduced from 13,806 in March 2025 to 9,403 in July 2026, a reduction of almost 32%. Red-flag waits had reduced by 54% and the number of patients waiting four years or more had reduced by 71%. Strong performance was also reported in Child and Adolescent Mental Health Services, home-care unmet need and a number of cancer pathways.

The Committee discussed the continued prevalence of red indicators. It was explained that approximately 15 red indicators were areas where local operational action could directly influence improvement, while 23 related mainly to ministerial access standards constrained by workforce, capacity, demand and historic backlog. Members agreed that the RAG position should be interpreted alongside direction of travel, reduction in longest waits, regional comparisons and evidence of recovery activity.

Three principal strategic risks remained: outpatient access, diagnostic capacity and workforce sustainability. First outpatient demand had increased by 4.1%; diagnostic waits continued to affect elective recovery, cancer pathways and flow; and workforce fragility remained evident in psychiatry, gastroenterology, haematology, imaging and dementia services. Continued reliance on locums, independent-sector capacity and non-recurrent funding also limited sustainability.

Members welcomed the improved clarity of the report and the inclusion of peer comparisons. The Committee was advised that dedicated performance discussions would be introduced within the Senior Leadership Team and that directorate-level frameworks were being developed to provide consistent monthly oversight. Future reporting would also seek to demonstrate the impact of financial and workforce controls on performance and patient flow.

9. SUPPORT AND INTERVENTION FRAMEWORK UPDATE

Mrs Wilson reported that eight service areas remained on the Support and Intervention Framework, unchanged from the previous report. Haematology remained at level 1, although a new consultant had commenced and regional work was continuing to support service sustainability. Psychiatry workforce pressures remained significant and were being considered through regional work.

The transfer of community mental health responsibility for the Kilkeel and Annalong area remained unresolved. The Trust was accepting new referrals but did not have resources to assume responsibility for the existing caseload.

A risk paper had been submitted to SPPG. Daisy Hill Hospital theatre utilisation also remained under review, with further work continuing to maximise capacity within current workforce constraints.

Emergency Department pressures remained at level 3. The Trust continued to perform strongly in ambulance handovers and was the highest-performing Trust regionally under Release to Rescue, although members noted the operational consequences of transferring pressure into hospitals. Winter planning was under development and additional investment was being targeted across the system.

Significant progress was reported in gastroenterology. Red-flag waits had reduced from 1,045 in June 2025 to 11, and the longest wait had reduced from more than 52 weeks to five days. This improvement continued to depend on waiting-list initiative funding, while the underlying stability of the core service and workforce remained a priority.

10. ELECTIVE ACCESS PROJECTS PRESENTATION

Mrs Lynn Lappin and Mrs Sharon Glenny presented the work of the MUSC and SCSelective care group and the patient access team. The elective care group provided a weekly, multidisciplinary forum for operational performance management across medicine, surgery and related services. Its remit has expanded from oversight of waiting-list funding and long waits to now include outpatient improvement, validation, radiology reform, capacity modelling, Encompass data-quality matters and implementation of the Integrated Elective Access Protocol.

A structured validation programme had been established to improve the accuracy of outpatient and elective waiting lists. The team used text messaging through Envoy, QR-code surveys and letters where mobile contact details were unavailable or invalid. Patients were given an appropriate opportunity to respond before removal from a waiting list. The earlier programme had validated approximately 15,000 patients waiting more than four years and removed approximately 4,000, a removal rate of around 23%.

The current programme aimed to reach the six-month validation standard by March 2027. Approximately 29,000 patients had been validated to the one-year point, with around 5,000 removed, while work continued across 18 specialties. The validation programme has improved data quality, reducing avoidable contacts and supporting better use of clinical capacity.

Members discussed use of MyCare, the need for safeguards where digital uptake was limited, and concerns about repeatedly validating the same long-waiting patients. The Committee agreed that regional and departmental consideration was required to ensure that repeated validation remained proportionate and effective. Concern was also expressed regarding the non-recurrent funding model for a function that had become essential to delivery of ministerial standards. The Interim Chief Executive agreed that options should be considered to provide greater stability for the team.

ACTION: The Executive team to consider options to provide greater stability for the patient access and validation function.

ACTION: The issue of repeated validation of long-waiting patients is to be raised through the appropriate regional arrangements and, if unresolved, escalated further.

11. SIGNAL DATA ON ENCOMPASS TO SHOW EFFICIENT/AREAS FOR IMPROVEMENT

Mrs Wilson introduced the first Trust report using Epic Signal data and emphasised that it was intended to support system optimisation, training and user experience rather than to serve as an individual performance-management tool. The Southern Trust was the first Trust in the region to present the information in this way.

Dr Damian Gormley and Mrs Siobhan Hanna outlined the limitations of the data. Signal measured active use within Epic but did not capture time spent in linked systems or activity where the application remained open in the background. Interpretation therefore required context, particularly when comparing specialties with different workloads and models of care. There are other activity times not captured as outline in the report.

The report identified variation in manual note composition, time spent outside scheduled hours, in-basket messaging and documentation patterns. Forty-one per cent of notes were manually composed. Allied Health Professional personalisation of the system was reported as strong, illustrating the benefit of local system experts. Medical Information Officers and digital champions may offer similar support for other professions to improve personalisation.. Signal data could help target training and optimisation support to specialties where the potential benefit was greatest.

The Committee noted promising results from ambient listening and voice-recognition technology, which had reduced documentation burden in pilot areas. Members emphasised that generated clinical records required appropriate review and proofreading.

In-basket management was identified as the most significant area of risk. Critical results and messages not actioned within defined timescales were being monitored and escalated to clinical directors, and the Committee was assured that high-risk items were being highlighted through relevant reports. Further work with Epic and Medical Information Officers would seek to reduce unnecessary messaging and embed routine oversight within service management arrangements.

Members considered the relevance of the work to clinical governance and the Trust's response to external inquiry recommendations. It was agreed that the implications should be discussed with the relevant governance leads and considered for reporting through the Patient Safety and Quality Committee.

ACTION: The Encompass Signal findings, particularly in-basket risk management, are to be discussed with the relevant governance leads and considered for reporting to the Patient Safety and Quality Committee.

FINANCE REPORTING

12. FINANCIAL POSITION MONTH 4

The Committee received the Month 4 financial report. The forecast year-end deficit was £7.9m, comprising the remaining £5.1m gap in the savings plan and the unfunded element of anticipated growth. The forecast assumed delivery in full of the approved £42.4m savings plan. It was noted that continued overspending and savings underachievement could increase the underlying deficit materially.

At Month 4, the Trust was expected to be £5.6m overspent but was approximately £1.6m above that trajectory. Around £0.6m of the variance related to savings underachievement, much of which was considered a timing issue. Vacancy-control performance had improved substantially since Month 3. The Month 4 report reflected Phase 1 savings only; the £12.5m Phase 2 programme would begin to be profiled from Month 5.

The principal pressures were approximately £5m in pay, mainly medical and nursing, and approximately £3m in non-pay, particularly medical and surgical supplies, escalated capacity and pharmacy drugs for which funding had not yet been confirmed. Flexible workforce expenditure was approximately £29m at Month 4, around £3.6m lower than the comparable period in the previous year. Medical locum expenditure remained the largest component at approximately £9m.

A budget realignment exercise would allocate approximately £8m of baseline deficit funding to directorates from Month 5, including provision for Agenda for Change regradings and previously approved commitments without recurrent funding. The Trust continued to operate without a formal opening allocation but had received no challenge to the assumptions reported to SPPG. Capital expenditure was forecast to break even and prompt-payment performance remained above the 95% target.

Members discussed the profiling of savings, the potential financial consequences of rising sickness absence and the risk attached to Phase 2 delivery. It was confirmed that savings were profiled against expected delivery points, although delays created a requirement for catch-up later in

the year. A rigorous Month 5 review would test the forecast, delivery risks and timing assumptions before the regional finance summit.

13. IMPLEMENTATION AND MONITORING OF FINANCIAL CONTINGENCY/SAVINGS PLAN – RISE

The Committee noted that the original financial requirement was £47.5m, comprising a 4% savings requirement and the Trust's underlying deficit. The approved plan totalled £42.4m, leaving a gap of £5.1m. Phase 1 totalled £29.9m and Phase 2 totalled £12.5m. Phase 2 carried increased risk because of the timing and complexity of implementation. The savings have been profiled in accordance with when they are expected to be delivered. Phase 2 savings are being profiled from month 5 onwards.

The programme was weighted heavily towards workforce-related schemes, with approximately £15m linked to staffing and workforce measures. PA Consulting was being engaged to support additional savings work, of c£3m over specific areas including: procurement and non-pay, flexible workforce arrangements, additional hours, overtime and allowances, nursing supernumerary arrangements and further pipeline opportunities. The commercial model would link the fee to delivery of verified savings.

The Chair welcomed the improved RISE Programme Board report, which brought together the financial position, scheme-level progress, risks and narrative in a more accessible format. Mr John McEntee had been appointed on secondment as RISE Programme Manager and would be supported by two additional internal appointments. Longer-term arrangements for the efficiency and savings function are being developed.

The Committee agreed that the latest available RISE Programme Board presentation should be included in future Committee reporting.

ACTION: Mrs Wilson to ensure that future Committee reports include the latest available RISE Programme Board presentation.

14. FINANCIAL PLANNING 2026/27

Mrs Marks advised that no further formal update had been received from SPPG on the financial plan. A regional finance summit at the end of September would review the Month 5 position across all Trusts, identify common delivery risks and consider regional enablers to bridge the gap in 26-27 and the approach to financial planning for 2027/28. No Trust had achieved the full 4% requirement at that stage.

The principal risks remained the Trust's statutory break-even duty, the £5.1m savings gap, unfunded growth and the deliverability of savings within the remaining financial year. The Committee noted that a detailed Month 5 review was already planned and would place the Trust in a stronger position for the regional discussion.

15. MUSC FINANCIAL REVIEW

The Committee received an update on the 25 recommendations arising from the external review. Fifteen recommendations were complete and ten were rated amber, with all actions in progress and the latest completion date set for the end of the financial year. No recommendations were rated red.

Progress included workforce and service reviews, the incorporation of identified efficiencies into the 2026/27 savings programme, establishment of budget ownership at ward level, improved financial reporting and strengthened protocols. Remaining actions related mainly to respiratory services, cardiology, medical staffing, Emergency Department workforce and private ambulance use.

Work on respiratory services included review of CPAP provision and the potential to replace rented equipment with purchased machines where this would reduce recurrent cost. Cardiology work was progressing through a service review covering virtual models of care, patient pathways and specialist workforce requirements. An approved business case would increase the Emergency Department consultant establishment from 12 to 16, with further work to stabilise the non-consultant medical workforce. Controls on private ambulance use were also being reviewed locally and regionally.

Members welcomed the progress and the absence of red-rated recommendations. It was noted that Getting It Right First Time (GIRFT) work was primarily focused on clinical pathways, patient safety and timely specialist input, but should also produce performance and financial benefits through improved flow, reduced length of stay and reduced reliance on escalated capacity.

16. PATIENT LEVEL INFORMATION AND COSTING SYSTEM (PLICS) DATA UPDATE

Mrs Marks presented the update on the Patient Level Information and Costing System. The system had been in use regionally for approximately three years, but further work was required to translate the data into operational insight and service improvement. IQVIA had been commissioned to assess the Trust's costing model, benchmark it against NHS England data and advise on a methodology for using the information to identify efficiencies.

IQVIA had concluded that the Southern Trust's costing model was mature, robust and fit for purpose. The assessment had reviewed 19,718 allocation methods and identified three initial cost-variance areas: general internal medicine, elderly medicine and obstetrics. Members noted that structural differences between Northern Ireland and England, particularly the integration of health and social care, could affect comparability and required careful interpretation.

Further analysis was required to determine whether variances reflected allocation methodology, data quality, differences in service models or genuine cost opportunity. IQVIA would present its findings regionally and provide a proposed approach for engaging clinicians and operational leads. The outcome would be considered by the Senior Leadership Team and medical leadership before an internal programme of work was agreed.

The Committee supported continued scrutiny of PLICS data and requested future updates on the development of the work programme, the three initial areas and the benefits secured.

ACTION: Mrs Marks to bring a further PLICS update to the Committee, setting out the agreed methodology, work programme and progress in the three initial areas identified by IQVIA.

17. EQUIP UPDATE

Mrs Barr presented the EQUIP update. Release 1 has a target go-live date of 1 December 2026, with cutover activity planned from 26th November. The programme remained rated red and amber regionally. Release 1 was approximately 22 weeks behind the original schedule, while Release 2 was approximately seven months behind and did not yet have a confirmed go-live date.

User acceptance testing remained at risk, although 79.7% of Release 1 testing had been completed against an 80% target. End-to-end testing was commencing, with some failed tests carried into the next tranche. Train-the-trainer activity was under way, but feedback indicated that training materials were lengthy and not sufficiently practical. A local training-needs analysis had therefore commenced across functional and operational teams.

The confirmed date had enabled more direct communication, organisational readiness activity and identification of change champions and super users. However, the same small group of subject-matter experts was supporting testing, training, data migration and business-as-usual functions. Resource constraints, staff availability and the quality of data migration remained significant risks. Reporting functionality was also not yet fully understood.

Mrs Marks advised that the Trust remained committed to the December implementation date, although the initial product would not represent the full functionality originally anticipated. Assurance was provided that the core finance and procurement functionality and the necessary Human Resources interface were expected to be available. Contingency planning was under way for Month 8 and Month 9 financial reporting, statutory payments and critical operational processes during cutover.

Members welcomed the transparency of the update and acknowledged the exceptional commitment of staff. The Chair requested that the Committee's appreciation be conveyed to all colleagues supporting implementation. The Equip implementation has been included as a risk on the Corporate Risk Register.

OTHER MATTERS

18. CORPORATE RISK REGISTER

The Corporate Risk Register is presented for information and discussion on impact to any of the risks based on discussions today.

19. COMMITTEE SELF ASSESSMENT

The Committee considered and accepted the 2025/26 self-assessment. Members noted generally positive results and agreed to maintain oversight of the areas receiving more moderate scores, including awareness of corporate governance best practice, the Committee's consideration of risk and the timing of papers and meetings.

20. TERMS OF REFERENCE

The Committee noted that the Terms of Reference would require further review in light of developing changes to committee structures, including the establishment of the Patient Safety and Quality Committee. The document would be revisited once the revised governance arrangements were clearer.

21. MEETING DATES 2027

The proposed meeting dates for 2027 were approved.

22. COMMITTEE ANNUAL REPORT

The Committee approved the Annual Report for 2025/26 without amendment.

23. ITEMS TO ESCALATE TO TRUST BOARD

No additional items were identified for escalation. Members noted that a number of the substantive reports considered would also progress to Trust Board through established reporting arrangements.

24. ANY OTHER BUSINESS

The meeting ended at 1p.m.

Date of next meeting 3rd December 2026