Paper B - Members' Issues

HSC Chairs' Paper Ministerial Meeting – 13 May 2026

1. INTRODUCTION

The purpose of this paper is to update the Minister on key board leadership progress in the system to support the delivery of the Reset Plan. The paper covers three key issues; progress on the establishment of Patient Safety committees and the being Human Framework, a Committee in Common update and an emerging approach to support improvement in board governance arrangements. In addition, the paper includes a suggestion to support effective system engagement.

At the meeting, Stuart Elborn, Christine Collins, Eileen Mullan and Anne O'Reilly will each add some comments on the paper or answer any questions during the discussion.

2. ESTABLISHMENT OF PATIENT SAFETY COMMITTEES AND BEING HUMAN FRAMEWORK PROGRESS

Belfast Trust

- September 2025 – January 2026: Belfast Trust reviewed and revised its Integrated Governance and Assurance Framework, informed by a range of considerations including by advice and recommendations in the Hill/McBride report commissioned by the Minister and published in October 2025. The establishment of the PSQC has been incorporated into the revised Framework. The Being Human Framework is being implemented through induction of all mew staff.

- January - March 2026: Belfast Trust has been consulting internally on the range of changes and adjustments made to the Framework.

- April 2026 onwards: Belfast Trust is transitioning to the new Framework. As at the end of April 2026, we are reviewing the DoH draft Terms of Reference (version 5 circulated in December 2025) and actively streamlining it to make it fit for purpose for implementation within Belfast Trust. This will be approved in May 2026 at the first meeting.

SHSCT

- Since October 2025, the Trust has undertaken a sustained programme of Board development aimed at strengthening governance maturity, improving the quality of scrutiny and reinforcing collective responsibility for safety, quality and performance.

- A key strand of this work has been alignment with Department of Health expectations in relation to patient safety and quality. The draft DoH Patient Safety and Quality Committee terms of reference place clear emphasis on visible Board leadership and continuous improvement. To meet the full scope of the broad draft terms of reference, elements of assurance are appropriately distributed across the Board's committee structure.

- The Patient Safety and Quality Committee is underpinned by three executive led steering groups for Safety and Quality, Standards, Risk and Compliance, and Organisational Governance.

NIAS

September 2024 – February 2025

- NIAS undertook redesign of its Board governance. This included a full review and refresh of all Board Committee Terms of Reference.

February – April 2025

- A revised committee architecture was implemented from April 2025, including the establishment of a strengthened Safety, Quality and Patient Experience (SQPE) Committee, chaired by a Non-Executive Director, with defined escalation routes to Trust Board. Its remit includes:
    - triangulation of safety, quality and patient experience intelligence
    - oversight of learning from adverse incidents and complaints
    - assurance on delivery of quality strategy and improvement programmes
    - escalation of emerging risks and system pressures to Board
- In the context of the Department's proposed Patient Safety and Quality Committee (PSQC), NIAS considers that many of the core functions described within the draft Terms of Reference are already reflected within the existing SQPE Committee and wider governance framework.

NHSCT

- NHSCT has undertaken a mapping and review of the purpose, duties and sources of Safety and Learning Intelligence set out in Draft ToR V5 against the current arrangements outlined in NHSCT Integrated Governance Framework.
- Currently the Outcomes and Assurance Committee which is a standing committee of Trust Board and chaired by a Non-Executive Director.

- NHSCT are carefully considering how best to respond to the request to establish a PSQC. There is an option to develop the Outcomes and Assurance Committee into PSQC or to establish a new committee that will provide oversight and triangulation of information from the existing committees reporting to Trust Board.

WHSCT

- December 2025 – February 2026: WHSCT undertook a detailed review of the Department of Health's draft Patient Safety and Quality Committee (PSQC) Terms of Reference, concluding that the majority of proposed assurance, escalation and advisory functions are already embedded within the Trust's existing Integrated Governance and Assurance Framework, principally through the Governance Committee, with defined contributions from the People Committee and Improvement Through Involvement Committee.
- The review highlighted the need to reconsider reporting routes for certain sub committees, particularly where responsibilities extend beyond patient safety into wider staff and organisational safety domains.
- Following formal consideration by the Governance Committee in March 2026, the Trust has agreed a preferred approach of incorporating the PSQC remit within existing arrangements by revising and renaming the Governance Committee as the Patient Safety and Quality Committee and increasing meeting frequency to support more timely scrutiny and escalation.
- Further work is underway to finalise revised Terms of Reference, committee interfaces and reporting arrangements, recognising regional challenges regarding data timeliness, dashboards and proportional implementation pending final DoH guidance. A final proposal will be taken to CMT and then Trust Board in June 2026 for implementation following Governance Committee later that month.

SEHSCT

- SEHSCT has established a Patient Safety and Quality Committee, following a full remapping and realignment of 26 lower-level committees, adjustment of reporting lines and revision of Terms of Reference so that all patient safety issues now flow to the new committee, which replaces the Governance Assurance Committee.
- The PSQC has wide membership (all Non-Executive, Executive and Board-level Directors) with a new escalation process in place for matters requiring Board or sub-committee action; the revised Terms of Reference, adapted from the extensive DoH draft, were approved by the Governance Assurance Committee at the end of April and will go to Trust Board in May for final approval.
- The Trust has invested significant time in dissecting and tailoring the DoH model to fit existing structures, ensuring that the PSQC is operationally

feasible (avoiding unmanageable 3–4-hour meetings) and focused on providing meaningful assurance rather than historic paperwork.

Being Human Framework

Following the successful launch of RQIA's Patient Safety Culture Assessment Framework ("Being Human") in September 2025, the framework has secured endorsement across the entire HSC system as a strategically critical initiative. It provides a structured, evidence-informed approach to identifying and addressing issues of culture that clearly impact on safety and provides a key mechanism for 'whole system' learning, assurance, and the delivery of safe, compassionate care.

Through the establishment of a regional oversight and implementation steering group, a comprehensive suite of enabling toolkits have been developed to support boards and system leaders, clinical and non-clinical staff, and, critically, people, families, and the wider public. In addition to the enabling tools and guidance, is the development of the "assurance approach" and a maturity matrix to assess progress in improving our safety culture. This will enable consistent, criteria-based assessment and support targeted, measurable cultural action and improvement. It is anticipated that the assurance framework and maturity matrix, along with the additional enabling guidance and toolkits will be made available to health and social care organisations by late June.

In parallel, and to support a period of testing and improving the framework, maturity matrix and toolkits, work is underway to develop a web-based platform, hosted by ECHO. This will act as a central repository for all the 'Being Human' resources, guidance, and the Framework, its assurance process and maturity matrix. This will further enable controlled accessibility to the materials, and with the support of ECHO, bring people together, and ensure consistency across the system in testing and later adopting the approach. Each HSC organisation has identified Non-Executive Ambassadors, Executive Sponsors, and local implementation Champions, establishing both local leadership and whole system, shared ownership during this next testing period and later the implementation phase.

Throughout the next year, RQIA will continue to assist and support health and social care organisations by fostering an environment that encourages effective collaborative testing and refinement, using the ECHO methodology. This approach aims to enhance and support whole system capabilities, facilitate shared learning, and ultimately promote uniform implementation in a Framework that has credibility based on the approach to its co-development from the outset. By utilising quality improvement science methodologies, the ECHO approach seeks not only to enable refinement of the products but importantly will build communities of practice to drive meaningful improvements in their own organisational culture. In the coming months,

further work will be undertaken, linking with the People to Partners initiative to strengthen the voice of people with lived experience in the formulation of an approach, which captures lived experience as part of the being human safety culture assessment framework across its domains.

The “being human” patient safety culture assessment framework is complementary to the “being open” policy framework, and other policy developments including redesigned SAI processes and learning. These policy developments and the assessment framework share objectives of strengthening cultures of safety, learning, and compassion across the HSC system, while each serves a distinct and important purpose. RQIA will continue to work in collaboration with the department to ensure strategic alignment in the utilisation of the being human framework to support policy implementation and positive impact across the HSC system.

3. COMMITTEE IN COMMON UPDATE

The Committee in Common continues to provide system-level oversight and coordination across the six Health and Social Care Trusts, focusing on shared priorities where collaborative delivery adds the greatest value. Through its advisory role, the Committee supports alignment, monitors progress, and facilitates shared learning across a portfolio of established and emerging Provider Collaboratives, while statutory accountability remains with individual Trust Boards.

Early progress indicates that collaborative working at scale is supporting more consistent approaches, improved coordination of clinical expertise, and tangible improvements in priority areas.

Provider Collaboratives deliver agreed programmes of work across two or more Trusts and remain accountable through individual Trust governance arrangements, with the Committee in Common providing oversight and alignment.

Further detail on the current and emerging Provider Collaborative portfolio is set out in the Appendix A.

Progress to date – selected examples

- Gynaecology Elective Care: The first clinical system priority has focused on standardising enhanced red-flag triage processes. Work with primary care is progressing to support care closer to home, aligned with the neighbourhood model. Outcomes: outpatient waits over three years have reduced by approximately 85% and inpatient/day-case waits by approximately 86% since September 2025.
- Enhanced Care: Progress in improving discharge pathways and care home capacity to reduce delays in acute settings, with over 200 patients awaiting placement; 246 bed offers identified, with 118 under active consideration.

- Regional Agency Reduction: Continued collaborative working to reduce off-framework agency usage and associated cost pressures.
- Virtual Wards: Design and implementation are underway, with first admissions anticipated in Belfast Trust in Autumn 2026, and work progressing to develop pilot sites in rural areas.

Learning and Forward Look

Learning to date highlights the importance of clear senior ownership, strong clinical leadership, and system partner engagement. This is informing ongoing delivery and future prioritisation.

Priority areas for 2026–27 are in development, with an initial focus on Care Homes, Procurement, and Information Governance.

4. BOARD IMPROVEMENT PROJECT

Context

The role and responsibilities and accountabilities of Trust/ALB Boards have increased significantly, and the level of political and public expectation requires an improved understanding of the current landscape and wider operating environment, essential to ensuring that ALB are able to respond effectively now and into the future

The recent NIAO Report- Partnership Working -Departments and ALB (March 2026) stated that ALB play a vital role in delivering public services across NI – in this case Health and Social Care across 18 organisations operating regionally and locally with key recommendations issued in 2018 which they consider remain relevant – for example,

- Develop shadowing, secondment and training opportunities at senior level for ALB and Departments
- Consider talent pool for Board appointments with the intention of ensuring good governance skills
- Utilise a 360-degree approach to develop honest, trusting and supportive arrangements
- Develop guidance on what ‘Earned Autonomy ‘look like
- Define and agree roles in the context of value and risk sharing

It is noted in the Reset Plan- Stabilise; Reform Deliver that DOH and H&SC intent is to operate as one system and references significant strategic leadership expectations of Boards to achieve the vision of reset – from hospital to home; prevention and partnership; innovation and digital. Reset outlines out the following -

- Enhance the accountability at the level of TB/ALB

- Delegate and mandate decision -making and planning /organisation of services to the right level; in particular promoting incentives and enabling collaborative working
- Establish and support leadership development and delivery
- Promote openness, honesty and a supportive culture -even when things go wrong
- Set high ambitions for success for the NI population and its H&SC system
- Put in place structures and governance arrangements that support collaboration, effective decision-making and delivery at pace

Of note is the statement “it is critical that our system leaders, particularly our CEO and Chairs are at the centre of leading and driving this agenda”

The current landscape of organisations with an interest in Board / NED development can be confusing e.g. leadership centre; commissioner public appointments; On board training; NIAO. Having a coherent approach would be helpful

Alongside this there is a range of governance recommendations from inquiries-eg neurology& MAH and the subsequent reports on MAH leadership and governance, Mc Bride/ Hill; the policy direction Being Open and work of RQIA on Being Human; People as Partners – all of which refers fundamentally to the centrality of Board leadership- and all have been consistent in calling for strong, capable, well informed, curious and sense making board members.

By way of noting Trust Boards are undertaking a piece of work in keeping with a whole system approach to look at standardising the work of a few key committees, reducing variation in agendas and reporting to achieve improved levels of consistency

In summary there has been a longstanding position among Chairs that attention to the role and responsibilities of Boards requires attention particularly in the current climate and to have due regard to the particular demands, scale and complexity of Boards and the need to provide greater assurance as to the capacity, competence and capabilities required of Chairs/NED

<u>Next Steps</u>

- To ask DOH to consider response to proposal from NICON Chairs
- To continue the work across Trust/ALB Chairs group to further consider and agree TOR for this proposal.

5. SUPPORTING SYSTEM ENGAGEMENT

The HSC Chairs' Forum is committed to working proactively and productively with the Department. As colleagues will be aware, non-executives do not work in trusts on a full-time basis and have significant other commitments, outside their HSC roles. They can in some cases be disappointed to miss important Departmental summits or significant regional meetings.

Chairs would like to invite Departmental consideration of the possibility of holding several dates in the diary, that could be used for significant regional meetings. These could be released if not required. We appreciate events sometimes need to be responsive but would welcome consideration of this planned approach to provide a greater level of involvement and support overall diary planning.

Appendix A:

CIC FREQUENTLY ASKED QUESTIONS

Committee in Common - Key Line
The Committee in Common is a formal collaborative governance arrangement that brings together the six Health and Social Care Trusts to address shared priorities through strategic alignment, oversight and collective problem-solving, while maintaining the statutory accountability of individual Trust Boards.

Supporting Points

- It is an advisory forum that enables Trusts to align priorities, share system-level insight, and oversee collaborative programmes
- It does not have decision-making authority, does not direct operational delivery, and has no independent budget or funding stream; all decisions remain with individual Trust Boards
- It focuses on shared priorities that are more effectively addressed through collaboration across Trusts, rather than by individual organisations acting alone
- Provider Collaboratives deliver agreed programmes at scale and remain accountable to their respective Trust Boards, with the Committee in Common providing oversight, alignment, and shared learning
- The model aligns with the Health and Social Care Reset Plan, which supports Committees in Common as a mechanism for addressing regional challenges through collaboration
- A structured communication and engagement approach is in development, supported by strong clinical leadership and staff involvement. Service user involvement is being developed through Provider Collaboratives.

LIKELY SUPPLEMENTARY QUESTIONS

Who is responsible for it?
The Committee is chaired by the Non-Executive Chair of the Southern Health and Social Care Trust, with the Chief Executive of the South Eastern Health and Social Care Trust as Chief Executive Lead for Provider Collaboration. However, all formal decisions remain with individual Trust Boards.

Does it remove accountability from Trusts?
No. Each Trust Board remains fully accountable in law for its decisions, performance, and the services it provides. The Committee in Common is advisory and supports, rather than replaces, existing governance arrangements.

Is this creating another layer of bureaucracy?
No. It brings existing Trust leadership together to coordinate action on shared priorities more

effectively. It does not create a new statutory body or additional decision-making layer, and accountability remains with individual Trust Boards.

Does the Committee Chair or the Chief Executive Lead for Provider Collaboration receive any additional remuneration for undertaking these roles?
No. These roles are undertaken as part of existing statutory responsibilities and within existing remuneration arrangements. No additional payment, allowance, or enhancement is provided.

What does it cost?
The Committee in Common has no independent budget or funding stream. Activity is delivered through existing Trust resources and governance arrangements.

How does the Committee in Common support collaboration across Trusts?
It supports collaboration by bringing Trusts together around shared priorities, with the Committee providing oversight of progress and Provider Collaboratives coordinating delivery across participating Trusts. This enables a more coordinated approach and better sharing of expertise.

What Provider Collaboratives are currently in-place?
Current and emerging priority areas include:

Current Provider Collaboratives	Emerging Provider Collaboratives
Enhanced Care	Psychiatry
Gynaecology Elective Care	Haematology
Candidate Passport (including Mandatory Training)	Head and Neck / Ear, Nose and Throat / Oral and Maxillofacial Surgery
Regional Agency Reduction	
Regional Coordination Centre	
Virtual Wards	

What difference is it making?
The Committee is supporting more coordinated action across Trusts to address shared priorities. This is contributing to measurable improvements, including reductions in long waiting times, for example, significant reductions in the longest gynaecology waits since September 2025. It also improves visibility of system-wide risks and supports shared learning across Trusts.

How are staff and clinicians involved?
Engagement with staff and clinicians is central. Clinical leadership is a core part of Provider Collaboratives, with clinicians directly involved in designing and delivering programmes. This is supported through Trust governance, clinical networks, and wider staff engagement.