



**Minutes of a meeting of the Audit & Risk Assurance Committee  
held on Monday, 19<sup>th</sup> February 2026 at 9.30 a.m., in the Committee  
room, First Floor, Trust Headquarters, Craigavon**

**PRESENT:**

Mrs L Ensor, Non-Executive Director (Chair)  
Mrs M Corkey, Non-Executive Director  
Mr A Hughes, Non-Executive Director

**IN ATTENDANCE FOR FULL MEETING:**

Mr S Spoerry, Interim Chief Executive, SHSCT  
Mrs C Marks, Director of Finance, Procurement & Estates, SHSCT  
Mrs F Jones, Corporate Financial Accountant, Fraud Liaison Officer, SHSCT  
Mrs C McKeown, Head of Internal Audit  
Ms G Jest, Assistant Head of Internal Audit  
Mr S Wallace, Head of Office, Chair & Chief Executive Office, SHSCT  
Mrs R Vennard, Committee Secretary, SHSCT – Via MS Teams

**IN ATTENDANCE FOR SPECIFIC ITEMS:**

Mrs Donna Murphy, Assistant Director of CYP Services - Item 5 & 7  
Children's Safeguarding  
Mrs J McGall, Director of Mental Health & Disability Services - Item 7  
Management of Patients – Willow Ward  
Mrs J McConville, Assistant Director of Corporate Planning item 7 Major  
Capital Projects  
Dr S Austin, Medical Director -Item 16 Risk Management  
Ms A Kane, Audit Manager, NIAO- item 6, 13 & 14  
Mr T Wilkinson, Director, NIAO - item 6, 13 & 14

**APOLOGIES**

Mrs A Rutherford, Assistant Director of Finance for Financial Services

**1) CHAIR'S WELCOME**

Mrs Ensor welcomed everyone to the meeting.

2) **DECLARATION OF INTERESTS**

Mrs Ensor asked members to declare any potential conflict of interest in relation to items on the agenda. None were noted.

3) **CHAIR'S BUSINESS**

None noted.

4) **MINUTES FROM THE MEETING HELD ON 9<sup>th</sup> October & 30<sup>th</sup> October 2025**

The minutes of the meeting held on the above dates were previously approved by email.

5) **MATTERS ARISING FROM THE PREVIOUS MEETING**

Members noted the progress updates from the relevant Directors to issues raised at the previous meeting.

- **Trust Monitoring Visits to Domiciliary Care Providers.** The Trust received the latest DLS response on Monday 16 February and are now considering the same. The Trust will now finalise our response to the Independent Sector Provider (ISP) in question, agree this final communication with DLS and then share this with the ISP in early March 2026. This will bring this matter to a conclusion. Mr Hughes asked why the matter has remained open for some time and what is the cause of the delay. Mrs C Marks stated that there were several points of clarification and information sought by DLS over a prolonged period relating to legal advice being prepared which caused the delay.
- **Year End Follow Up on outstanding IA Recommendations on Payments to staff.** It was noted that Trust Board was provided with an update in November 2025 regarding this item. The Committee agreed to close the item on the action log.
- **Internal Audit Progress Reports 2025/26 - Claims Management.** Item regarding rationale regarding Belfast Trust practice of reporting on the triangulation of new claims to Trust Board brought forward to next Committee meeting, April 2026.

- **Mid-Year Follow Up on Cyber Security Internal Audit Recommendations.** Ms Wilson in absence provided a paper that detailed updates on progress regarding Cyber Security Internal Audit recommendations. Ms Ensor asked that Ms Wilson be invited to the next ARAC meeting to present a short presentation on the Cyber security within the Trust and the processes in place.

***ACTION – MS WILSON TO BE INVITED TO ARAC APRIL 2026 MEETING TO PROVIDE AN UPDATE ON CYBER SECURITY AND DIGITAL SERVICES***

- **Internal Audit Progress Report - Client monies and cash valuables handling in Social Services.** Mrs Murphy provided an update on the implementation of new cash handling procedures at Bluebell House and Cedar Grove, including the appointment of administration staff, standardising of documentation, and ongoing audits to improve governance and reduce risks of misappropriation. She noted that a corporate accounting and systems review found improvements in cash handling and no evidence of misappropriation, with no need for referral to BSO counter-fraud services. Four recommendations were made, including the separation of petty cash from other funds and a move towards a cashless system where possible.

Mrs Murphy also referenced a new standardised financial procedures and documentation have been introduced and are being piloted until the end of February, with evaluation planned for March. All relevant staff have read and signed the new procedures, and ongoing training is provided, especially given staff turnover. She added that spot checks are regularly conducted by the head of service and operational leads to ensure compliance with procedures. Internal audits of client monies and financial transactions are planned for all homes, with a focus on strengthening controls in children's homes. The Committee agreed to close the item on the action log.

Mrs Ensor congratulated Mrs Murphy along with Mrs Marks on the improvement work to date. Mr Hughes asked are the procedures that are in place universal across the different sites or are they tailored for each of the houses. Mrs Marks stated these are universal in terms of petty cash oversight, on top of this there are specific procedures in place in relation to the structure and the team depending on the nature of the requirements.

Mrs Ensor asked are the operational procedures in a single volume and if so, is this available for anyone to view. Mrs Murphy stated that for new staff it is part of their induction to know and understand the operational procedures of cash handling. Mrs Murphy noted that at Bluebell house the nature of the cash handling is a different clientele and requirements are slightly different though procedures are the same across facilities.

Mrs Corkey asked the lessons learned from this work that is applicable to other areas, Mrs Marks agreed to check on standardisation of other processes at Trust homes and advise at next meeting.

***ACTION – MS MARKS TO PROVIDE DETAILS ON STANDARDISATION OF OTHER PROCESSES AT TRUST HOMES AND ADVISE AT NEXT MEETING***

## **6) EXTERNAL AUDIT STRATEGY 2025/26**

Mrs Kane presented the Committee with the External Strategy. She outlined the audit strategy for public funds, charitable trust funds, and patients' monies, identifying key risks, materiality thresholds, and the impact of the EQUIP implementation on the finance team's workload and audit timetable. Mrs Kane noted the main audit risks identified were the risk of material misstatement or fraud and the potential breach of the trust's duty to break even. Materiality thresholds were set for each account, with error reporting thresholds specified.

Mrs Ensor noted the audit timetable is tight in terms of schedule due to the EQUIP implementation, which requires significant input from the finance team. Mrs Kane noted that efforts are being made to bring work forward and spread the workload to avoid high peaks, with interim audit work already underway.

Mrs Kane noted NIAO will leverage internal audit work, with meetings scheduled to discuss findings. Robust procedures are in place for managing personal data, ensuring secure handling and destruction post-audit.

## **7) INTERNAL AUDIT**

### **i) Internal Audit Progress Report**

Mrs McKeown presented the internal audit progress report.

### **Management of patients with Dementia – Satisfactory**

Mrs McKeown advised that Internal Audit are providing satisfactory assurance in relation to the Management of Dementia Patients on Willows Ward in Bluestone at Craigavon Area Hospital. Mrs McKeown noted the following key audit findings:

- Discharge of patients with Dementia from Gillis and Willows wards is challenging. The average length of stay in Gillis/Willows is 34 weeks; there are three current inpatients who have been on the Gillis ward for 1 year or more. 2 of 9 inpatients remain on the ward, 37 and 15 weeks after being deemed medically fit for discharge. Delays in discharge can impact the ward's ability to accept new patients. It is acknowledged that there are regular reviews and daily management within Bluestone in relation to delayed discharges.
- The Mental Health and Disability directorate's high risk relating to the Dementia inpatient service and the future provision of Dementia Inpatient Services within the Trust should be reviewed and updated. There are no controls noted on the most recent risk register and actions listed have been implemented and should be listed as controls.
- Policies and procedures require review and update.
- 13% of staff at Gillis/Willows did not have up to date Violence and Aggression training and 17% did not have up to date Manual Handling training as required for their role.

Mrs Ensor invited Mrs McGall to speak regarding service challenges and delays in ability to discharge medically fit patients. Mrs McGall provided the committee with an overview of the challenges within the service. She noted that the Trust aims to support service users with dementia to be able to live at home for as long as possible. She referred to patients being in hospital wards for extended periods as unfortunately not unusual, noting the challenges caring for patients with middle and end stage dementia. Mrs McGall noted where there is coexisting significant behaviours of challenge it can take quite some time for ward staff and multidisciplinary team to understand what is driving the changes and offer appropriate medication and medical care. This is also exacerbated with challenges in finding ongoing placement arrangements once a patient has been assessed, treated and deemed medically fit. She noted it is a challenge within the Independent Sector to be able to meet the needs and behaviours of the patients.

Mrs McGall noted that as part of the Trust Timely Care programme work is underway that involves the independent sector to develop bespoke arrangements to manage individuals with dementia and coexisting challenging behaviours. She noted to date there has been arrangements with a care home in Newry to assist and work is ongoing.

Mrs Ensor asked regarding the item on the Corporate Risk Register regarding Inpatient Dementia Services noting it reads that the risk has been addressed but remains on the register. Mrs McGall stated that although the risk is managed the Trust is awaiting further engagement with the SPPG regarding the permanence of the change. Mrs McGall agreed to revise the risk description to clearly articulate this.

The Committee thanked Ms McGall and recognised the work ongoing to deal with the challenges.

### **Children's Safeguarding – Limited Assurance**

Mrs McKeown advised that Internal Audit are providing limited assurance regarding Children's Safeguarding however do acknowledge that the controls in relation to prioritisation of the children's protection cases were adequate and as of September 2025, there was no unallocated child protection cases within the Trust, which was the time for the audit. There's also regular reporting, the SPPG and Department of Health as well as internally, internally monitored.

Mrs McKeown noted the following significant findings in the report:

- There is a lack of compliance with timelines set in the regional safeguarding procedures. Delays were noted in 27% of child protection investigations. 40% of initial cases conferences reviewed were not held within 15 working days of completion of the investigation. Delays occurred in 27% of cases in approval of minutes for circulation to family. It is not possible to evidence that reports for case conferences were submitted on a timely basis to the chair or the family in advance of the meeting.
- The Core Group and case co-ordinators are responsible for carrying out the inter-agency work outlined in the child protection plan. Internal Audit reviewed 15 cases on the child protection register and identified that:
  - In 8 (53%) cases, the core group meetings did not take place within 10 working days of the Initial Case Conference as required by procedures.

- In 6 (40%) cases, a second core group meeting had not taken place as required.
  - In 5 (33%) cases, the attendees at the core group meeting were not recorded on the Core Group Meeting Record (CP6) as required by procedure.
- A Child Protection Plan must be in place for every child/young person on the Child Protection Register and should be recorded in the minutes of the case conference. In addition, children/young people with a child protection plan must be seen at least every 4 weeks, and more often if specified in the child protection plan. Review of 15 cases identified: -
    - In 4 (27%) cases reviewed, although regular visits had been made, these were not at 4 weekly intervals as required by procedure with delays ranging from 5 to 9 weeks.
    - In 10 cases target dates for implementation of actions were not detailed on the plan as required by procedure.

46% of staff in the Family Intervention and Gateway Teams have not undertaken Level 2 safeguarding training.

Mrs Murphy noted an action plan has been developed and accepted by internal audit, with progress reported up to 12<sup>th</sup> February 2026 and further activities scheduled by the end of March 2026. She noted the plan includes meetings with chairpersons and operational leads to improve compliance with timelines and a review of all audited cases to ensure no outstanding risks. Mrs Murphy referred to delays and stated these were linked to workforce capacity issues, high vacancy rates (over 30%) and challenges in coordinating with external agencies during holiday periods. Recruitment of new social workers is expected in September 2026 via students qualifying in July.

Mrs Murphy noted that all staff requiring level 2 safeguarding training have been identified, with completion dates set by April. Some compliance challenges remain due to staff on maternity or sick leave. Monthly reporting systems and escalation processes have been established to monitor statutory visits and training compliance.

The Committee noted the risks relating to non-compliance with regional child protection policies and procedures however was assured the Trust does have a safe child protection service and proactively and effectively manages risks in this area and will note in the Committee Chair Report to Trust Board.

## **Management of Major Capital projects - split – Satisfactory / Limited**

Mrs McKeown noted that Internal Audit are providing Satisfactory / Limited assurance in relation to Management of Major Capital Projects (with the exception of learning). Mrs McKeown noted there is an established, adequate process in place for management of major capital projects within the Trust. She advised that sampled business cases were approved by the senior leadership team through the Strategic Investment Committee. For the projects reviewed (CAH CT Scanner and Craigavon Area Low Voltage) there was no significant overspends and there was evidence of ongoing review and monitoring of expenditure against business case value.

Mrs McKeown stated there is one significant finding impacting on the assurance provided relating to the Post Project Evaluation (PPE) for the CT Scanner Project at Craigavon Area Hospital has not been agreed and finalised 18 months after the project was finished noting the process for identifying learning during capital projects and through PPEs for taking into future projects needs reviewed and strengthened.

Mrs McConville attended for this item to discuss the findings of this internal audit report. Mrs McConville stated that there is a robust process for PPE within the Trust and completed PPEs by this or other Trusts are a key component considered when developing new Capital Business cases. She noted that during the period of the internal audit there had only been one project and unfortunately there had not yet been a PPE completed. Mrs Marks and Mrs McConville referred to the resources required to meet the 6- and 12-month timescales however assured that where significant learning came to light this would be addressed and shared as appropriate.

## **Payments to Nursing Staff – Satisfactory**

Mrs McKeown stated that Internal Audit are providing Satisfactory assurance in relation to Payments to Nursing Staff. There are no significant findings in this audit, impacting on the assurance provided, key findings were as follows:

- There are potentially unnecessary role profiles on Health Roster that allow staff to alter rotas and request changes, which should be reviewed and standardised. In addition, 1,110 inactive accounts remain enabled beyond 90 days. A leavers report is provided by HR to the Health Roster Team on a monthly basis however this list is not used to remove leavers from the system.

- At September 2025, 24 (1%) staff across the directorates of MUSC (22) and MHD (2) owed the Trust in excess of 37.5 hours. However, on further review 17 of these 24 staff are on Health Roster in name only, their shifts are not recorded on the Health Roster system and they aren't paid any enhancements they usually work on a 9 to 5 pattern.
- Full population data analysis of additional payments to nursing staff in the MUSC and MHD directorates for one month identified overpayments totalling £1,307. In addition, as per DoH guidance, staff who worked Saturday 12 July were entitled to claim Bank Holiday, but only if they didn't work the Monday 14th, 14 staff were identified that received a Bank Holiday payment for both days.

Mr Hughes asked is the Health Roster system linked to HR payroll systems or is it freestanding. Mrs Marks stated they are not linked it is a separate software, will seek advice from Mrs Vivienne Toal on this.

***ACTION – MRS MARKS TO SEEK CLARIFICATION ON HOW THE HEALTHCARE ROSTER AND HR ARE LINKED / WORK ALONGSIDE EACH OTHER.***

#### **Follow up Medical Job Planning – Satisfactory**

Mrs McKeown noted a follow-up audit on medical job planning showed significant improvement, with most recommendations implemented and the assurance level raised from limited to satisfactory. She noted that further work is required on including objectives in job plans and pre-authorisation of activities.

#### **Purchased Healthcare – Deferred**

The purchased healthcare audit presentation was deferred pending further regional and Internal Audit discussion.

#### **8. INTERNAL AUDIT PLAN 2026/27 - DEFERRED**

This item was deferred until April 2026 meeting.

***ACTION – INTERNAL AUDIT PLAN 2026/27 TO BE TABLED AT APRIL 2026 MEETING.***

#### **9. INTERNAL AUDIT CHARTER**

Mrs McKeown presented the Internal Audit charter advised the document had been refreshed to align with new global internal audit standards, introducing essential conditions for Boards and Committees. She advised that the document outlines the purpose, mandate, and reporting relationships of internal audit.

### ***THE INTERNAL AUDIT CHARTER WAS APPROVED BY THE COMMITTEE***

## **10. INTERNAL AUDIT FORUM UPDATE INCLUDING PRIORITY ONE RECOMMENDATIONS**

Mrs Jones gave a high-level summary on the Trust Internal Audit forum and Priority One Internal Audit recommendations.

### **Priority One Internal Audit Recommendations**

Mrs Jones advised that there remain Priority one recommendations which were carried forward into 2025/26 and these remain outstanding at this stage. She noted three have been assigned Red RAG status as above, indicating they will not be achieved in 2025/26 and one is Amber and expected to be delivered by 31 March 2026. The three not expected to be delivered in 2025/26 relate to audits regarding Business Continuity, payments to Laboratory staff and the ACS issue around Anns Homecare where legal advice is awaited to inform the Trust approach concerning commissioned care hours.

### **25/26 Internal Audit Forum**

Mrs Jones advised that the Internal Audit Forum has increased its frequency of meeting to every fortnight over January and February to monitor implementation as year-end approaches.

Mrs Jones noted there are currently 71 recommendations outstanding. Of these she noted that 26 are significant recommendations remain for implementation, of which 3 are priority one recommendations which were carried forward from 24/25. At this date, there are 9 recommendations, that Directorate Internal audit representatives are indicating will not be achieved in 2025/26 with implementation dates in the future noted.

Mrs Jones stated following the Trust Internal Audit Forum held on 16<sup>th</sup> February 2026, this number will increase from 9 to an estimated 20 which for a range of reasons will not be achievable by March 2026. She noted this will leave approximately 51 recommendations for implementation between now and 31<sup>st</sup> March 2026. The number of recommendations on

the database on 31<sup>st</sup> January 2026 with a date for implementation beyond 31 March 2026 is 28 of which 7 are related to business continuity recommendations.

Mr Hughes asked how many Priority one recommendations will not be achievable by year end and what the impact will be. Mrs Marks stated that of the 9 recommendations, 7 are planned to be implemented before year end and have with extensive of controls in place.

## **11. UPDATE ON EXTERNAL AUDIT RECOMMENDATIONS**

Mrs Jones provided updates on the implementation of external audit recommendations, including the Direct Award Contracts, cleansing of the fixed asset register in preparation for EQUIP and ongoing work on annual leave accruals and holiday pay provisions. She noted that the Trust has stratified and cleansed assets with low original cost, with ongoing work on higher value items. Mrs Jones advised that assets beyond their useful life are scheduled for replacement, and the process is aligned with EQUIP implementation. She noted that the annual leave survey is underway, with efforts to improve data accuracy. Work on the regional holiday pay provision following the PSNI legal case is ongoing, with sensitivity analysis being conducted in collaboration with other Trusts.

## **12. FRAUD UPDATE**

### **i) SHSCT Fraud Report**

Mrs Jones gave an update on Fraud cases highlighting some issues detailed below.

- Agency Worker Fraud Investigation - A regional issue involving fraudulent references for agency workers is being investigated, led by BSO counter fraud. The Trust has identified three reports of concern, with most implicated individuals no longer employed. The investigation involves coordination with border control and other agencies.
- Overpayments and Controls - The Trust is piloting the classification of overpayments above certain thresholds as potential fraud cases, balancing proportionality and employee circumstances. New attendance records and processes are being introduced to improve oversight.
- Lessons Learned and System Improvements - Lessons learned from fraud cases are shared across the trust, with training sessions conducted to raise awareness. The staff and post system, though

manual, provides assurance over payments, and a new system for medical locums is expected to enhance controls.

- Fraud, Overpayments, and Lessons Learned – Mrs Jones referred to ongoing fraud cases, including agency worker references and overpayments, with regional collaboration on counter-fraud efforts and new processes being piloted to improve detection and prevention. The Committee asked for details at a future meeting on the number of fraud cases within the current financial year in comparison with previous years.

***ACTION – INCLUDE THE NUMBER OF FRAUD CASES WITHIN THE CURRENT FINANCIAL YEAR AND A COMPARISON WITH PREVIOUS YEARS. – MRS JONES***

***ii) National Fraud Initiative (NFI) Update***

Mrs Jones stated the NFI exercise commenced in September 2024 and is now complete. She advised there were no Trust cases of fraud or losses identified. The next NFI Exercise will commence in September 2026 with data extracts from Trust systems for matching with other participating public sector organisations.

**13. COMPTROLLER AND AUDITOR GENERAL'S REPORT ON FINANCIAL AUDIT FINDINGS 2025**

Mr Wilkinson outlined the Comptroller and Auditor General's Report that is provided every year, summarising the results of Financial Audit Findings. He noted that Encompass was highlighted as a concern regarding the availability of general data that was previously available at a high level, now cannot be produce by the Encompass system.

Mrs Ensor asked Mr Spoerry if the challenges of obtaining information from Encompass was a concern. Mr Spoerry responded that operational information is improving and provides much richer functionality. He added that there is a strong interest in encouraging its use at a regional level. Mr Hughes asked whether there was likely to be an issue obtaining the information required for the annual report from Encompass. Mrs Marks confirmed that performance data was required, however, the necessary information has generally been obtained.

**14. NIAO SOUTHERN HEALTH & SOCIAL CARE TRUST – LETTER OF UNDERSTANDING**

Mr Wilkinson referred to the NIAO Letter of Understanding. He advised the at the letter is a standard document that outlines the relationship between us and the Trust and management and clarifies the respective responsibilities of each party.

**15. LOG OF FINANCE CIRCULARS**

Financial circulars were noted for information

**16. RISK MANAGEMENT**

**i. Risk Management Strategy 2026**

Dr Austin presented the Risk Management Strategy noting the strategy was updated using guidance from both healthcare and non-healthcare organisations. He advised that the next phase involves developing a training programme to ensure staff understand and implement the strategy effectively.

**ii. Corporate Risk Register Update**

Dr Austin provided an update on the risk register documented below. He noted that the risk register is maintained as a live document, with regular four to six weekly reviews by the leadership team and updates presented to various committees. Risks are regraded, rewritten, or removed as appropriate. Dr Austin also advised that the Trust is moving to an electronic risk register, allowing for real-time updates and cascading of risks throughout the organisation. This transition is expected to improve the accuracy and responsiveness of risk management.

Dr Austin also noted that resources will be required to manage risk effectively, with recognition that additional staff and engagement from services are needed to fully embed the strategy.

**17. COMMITTEE TERMS OF REFERENCE**

The Committee approved the revised terms of reference subject to an amendment to update reference to the Institute of Internal Auditors Global Internal Audit Standards (GIAS)

**18. TRAINING AND DEVELOPMENT**

None Noted

**19. ITEMS FOR TRUST BOARD ESCALATION**

No escalation items noted however the Committee agreed the Board should be informed that the Committee is assured in relation to the limited assurance presented in the Childrens Safeguarding 2025/26 Internal Audit Report that overall, the Trust does have a safe child protection service and proactively and effectively manages risks in this area.

**20. ANY OTHER BUSINESS**

No other business was noted.

***The meeting concluded at 11.50 a.m.***