Southern Health and Social Care Trust

TOGETHER, IMPROVING CARE, TRANSFORMING LIVES

Minutes of a meeting of the Audit & Risk Assurance Committee held on Monday, 23rd April 2026 at 9.30 a.m., in the Committee room, First Floor, Trust Headquarters, Craigavon

PRESENT:

Mrs L Ensor, Non-Executive Director (Chair)
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 A Rutherford, Assistant Director of Finance for Financial Services
Mrs C McKeown, Head of Internal Audit
Ms G Jest, Assistant Head of Internal Audit
Mr T Wilkinson, Director, NIAO
Mr S Wallace, Head of Office, Chair & Chief Executive Office, SHSCT

IN ATTENDANCE FOR SPECIFIC ITEMS:

Ms E Wilson, Director Planning, Performance and Informatics (Item 6)
Mrs V Toal, Director Human Resources and Organisational Development (Item 7)

APOLOGIES

Mrs M Corkey, Non-Executive Director
Mrs F Jones, Corporate Financial Accountant, Fraud Liaison Officer, SHSCT
Dr S Austin, Medical Director
Ms A Kane, Audit Manager, NIAO

1) CHAIR'S WELCOME

Mrs Ensor welcomed everyone to the meeting and noted apologies

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 19th FEBRUARY 2026

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 –*** This matter in final stages, Mr Brian Beattie will provide an update to committee members via email shortly.
- ***Cyber Security Update –*** Mrs Elaine Wilson providing a presentation at todays meeting.
- ***Fraud Update –*** Trend year on year on fraud cases provided in paper at todays meeting.

6) CYBER SECURITY AND DIGITAL SERVICES PRESENTATION

Mrs Wilson presented a comprehensive update on the Trust's cyber security position, including progress against outstanding internal audit recommendations and the strength of current governance and assurance arrangements.

It was noted that the Trust is subject to annual IT internal audits. The 2023/24 internal audit on incident management reviewed the Trust's preparedness to respond to and recover from cyber incidents and resulted in Limited Assurance, with 20 Priority 2 recommendations agreed by management. Mrs Wilson advised that a further audit in 2024/25 examined Trust arrangements for managing cyber security risks arising from the supply chain, noting this as the most likely source of cyber-attack. This audit received a Satisfactory opinion.

Mrs Wilson outlined that there were consistent themes across IT audits, particularly the need to formally define essential services, strengthen governance arrangements, and improve contractual and assurance

controls. Members were advised that essential services have now been formally agreed, following a period of engagement. Governance around digital contracts had been strengthened through the establishment of a Technical Design Authority, providing structured scrutiny of new systems and associated cyber risks prior to approval.

It was highlighted by Mrs Wilson that most line-of-business systems are owned and managed by operational services rather than the IT function, reflecting their specialist clinical and operational nature. While this approach was considered appropriate, Mrs Wilson acknowledged the inherent risks and confirmed that training and support for system and contract owners had been strengthened. She advised that capability had improved, although some residual risk remains, particularly in relation to legacy contracts that pre-date current governance arrangements.

Mrs Ensor queried whether the corporate risk register adequately reflected cyber risk. Mrs Wilson confirmed that the corporate risk register had been recently reviewed and updated and now includes three specific risks relating to cyber, digital delivery, and technology enablement. She advised that significant work had been undertaken over the past year to strengthen the articulation of cyber risk, particularly in preparation for compliance with the Network and Information Systems (NIS) Regulations. The use of Data Protection Impact Assessments was highlighted as a key control, ensuring cyber risks are explicitly considered and owned by Information Asset Owners as part of contract approval processes.

Mrs Ensor raised the interaction between major digital programmes, including EQUIP, and cyber risk. Mrs Marks confirmed that cyber risks associated with EQUIP are managed through regional governance arrangements, including the Regional EQUIP Programme Board and the Regional Cyber Programme Board.

Mr Hughes sought assurance regarding controls over information leaving Trust systems, including the automatic transmission of diagnostic or fault reports to third-party suppliers. Mrs Wilson confirmed that robust technical controls, including firewalls and system permissions, are in place to prevent inappropriate information sharing, and that information flows are formally assessed as part of system implementation and approval.

The Committee discussed business continuity and disaster recovery recommendations arising from the 2023/24 audit. Mr Spoerry queried whether these recommendations remained valid following the recent live IT outage. Mrs Wilson advised that the incident had provided significant learning and reassurance regarding the robustness of the Trust's technical

response. She acknowledged that full live testing, including taking systems offline, is recognised best practice but carries operational risk and must be carefully planned. The Trust currently relies largely on desk-based exercises, with further work underway to consider how more live testing could be taken forward in a safe and proportionate way. Mrs Wilson confirmed that business continuity planning across services has been strengthened, with explicit consideration of cyber incidents and IT failure.

Mrs Ensor asked whether external cyber security bodies had assessed the Trust's readiness in the event of a cyber attack. Mrs Wilson confirmed that, at regional level, specialist cyber security support is commissioned to assess resilience and provide incident response capability. She emphasised that, while technical recovery would be supported regionally, the key challenge for the Trust would be sustaining clinical services over a prolonged period without digital systems.

Mrs Wilson provided an update on outstanding internal audit recommendations, advising that 15 of the 20 recommendations from the 2023/24 audit have now been closed. For the 2024/25 audit, all recommendations have been completed with the exception of one relating to contractual cyber assurance for a specific line-of-business system, which is being progressed in conjunction with operational management, IT, and the contracts team. Remaining open recommendations relate to disaster recovery testing, the development of a separate network for critical systems (requiring a business case and likely regional funding), and assurance over the recoverability of BSO-managed systems, which is dependent on regional engagement.

Mr Hughes asked whether the Trust was in the strongest position achievable given current constraints. Mrs Wilson advised that the Trust has a clear understanding of remaining gaps and associated risks and is addressing those within its control. She highlighted concern regarding the absence of approved regional capital funding for cyber resilience, which remains a significant dependency outside the Trust's control, despite sustained escalation.

Mrs Ensor queried whether learning from cyber incidents in the Republic of Ireland had informed local arrangements. Mrs Wilson confirmed that this learning had informed general awareness and regional thinking, although she was unsure whether a formal lessons-learned report had been undertaken locally.

Members confirmed that the update provided the depth of assurance and challenge sought and satisfied the Committee's earlier request for a deep

dive on cyber security and digital services. It was noted that further assurance would be provided through a forthcoming Trust Board update on NIS preparedness. The Committee emphasised the importance of continuing to frame cyber security as a patient safety and service continuity risk, rather than solely an IT issue.

The Committee noted the update and was content with the level of assurance provided.

7) INTERNAL AUDIT

The Committee discussed the Internal Audit progress report and sought clarification on the status of audits not formally presented within the papers.

Mrs Ensor queried the position regarding four audits that had been expected by the Committee but were not yet finalised. The Head of Internal Audit advised that, unfortunately, formal management responses had not been received in time to meet the paper deadline. It was noted that progress had been made as recently as the previous day and that, subject to final responses, the audits relating to risk management, discharge processes, purchased healthcare, and utilisation were expected to be finalised within the coming days. Mrs McKeown emphasised that management engagement had been ongoing, but the absence of finalised responses had prevented completion within the reporting timeline.

The Committee was advised that the Internal Audit performance indicators on the first page of the report reflected some slippage against targets, particularly in relation to the turnaround time from draft to final reports and the issuing of draft reports within four weeks. Mrs McKeown confirmed that these performance variances would be analysed in more detail and reported formally within the Head of Internal Audit's next report to the Committee, including underlying reasons for the shortfall.

Members were informed that four reports were being presented to the Committee at this meeting, along with follow-up work, while a further six reports remain in draft format awaiting management comments and agreement. The Head of Internal Audit highlighted that, with the exception of the risk management audit, all outstanding draft reports currently carry at least a partial limitation opinion.

The Committee noted the update and the explanation provided regarding report finalisation timescales and performance against internal audit key performance indicators.

i) Internal Audit Progress Report

Mrs McKeown presented the internal audit progress report.

People Framework – ***Limited Assurance***

Mrs McKeown advised that Internal Audit are providing limited assurance in relation to management delivery of the Trust's People Framework. Mrs Toal attended the meeting to provide management context and respond to questions.

Mrs McKeown noted while the audit recognised a wide range of initiatives and opportunities in place to support staff health and wellbeing, learning, recognition and development, it identified two significant findings. Members were advised that the previous People Framework formally concluded in October 2025 and, at the time of the audit, there was no updated or refreshed framework in place. In addition, there had been limited reporting on delivery of the People Framework to the Trust Board and its committees, with only one workforce dashboard presented between April 2025 and January 2026. As a result, assurance could not be obtained that the desired outcomes of the framework were being achieved. Recommendations focused on refreshing the People Framework and ensuring regular monitoring and reporting of progress.

The Committee noted a decline in overall staff satisfaction reflected in the 2024 Pulse Survey. Limited action had been taken following the survey to address the results, and some of the issues identified were echoed in staff discussions during the audit. The audit also highlighted low compliance with annual staff appraisal requirements, with overall completion at 54% at the time of the audit and particular concern in relation to medical appraisals, where 13% had not been completed for the 2024 year as at February 2026. Management confirmed that all recommendations arising from the audit had been accepted.

Mrs Ensor queried the low response rate to the Pulse Survey and whether participation should be linked to the appraisal process. Mrs Toal explained that the last regional HSCNI staff survey had taken place in 2019 and that typical response rates across Trusts are around 20%. The Pulse Survey was intended as a shorter, locally-run "temperature check" and was deliberately timed ahead of Encompass go-live. She advised that staff

were heavily engaged in Encompass implementation at that time, which limited both response rates and the organisation's capacity to follow up on actions in advance of go-live.

Mrs Toal outlined that learning from the survey had been incorporated into the Encompass implementation approach, particularly around staff recognition and health and wellbeing messaging. She further noted that Pulse surveys generally attract lower uptake than larger national or regional surveys and that engagement had been driven through a global email, which was not ideal but reflected capacity constraints at that time.

Mrs Toal advised that the next phase of work would focus on stronger ownership of survey outcomes at directorate level. Individual directorates will be required to present their action plans to the People and Culture Committee during 2026/27, with corporate directorates scheduled first and operational directorates to follow. She emphasised that improvement in organisational culture would take time and require sustained stability and leadership, noting recent organisational change, interim arrangements and the impact of Encompass on governance and reporting structures.

Mr Hughes asked whether the Trust could assess generational or longitudinal changes in staff engagement, particularly for newer staff. Mrs Toal advised that this would require clearer demographic profiling within surveys and that such data is not currently available, although it could be considered in future survey design.

Mrs Toal acknowledged that significant groundwork has been undertaken corporately, but emphasised that directorate and team-level ownership will be critical to driving meaningful improvement. She noted that the People and Culture Committee will be central to providing oversight and challenge as actions are implemented.

It was agreed that Mrs Toal would share the Pulse Survey results with Non-Executive Directors for information. Mr Spoerry expressed support for the use of staff surveys over the longer term and emphasised the importance of visible recognition and appreciation of staff and teams who demonstrate positive behaviours and achievements, noting this as an important aspect of leadership during a period of financial and operational pressure.

The Committee noted the Limited Assurance opinion, accepted management's response to the findings, and was content with the actions proposed to strengthen delivery and oversight of the People Framework.

ACTION – MRS TOAL TO SHARE THE RESULTS OF THE 2024 PULSE SURVEY WITH COMMITTEE MEMBERS

Maternity and Gynae – *Satisfactory Assurance*

Mrs McKeown advised that Internal Audit are providing satisfactory assurance regarding Maternity and Gynae Services

Mrs McKeown noted the audit specifically reviewed the effectiveness of risk stratification arrangements for patients transferred from Daisy Hill Hospital to Craigavon Area Hospital. The Committee was advised that the audit confirmed that an appropriate risk stratification process was in place and operating as intended at patient level. There were no significant audit findings, although three key findings were highlighted. The principal issue related to the risk stratification database not being updated for a six-month period. Management has accepted all recommendations arising from the audit.

Mrs Ensor queried the assurance rating, noting concern that the database had not been updated for a prolonged period and seeking clarity as to how satisfactory assurance could be concluded where a key system element had not been maintained.

Mrs McKeown explained that, while the high-level database used for oversight and monitoring had not been fully updated during that period, the underlying risk stratification process was continuing to operate effectively. She confirmed that clinical risk assessments and decisions regarding place of delivery were being undertaken and acted upon appropriately on a patient-by-patient basis. The issue identified related to the absence of timely data entry into a specific field within the database, which limited the ability to undertake higher-level trend analysis and monitoring rather than impacting direct patient care.

Mrs McKeown advised that the gap related to a specific data field within the database and reflected temporary resourcing challenges. All relevant information had been captured through alternative manual processes and the database has since been fully updated. Mr Spoerry noted that incomplete data entry would primarily affect the Trust's ability to undertake pattern recognition and longer-term monitoring. However he noted from the report that once the database was fully completed, no concerns were identified from the retrospective review of the data.

The Committee acknowledged the explanation provided and agreed that, on balance, the assurance rating was appropriate, noting that the core

clinical risk stratification process remained in place and effective throughout the period. Members nonetheless emphasised the importance of maintaining accurate and timely data entry to support ongoing assurance, oversight, and trend analysis.

The Committee noted the report, accepted the Satisfactory Assurance opinion, and emphasised the importance of maintaining complete and up-to-date monitoring data to support continued assurance over risk stratification arrangements.

Independent Neurology Recommendation Implementation – *Satisfactory Assurance*

Mrs McKeown advised that Internal Audit are providing satisfactory assurance regarding Neurology Recommendation Implementation.

Members were advised that the Trust has a comprehensive action plan in place to manage and track delivery of the recommendations. It was noted that the Department of Health has reviewed the Trust's implementation assessment and that 91% of the recommendations have been assessed as implemented. The audit also identified a number of examples of good practice observed during the review.

There were no significant audit findings. Two key findings were highlighted. The first related to the need for clearer and more regular reporting at Board or Committee level on the status and implementation of the Inquiry recommendations. The second identified a small number of further actions which, if progressed, would help to better embed and sustain delivery of the action plan, including aspects relating to whistleblowing training. Mrs McKeown noted that Trust management confirmed acceptance of all recommendations arising from the audit.

The Committee noted the Satisfactory Assurance opinion, acknowledged the high level of implementation achieved, and was content with the actions proposed to strengthen reporting and further embed the Independent Neurology Inquiry recommendations.

Management of Sickness and Absence – *Satisfactory Assurance*

Mrs McKeown advised that Internal Audit are providing satisfactory assurance regarding Trust Management of Sickness and Absence.

Members were advised that the Trust has a procedure in place for the management of sickness absence and that sample testing confirmed

managers are generally complying with the procedure. Absence management performance is reported quarterly to the People and Culture Committee, with more detailed monthly reporting undertaken at directorate level.

No significant audit findings were identified. Five key findings were highlighted. It was noted that, as at January 2026, the Trust's sickness absence rate was just over 7%, which is above the regional target. The audit identified instances where required supporting documentation was not available, including self-certification forms and return-to-work documentation. It was also identified that some managers misunderstood the requirement to complete return-to-work interviews for short-term absences. Medical and dental staff sickness absence rates were significantly lower than other staff groups. However, variation in the way medical absence is recorded and reported increases the risk of inconsistencies or gaps, highlighting the need for a clearer and more consistent Trust-wide process so that managers understand the correct route for recording and reporting medical absence.

Mrs Ensor commented on the financial cost of sickness absence to the Trust and noted the scale of the impact in the context of wider financial pressures. Ms McKeown advised that the quality and frequency of absence reporting is strong and provides management with good visibility at directorate and corporate level, supporting more effective absence management and targeted intervention. She confirmed that limited availability of training for managers was linked to the introduction of a new regional sickness absence procedure and that updated training will be required to support consistent application of the revised arrangements. Mrs McKeown noted Trust management confirmed acceptance of all audit recommendations.

The Committee noted the Satisfactory Assurance opinion, acknowledged the financial and operational impact of sickness absence, and was content with the actions proposed to strengthen documentation compliance, training, and consistency in absence reporting.

8) YEAR-END FOLLOW-UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS

The Committee received the year-end follow-up report on outstanding internal audit recommendations, covering both the main follow-up pack and cyber-related recommendations.

Mrs Jest advised that 387 recommendations were examined. Of these, 86% were fully implemented, 11% partially implemented, and 3% not implemented, compared with 84% at mid-year and 90% at year-end in the previous year. Members were advised that 47 recommendations related to significant audit findings, of which 20 (43%) have been implemented by the Trust, leaving 27 significant recommendations not implemented, compared to 22–23 at the mid-year follow-up. Of these, 21 significant recommendations carried forward from mid-year, with six new significant recommendations added, three relating to medical recruitment and three to children's safeguarding.

The Committee noted that the outstanding significant recommendations span 14 internal audit reports, with the oldest dating back to 2017/18 in relation to risk management. In addition, three recommendations from 2019/20 remain partially implemented, relating to absence management, recruitment, and risk. Mrs Jest acknowledged that the overall percentage of fully implemented recommendations is lower for these long-standing reports.

Members were advised that six recommendations (approximately 11%) require third-party or regional input, limiting the Trust's ability to progress them independently. These include recommendations relating to Human Resources, implementation of EQUIP, agreement of regional and local rates, and a contract management solution reliant on a regional system led by BSO. One recommendation has been accepted by Finance but requires additional resources, with proposals being progressed through the Strategic Investment Committee. Limited progress was also noted in relation to social care contract procurement.

Cyber-related recommendations were noted as covered elsewhere on the agenda, including five outstanding recommendations from 2023/24 and one from 2024/25, along with four outstanding regional ICT recommendations relating to governance, policies, and procedures.

Mrs McKeown provided additional context on social care contract procurement, advising that all Trusts wish to see these recommendations progressed. A milestone date of March 2026 had previously been agreed; however, returning to the review showed evidence of limited progress. While the scale and complexity of the challenge was acknowledged, Members noted that these issues are long-standing. Mrs McKeown invited the Committee to consider whether Audit and Risk Assurance Committee regional chair group should seek a regional timeline for addressing these matters, noting that Trust-level timelines are insufficient where the underlying issues are regional.

Mrs Marks advised that medical contracting is now a standing item at the Regional Procurement Board. Previous approaches led by SPPG had not resulted in a viable solution due to capacity and resourcing constraints. She confirmed that the Southern Trust Executive Team has agreed to lead a regional group, with Department of Health input, to progress medical contracting arrangements, with terms of reference in development. Trust Procurement Boards are also exploring options for agreeing regional rates to reduce variability and improve value for money. She noted that work is progressing, albeit gradually.

Mr Spoerry suggested that the Committee in Common may have a role in supporting and escalating regional work on social care contracting. Mrs Ensor queried whether recommendations rated red but not overdue should be subject to more explicit Committee follow-up, particularly those longstanding items. In response, Mrs Marks advised that a dedicated report would be brought to the June meeting, focusing on older outstanding recommendations, setting out what action is being taken locally and regionally and clarifying where progress is constrained.

Mrs McKeown further suggested that the issue could be raised through the Audit and Risk Assurance Committee Chairs' Forum to promote regional challenge and shared understanding.

It was agreed that a report on older outstanding internal audit recommendations would be brought to the June meeting

Committee noted the year-end position, acknowledged the progress made, and recognised that a proportion of long-standing recommendations remain dependent on regional solutions outside the Trust's direct control.

ACTION - REPORT ON OLDER OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS WOULD BE BROUGHT TO THE JUNE MEETING – MRS RUTHERFORD

ACTION - AUDIT AND RISK ASSURANCE COMMITTEE REGIONAL CHAIR GROUP SHOULD SEEK A REGIONAL TIMELINE FOR ADDRESSING TRUST-LEVEL WHERE THE UNDERLYING ISSUES ARE REGIONAL. TO BE RAISED AT THEGIONALAUDIT AND RISK COMMITTEE CHAIRS FORUM 13TH MAY 2026 – MRS ENSOR

9. INTERNAL AUDIT PLAN 2026/27

The Committee received the Internal Audit Plan for 2026/27, presented in the context of the previously approved three-year internal audit strategy. She noted an error on the paper which reads 990 audit days for the year that should read 890 days.

Mrs McKeown outlined the approach to audit planning, confirming that the plan reflects the annual refresh of the three-year programme and is aligned to the current corporate risk register. She confirmed the agreed service level agreement (SLA) days, noting a correction in the narrative where an historic figure was referenced. It was confirmed that Internal Audit has sufficient resources in place to deliver the proposed plan.

Members were advised that the Internal Audit Key Performance Indicators have been reviewed and refreshed. In addition to existing process-based measures, new indicators have been introduced to provide greater insight into audit outcomes, including the percentage implementation of audit recommendations and customer satisfaction, which will be reported formally through the Head of Internal Audit reports.

The Committee noted that 79% of current high and extreme corporate risks are covered within the three-year audit plan. Of the 24 high and extreme risks on the corporate risk register, 19 are included in the plan, with a further one covered in the preceding year. Four risks are not reflected in the current plan, with justification provided, including coverage through alternative assurance arrangements and prioritisation of audit resources.
Mrs McKeown confirmed that the plan has been refreshed in line with discussions with the Director of Finance and Medical Director and had been considered and agreed by the Senior Leadership Team prior to submission to the Committee. Limited changes are proposed for 2026/27, with the annual plan summarised in Appendix A.

Key areas of focus for 2026/27 include:

- EQUIP, subject to go-live timing, with an intention to provide assurance over new processes where practical
- Procurement and contract management, focusing on transport
- Patient flow, including management of work queues and inboxes within Encompass
- Actioning abnormal diagnostic blood results
- Management of referrals, including cancer performance targets
- Encompass system governance, administration and reporting
- Governance audits, including raising concerns, management of serious adverse incidents and never events

- Business continuity, building on the 2023/24 Limited Assurance audit
- Management of Violence and Aggression (MOVA), brought forward to align with other Trusts
- Advisory work on sustainability and regional sharing of good practice

Mrs Ensor queried three finance-related audits that are reliant on EQUIP being operational and whether the system would be sufficiently embedded to support meaningful assurance activity. In response, Mrs Marks confirmed that further delay to EQUIP is anticipated and that assurance work would proceed where possible using existing systems. She advised that non-pay expenditure audits will be progressed, with flexibility over timing and system focus depending on implementation progress.

Mrs McKeown further advised that management is currently undertaking an extensive review of domiciliary care arrangements and that an internal audit in this area during 2026/27 would not be beneficial while improvement activity is underway. It was therefore proposed that a different audit within the Adult Community Services directorate be undertaken in place of domiciliary care payments, subject to confirmation. Mrs McKeown confirmed that, following completion of the audit cycle and subject to finalisation of outstanding reports, she is providing Satisfactory Assurance overall.

The Committee formally approved the Internal Audit Plan for 2026/27, subject to revision to reflect the proposed alternative to the domiciliary care payments audit.

COMMITTEE FORMALLY APPROVED THE INTERNAL AUDIT PLAN FOR 2026/27

10. LOG OF FINANCE CIRCULARS

The Committee received an update on finance circulars issued during the 2026 calendar year and the statutory accounts timetable.

Mrs Rutherford advised that seven finance circulars had been issued to date. Five relate primarily to year-end financial reporting and statutory accounts preparation. One circular did not apply to HSC Trusts, as it related to HSE pension scheme accounts, and one circular related to confidentiality agreements, which has been shared with Human Resources. Members were advised that the circulars contain technical accounting and timetable requirements and did not require specific action or consideration by the Committee.

11. FINANCE CIRCULAR - FAU MEMO 04-2025 – TIMETABLE FOR ALB ANNUAL ACCOUNTS 2025-26

Mrs Rutherford outlined the key statutory accounts submission dates for 2025/26. The Trust is required to submit the following by 1 May:

- Draft Governance Statement
- Draft Trust accounts
- Draft Charitable Trust Funds (CTF) accounts
- Consolidation data capture / financial reporting template

She advised that the full annual report and accounts pack is required by 5 May, noting the compressed timescale over the bank holiday period.

In relation to audit completion and approval, Mrs Rutherford confirmed that the audited accounts must be approved by the Audit and Risk Assurance Committee and Trust Board by 1 July, with submission to the Department of Health and laying by 3 July.

Members noted that a revised timetable for Charitable Trust Funds accounts had been issued separately this year, which did not align with the Trust's established committee cycle. Mrs Rutherford confirmed that this issue had been raised with the Department of Health and that assurance had been received confirming that Charitable Trust Funds accounts may follow the same timetable as the public funds accounts, ensuring alignment with Committee and Board review arrangements.

The Committee discussed the sequencing of Audit and Risk Committee meetings and confirmed that draft accounts would be submitted to the Department of Health on 1 May, with detailed scrutiny by the Audit and Risk Assurance Committee later in May, in line with arrangements agreed in previous years.

The Committee noted the finance circulars, the statutory accounts timetable, and the confirmation from the Department of Health regarding alignment of Charitable Trust Funds accounts with public funds accounts.

12. TRAINING AND DEVELOPMENT

None Noted.

13. FINAL FRAUD UPDATE REPORT 2025/26

i) SHSCT Fraud Report

Mrs Rutherford presented the Counter Fraud update report, including notification of new cases since the last meeting and a summary of fraud activity during 2025/26.

Members were advised that five new cases have been reported since the Committee last met. Of these, four remain ongoing and one has been closed. The new cases include a matter relating to controlled drugs within pharmacy, which is under investigation, with Members querying the value associated with the incident and noting that the primary concern relates to control of medication rather than financial value.

A further case relates to an employee accepting gifts of a substantial nature from a service user which is currently under investigation by Human Resources in conjunction with Counter Fraud. Another case concerns payment for training time not fulfilled, which remains under investigation, and a further case relating to home care on-call monitoring arrangements, which has been closed as no evidence of financial benefit or fraud was identified.

Members were also advised of three theft incidents at Trust premises, reported in February, which has been referred to the PSNI.

By way of overview, the Committee noted that during 2025/26, a total of 29 suspected fraud cases were reported, compared to 24 in the previous year. Of these, a significant proportion relates to a regional issue concerning false or fraudulent references for agency staff, which has been discussed at previous meetings.

Mrs Marks provided an update on this regional matter, advising that the issue was originally identified within another Trust and is being investigated regionally by Counter Fraud. Each Trust has identified cases linked to this issue, with nine cases identified within the Southern Trust. Members were advised that, as a control measure, the Trust has not onboarded any new agency workers for the past 12 months. Any future onboarding will require individuals to progress through the recruitment bank nurse route, with enhanced checks undertaken in advance by BSO PALS. Disciplinary proceedings have commenced where appropriate, and dismissals have taken place in cases where fraudulent activity has been substantiated. Additional controls, including strengthened identification checks, have also been implemented.

Members noted that all suspected fraud cases are reported through the Counter Fraud portal and that learning from investigations will inform

ongoing control improvements. The information provided will inform disclosures within the Governance Statement and Annual Report.

The Committee noted the update, the number and nature of new fraud cases since the last meeting, and the strengthened controls in place to address regional risks associated with agency staff recruitment and references.

14. SELF ASSESSMENT

i) COMMITTEE SELF-ASSESSMENT 2024/25

Mrs Ensor referred to the Committee Self-Assessment undertaken for 2024/25 using the NIAO Self-Assessment tool. The Committee noted the document.

ii) REVIEW OF SPONSORSHIP ARRANGEMENTS

Mrs Ensor referred to the letter from the Department of Health regarding using the NIAO Self-Assessment tool for Committee self-assessment. She confirmed this is the tool the Committee used for 2024/25 and will use again for 2025/26.

16. RISK MANAGEMENT

Deferred as Dr Austin unable to attend the meeting.

15. ITEMS FOR TRUST BOARD ESCALATION

No escalation items noted.

16. ANY OTHER BUSINESS

No other business was noted.

The meeting concluded at 12.10 p.m.