SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

Minutes of the Audit Committee Meeting of the South Eastern Health & Social Care Trust held on Thursday 6 October 2022 at 12.15pm in the Boardroom, Trust Headquarters, Ulster Hospital, Dundonald

PRESENT: Mr N Brady, Non-Executive Director (Chair)

Mrs J O'Hagan, Non-Executive Director
Dr M Briscoe, Non-Executive Director
Ms W Thompson, Director of Finance and Estates
Mrs C McKeown, Head of Internal Audit, BSO Internal Audit
Mrs J McCaw, Internal Auditor, BSO Internal Audit

IN ATTENDANCE: Ms L Campbell, Assistant Director, Financial Services
Mrs M McNally, Assistant Director, Risk Management and Governance (Board Secretary)
Mr S Knox, Audit Manager, Northern Ireland Audit Office (NIAO)
Mr B Clerkin, Engagement Director, ASM

Mr D Pickett, Northern Ireland Audit Office (NIAO Observer)
Mr S Martin, Executive Support Services Manager (Minutes)

OPENING REMARKS

Members agreed Mrs O'Hagan would take the chair to commence the business of the meeting as Mr Brady had advised he had been delayed.

Mrs O'Hagan welcomed those present and extended a special welcome to Mr David Pickett attending as an observer having recently taken up post as a trainee accountant with NIAO.

1.0 APOLOGIES

Apologies were recorded on behalf of Ms Coulter (Chief Executive).

2.0 DECLARATION OF POTENTIAL CONFLICT OF INTEREST

No declarations were made at this stage or during the course of the meeting.

3.0 MINUTES OF THE PREVIOUS MEETING HELD ON 15 JUNE 2022

The minutes of the meeting held on 15 June 2022, having been previously circulated, were agreed as a true and accurate record.

4.0 MATTERS ARISING

Members received, for noting, **SET/AC/34/22** Matter Arising Sheet which confirmed one item arising had been actioned.

5.0 ITEMS FOR NOTING

5.1 REPORT ON INCIDENTS OF THEFT, FRAUD, BRIBERY OR WHISTLEBLOWING & NFI UPDATE – OCTOBER 2022

Members received, for noting, **SET/AC/35/22 Report on Incidents of Theft, Fraud, Bribery or Whistleblowing & NFI Update**. **Ms Campbell** referred to the 2022/23 Case Summary Report and provided a detailed update in relation to three open cases therein listed.

Mr Brady joined the meeting at 12.23pm.

Mrs O'Hagan highlighted some cases had references stating PSNI/PPS had indicated there was a low likelihood of a successful prosecution but there was a lack of information as to what the Trust did thereafter. **Mrs O'Hagan** suggested inclusion of additional narrative would be beneficial.

5.2 NIAO HEALTHCARE BENCHMARKING EXERCISE – PROJECT SPECIFICATION

Members received, for noting, **SET/AC/36/22 NIAO Healthcare Benchmarking Exercise – Project Specification**.

Ms Campbell noted NIAO had commissioned an independent benchmarking exercise to examine the performance of healthcare services in Northern Ireland against that of the other three UK countries as well as the Republic of Ireland. **Ms Campbell** advised the work will be used as the basis for the development of a health dashboard which could be accessed interactively by users of the NIAO's website. The aim is to document the quality of care the health service provides, over time, at regional/Trust level and to benchmark against the services provided in the UK and ROI covering the five year period from 2016/17 to 2020/21.

Mr Knox advised the new Comptroller & Auditor General wished to highlight this particular project and the detail contained within the paper in terms of Value for Money (VFM) adding it was envisaged the dashboard would be ready by 31 March 2023. **Dr Briscoe** commended the benchmarking exercise but noted the cross-jurisdiction challenges the team might encounter. **Mrs O'Hagan** stated if the exercise was being approached from a VFM perspective, that in itself may dictate what would be useful to look at

Dr Briscoe added the indicators were across five core areas and there may be benefit in utilising external input available such as via the Institute of Public Health and Queen's University Belfast to input into the audit which would add benefit with additional expertise.

At this juncture, Mr Brady re-took the Chair and expressed his appreciation to Mrs O'Hagan for stepping in.

5.3 SELF ASSESSMENT AGAINST NIAO INTERNAL FRAUD RISKS

Members received, for noting, **SET/AC/37/22 Self-Assessment Against NIAO Internal Fraud Risks**.

Ms Campbell highlighted the SET responses to the Self-Assessment Checklist. **Mr Knox** added a number of the examples used were thought-provoking and the checklist was particularly useful.

5.4 DEPARTMENT OF FINANCE (DoF) ANNUAL THEFT & FRAUD REPORT 2019/20

Members received, for noting, **SET/AC/38/22 DoF Annual Theft & Fraud Report 2019/20.**

Ms Campbell advised under Managing Public Money NI (MPMNI), all departments were required to report to DoF annually on all actual, suspected and attempted frauds which involve public money. Members noted 224 cases were reported in 2019/20 across all departments (an increase of 5 on 2018/19). Within DoH, there were 92 new cases, 65 of which were included in the annual fraud return equating to an actual or estimated value of £447k. Covid-19 related fraud became a factor with emerging trends and high risk areas identified including mandate fraud, suspected theft of PPE equipment, increase in staff cases involving pay or pay related allowances.

Ms Campbell highlighted a number of lessons learned as follows:-

1. Robust controls must be established and applied consistently to act as a deterrent and enable fraudulent activity to be identified.
2. Staff need to be aware of their responsibilities if fraud is suspected.
3. Clear channels for reporting fraud must be established and communicated.
4. Conflicts of interest need to be properly documented and managed.
5. Early intervention is key to stopping and reducing the impact of fraud.

5.5 DEPARTMENT OF HEALTH REVENUE BUSINESS CASE TEST DRILLING RESULTS 2021/22

Members received, for noting, **SET/AC/39/22 DoH Revenue Business Case Test Drilling Results 2021/22**.

Ms Campbell confirmed the Summary of Business Case Main Findings alongside the PPE Main Findings had all been found to been RAG rated green which was a good result. **Mr Brady** recorded that this was an excellent result. **Mrs O'Hagan** asked in terms of staff training what was the Trust doing to enable operational staff to develop good business cases. **Ms Campbell** replied Revenue Business Cases form part of quarterly financial training and when submitted she would quickly revert with feedback if the documentation contained insufficient narrative. **Ms Thompson** added Mrs Smyth was considering training options through the HSC Leadership Centre as EMT recognise the need for service managers to have this resource.

Mr Brady asked if there was any scope to reform the document template. **Ms Thompson** replied Members would see new forms coming through the Finance & Performance Committee in the near future with the aim of

avoiding repetition. **Mr Brady** added the use of photos in business cases was helpful so Members can visualise the current and potential side by side.

6.0 REPORT FROM INTERNAL AUDIT

6.1 BSO INTERNAL AUDIT GENERAL REPORT ON HSCNI 2021/22

Members received, for discussion, **SET/AC/40/22 BSO Internal Audit General Report on HSCNI 2021/22**. **Mrs McKeown** outlined that the report summarised the performance and outcome of Internal Audit activity in the HSC during 2021/22. Across HSC, 51% of assurance opinions were Satisfactory, a further 15 were split Satisfactory/Limited assurance, 32% were Limited assurance, 1% split Satisfactory/Limited/Unacceptable assurance and 1% Unacceptable Assurance. It was noted that in 2019/20 56% of audit assurance were satisfactory and 27% were limited. A summary of the most common areas of Limited and Unacceptable assurances included Contract Management (29% of total), Clinical Governance (15%), Payments to Staff (15%) and Corporate Governance elements (13%).

Mr Brady sought an update on the current status of the Audit Programme. **Mrs McKeown** replied she had summarised a briefing within the Progress Report noting their staff vacancy rate was at a sufficiently high level to flag it as a concern hence the request to HSC Trusts to defer a number of audits.

Mrs McKeown advised SET was listed as Organisation Number 4 within the Report and showed 60% Limited, 20% split Satisfactory/Limited and 20% Satisfactory. **Mrs McKeown** highlighted this was the lowest level of Satisfactory assurances for SET since this exercise commenced some six years ago. On a positive note, the implementation rate of previous recommendations is at its highest with 1% not implemented, 10% partly implemented and 89% implemented representing a strong performance.

Mrs McKeown noted that of 19 Priority 1 recommendations made, 2 related to SET. The audit areas in which Priority 1 recommendations were provided most frequently are Domiciliary Care, Management of Medical Devices and Payments to Staff audits (including shared services).

Mr Brady stated he was not comfortable with the level of Limited assurances. **Mrs McKeown** replied the Trust did have an unusually high level of Limited assurances in 2021/22 but this should be viewed alongside a strong performance in implementing recommendations and the entirety of the three year plan from which solid pillars of risk management and assurance across the Trust can be identified. **Mr Brady** replied that it will be interesting to see what next year shows. **Mrs O'Hagan** stated sometimes there were no responses from some areas and asked if Internal Audit were content with the level of engagement.

Mrs McKeown advised she was content given the high implementation rate which left a relatively small number to action. **Mrs McKeown** added it was unusual for this Trust and inconsistent with previous years but she had explained within the Report why this might have been given her team had auditing new higher risk areas.

Mrs McKeown noted there continued to be a limiting factor associated with the pandemic and resource challenges in this current environment.

Dr Briscoe queried the Corporate Governance figure across HSC Trusts and asked for additional information as to why this would be. **Mrs McKeown** replied this category covered a wide range of areas.

6.2 SET AUDIT COMMITTEE PROGRESS REPORT 2022/23

Members received, for discussion, **SET/AC/41/22 SET Audit Committee Progress Report 2022/23**.

Mrs McKeown referred to the first page of the Report as a means of closing down the 2021/22 position paragraph highlighting the Post Payment Validation Work on Special Recognition Payments (SRP) to Independent Sector Provider Staff Conducted in 2021/22. **Mrs McKeown** noted she had provided a number of verbal briefings to Committee throughout the year and as work evolved it became clear it was a DoH audit since they directly funded the SRP scheme. **Mrs McKeown** advised the Report had been issued in June 2022 and DoH Management had accepted all the recommendations made.

Mrs McKeown drew attention to the challenges in recruiting experienced auditors resulting in their current staff vacancy rate. **Mrs McKeown** advised her team were seeking a deferral of a number of specific audits agreed with Management in each HSC organisation from this current year into 2023/24. **Mrs McKeown** advised the deferrals would not impact on the ability to provide an overall assurance opinion and for SET the proposed deferred audit would be Patient Journey within Emergency Care. **Mrs McKeown** also advised of the deferment of one of the two outstanding regional audits namely Management of Independent Nursing Home contracts. In respect of the second regional assignment (Management of SAIs), **Mrs McKeown** proposed this audit was paused until Q4 2022/23 with a decision on deliverability to be made in January 2023 subject to resource availability.

Mrs McNally stated there was benefit in postponing the SAI audit due to proposed regional changes to the system and anticipated direction being given by DoH on next steps. **Dr Briscoe** agreed noting Members had considered SAIs at length within the Governance Assurance Committee. **Dr Briscoe** raised concern regarding the delay in the Independent Nursing Home contract management audit. **Mrs McKeown** explained the deferral was as a result of available staff resource and the audit in question had lost its regional dimension as another HSC Trust had already sought a deferral. **Mrs McKeown** added the intention was to complete the audit in 2023/24 so the delay was in practical terms only for a matter of months which would also align better with the annual contracting process.

Mr Brady signalled his agreement noting a delay in the Patient Journey audit made sense given the transition from current to new facilities on the UHD site. **Mrs McKeown** stressed the proposals had been considered alongside Management and would not impact on her team's ability to

provide the necessary assessment of overall assurance for the year. At this point, **Mr Brady** sought and obtained approval for the proposed deferrals.

Mrs McKeown then provided a detailed update on a number of audits.

Management of Client Monies in Independent Sector Homes 2022/23

A sample of 5 facilities split between Independent Sector Homes and Adult Support Living Facilities were selected for this audit based on the number of beds (Independent Sector Homes), when last visited, whether any concerns had been identified by RQIA and/or the Trust. For context, the Trust contracts with 110 Independent Sector Homes and 40 Adult Supported Living Independent Sector Providers.

The scope was to review processes within the five facilities sampled, to manage client monies and the objectives included ensuring the Trust was adhering to circular HSC(F) 15-2016 on the safeguarding of service users finances within residential and nursing homes and supported living settings.

Overall, it was found that there was a Satisfactory level of assurance on the basis that financial controls were generally found to be operating effectively although some control improvements. There were no significant findings impacting on assurance.

A number of key findings were made in respect of the following:

1. **Management of Residents Personal Bank Accounts/Monies**
2. **Residents Agreements**
3. **Residents Expenditure**
4. **Cash & Bank Balances**
5. **Trust Monitoring of Residents Finances**

Internal Audit noted evidence at 2 of 3 homes visited that annual reviews were not performed consistently across all residents and no evidence of a review of finances were found in 2 of 5 homes. It is important that Key Workers regularly monitor resident expenditure to ensure it is reasonable and appropriate and that there are no indicators of financial abuse.

Other findings included:

6. **Policies and Written Procedures**
7. **Property Inventory & Safe Contents**
8. **Comfort Funds**

Mrs McKeown highlighted two Priority 2 Recommendations as follows:

General Communication and Monitoring of Residents Finances

- The Trust should communicate the audit findings to the specific homes and agree an action plan with each of the homes visited that addresses the issues raised as well as how these will be taken forward including timescales for implementation of

recommendations. This was accepted by Management with an Implementation Date agreed of 31 December 2022.

- The Trust should strengthen processes around monitoring the finances of residents in independent sector homes. Key Workers should regularly monitor resident expenditure for appropriateness and obtain reasonable assurances that appropriate controls are in place to safeguard residents' money/valuables and that these are operating effectively. These reviews should be documented and reviewed. This was accepted by Management with a revised Implementation Date agreed of 30 September 2022.

Mrs McKeown noted one Priority 3 Recommendation – **Lessons Learnt**:

- The Trust should communicate the lessons learned from this audit for all independent homes and reiterate the importance of appropriate and correct handling of residents' monies. This was accepted by Management with an Implementation Date of 30 September 2022.

Mr Brady referred to one facility as being of concern since it appeared to feature in all of the testing. **Mrs McKeown** replied Internal Audit were generally satisfied with the controls in place otherwise a limited assurance would have been arrived at.

CONTRACT PERFORMANCE REVIEW (CHILDREN'S RESPITE UNIT)

Mrs McKeown stated the Trust had requested this audit as RQIA had deregistered the Respite Unit in March 2022 resulting in the Trust having to run the service directly. **Mrs McKeown** advised during hand over discussions, the previous provider informed the Trust that approximately 7,000 hours of commissioned and paid for service as per the 2021/22 contract with the Trust had not been delivered.

Mrs McKeown advised her team concluded there was a limited level of assurance on the basis there was evidence the previous provider had under-delivered 5,401 hours during 2021/22 with actual and potential overpayments made by the Trust. Trust contract documentation, management and monitoring was found not to be robust as well as Service Users care and support plans not being consistently signed off as required.

Mrs McKeown highlighted the need for controls over service user income and the need for management of service users' finances to be strengthened.

Mrs McKeown highlighted nine Priority 2 Recommendations which included the following areas:

- **Commissioned Activity Not Delivered**

The Trust should consider the various elements of the over-payment/potential over-payment outlined above and seek appropriate reimbursement from the previous provider in line with contract requirements.

- **Trust Contract Management**

Management should ensure any variations to contract, value and/or services commissioned, are appropriately documented in formal contracts, that the contract details the specific monitoring arrangements and agreement is obtained in a timely basis.

- **Care and Support Plans**

The Trust should ensure all care and support plans for the service users within the facility are reviewed and replaced with Trust care planning documentation addressing any changes to the service user's plans and planned outcomes.

- **Service Users Monies**

The Trust should ensure large cash balances are not held in the facility. The Trust should conduct of review of all monies paid to the service users in this Unit, during 2021/22. Any monies overpaid should be recovered, including the specific issues noted in the finding above. The Trust should ensure that social workers claim the correct allowances for service users on a timely basis. The Trust should ensure that social workers complete, document and sign a financial review has been undertaken quarterly for service users to ensure that monies claimed are being utilised as expected. Entitlements should be documented in the care/support plan.

- **Service User Ledgers**

The Trust should strengthen control over the management of service users finances including ensuring staff are appropriately trained and that independent checks by a SEHSCT Children's Services Independent Monitoring Officer are conducted to ensure staff are complying with procedures and regulation 32 of The Children's Homes Monthly Monitoring Regulations 2005 which should be submitted to RQIA. A listing of specimen authorised signatures should be created and maintained.

Where the Trust retains any contracts with the previous provider, the Trust should write to them requesting their Managing Service Users Finance procedures be submitted to the Trust's Financial Governance Manager. The previous provider should to be advised of the need to inform the Trust, in writing every 6 months, of any monies or valuable they hold on behalf of service users. The previous provider should also be advised that a list of specimen authorised signatures is to be created and maintained at all facilities.

MENTAL CAPACITY ACT (MCA) IMPLEMENTATION 2022/23 – MANAGEMENT OF DEPRIVATION OF LIBERTY (DoL) PROCESSES

Mrs McKeown stated this audit was to assess the appropriateness and effectiveness of the controls in place surrounding the implementation of the MCA including authorisation and review of both Legacy and New DoLs, MCA staff training and Governance Arrangements in place for the

management and monitoring of the implementation of the requirements of the Act. **Mrs McKeown** added this audit was based on the Corporate Risk that the Trust was unable to deliver MCA Phase 1 by 31 May 2021 being classed as high.

Mrs McKeown advised that limited assurance has been provided on the basis that there are significant delays between admissions and completion of medical assessments (completion of Form 6 – Medical Reports). Delays in completion of medical assessment impacted on the timely completion of the applications meaning the Trust was not compliant with MCA legislation specifically the timely processing of new cases. **Mrs McKeown** also referred to a backlog of DoL applications awaiting approval. Testing also identified the recording of staff training in relation to DoL needed strengthened to evidence staff having been appropriately trained. **Mrs McKeown** acknowledged the Trust had now evaluated all legacy cases, DoLs were in place and DoH were being informed through the quarterly assurance process. Records are maintained e.g. there were 311 short term detentions at the time of the audit and **Mrs McKeown** also observed the Trust had appropriate governance arrangements in place including a steering group, three work streams and regular assurance reporting to DoH.

The main challenge remains recruiting doctors to complete the Medical Report. Where medical reports are not signed off, a deprivation of liberty cannot be processed through a Trust panel. Delays result in patients being deprived of their liberty without an appropriated authorisation in place therefore putting the Trust in breach of MCA legislation.

It was recommended the Trust should modify current processes to increase the number of trained medics who can complete Form 6s. **Mrs McKeown** advised an update of trained medical staff should be monitored and corrective action taken where necessary. In addition, the Trust should ensure that the training records database includes the date that staff are trained and due date for refresher training with the MCA administration team reminded of the importance of maintaining an accurate database.

CLAIMS MANAGEMENT

Mrs McKeown briefed Members on the aforementioned assignment focused on the work of the Litigation Department based on the risk that the Trust processes for managing claims were not robust and DoH guidance in relation to claims management might not be adhered to. **Mrs McKeown** advised a conclusion of Satisfactory assurance had been reached on the basis that appropriate procedures and processes for managing claims are in place, DoH guidance was followed in sampled cases and claims information monitored for the sample tested. **Mrs McKeown** did note there was a need to further develop the SLA between the Trust and BSO DLS including improving the performance arrangements and the format of both the quarterly and annual reports presented to Trust Board Committees requiring review. **Mrs McKeown** stated testing noted an inconsistency between the expected values of ongoing claims reported internally to the Corporate Control Committee and the Governance Assurance Committee by the Litigation Department and externally to DoH by Finance in line with

Internal Accounting Standard 37 (IAS370). **Mrs McKeown** added the maximum value was reported internally whereas the medium value was reported to DoH. **Mrs McKeown** highlighted a number of key findings:

- The Trust has a Service Level Agreement with BSO DLS for the provision of legal services which should be further developed to include KPIs to monitor the performance of DLS and enhance reporting requirements;
- The format of the Quarterly Risk Management Report and Annual Report on Claims and Coronial Investigations require review with a number of gaps/omissions identified which were impacting on the completeness/accuracy of both reports. Testing also identified that the 2021/22 claims and coronial investigations annual report had not yet been prepared despite several months having passed since year end and that the Finance Team were not involved in the preparation of either report.
- A number of issues were noted in relation to the governance arrangements in respect of claims including:
- The Claims Review Group did not hold quarterly meetings in 2 of the 4 quarters sampled.
- The Terms of Reference of the Preliminary Advisory Group and the Claims Review Group had not been updated since 2016.
- Some minor issues were noted in relation to policies and procedures as well as file and case management.

Mrs McKeown noted four Priority 2 and three Priority 3 Recommendations including the Litigation Department should now produce and present the 2021/22 Claims and Coronial Investigations Annual Report.

Mr Brady sought further information on the de-registration of the Children's Respite facility by RQIA and the Trust's involvement thereafter. **Mrs McKeown** advised their understanding was that the previous provider raised the under-delivery of contracted hours at the time of handover. **Ms Thompson** stated processes had been brought up to Trust internal standards following the change in management. **Ms Thompson** explained the Trust requested the audit having identified gaps in contract management given their concern to ensure there were no overpayment adding an internal review had also been initiated to close any potential gaps in other contracts.

Mr Brady expressed concern the Trust appeared to react meaningfully only when RQIA sought to de-register the facility. **Dr Briscoe** noted RQIA would have exhausted their own process before de-registration of this particular facility to allow space for improvement. **Mrs O'Hagan** added RQIA had a primary responsibility in this area though there were obvious issues in relation to contract management the Trust needed to address going forward. **Mrs McKeown** clarified that the reason for de-registration was separate to the reasons why BSO were asked to audit. **Dr Briscoe** sought assurance of lessons learnt for future engagement with the company who had been operating the facility arising from the audit. In addition, **Dr Briscoe** sought assurance that the Trust was currently meeting RQIA standards for residential care in this setting given the background. **Mrs McKeown** replied her understanding was the Trust's Contract and Commissioning team were

reviewing all aspects of the audit findings. **Ms Campbell** added she would liaise with Ms Davidson in respect of Dr Briscoe's queries. **Mrs O'Hagan** highlighted the Contract Management findings and specifically the failure to issue a new contract which demonstrated shortcomings in our own contracting process. **Mrs O'Hagan** commented it was important these were addressed now and implemented across the system. **Ms Thompson** replied there was an Action Plan in place with a number of actions agreed which should demonstrate progress made.

Mr Brady stated that some Government Departments had invested in training staff in contract management with third parties. **Mr Brady** asked if this was an issue for the Trust and sought Mr Knox's input in terms of NIAO's perspective. **Mr Knox** advised the domiciliary care oversight report highlighted issues across all HSC Trusts with actions to be undertaken. **Mrs McKeown** added 29% of her team's limited assurances last year were contact management related. **Mr Brady** commented it did appear to be a recurring theme and what could the Trust do to further mitigate the risks associated with this area. **Ms Thompson** suggested this was an area which the Regional Procurement Board might consider a need to develop training to showcase best practice in contract management being developed. **Dr Briscoe** stated it was fair to say the Trust's Contract Management Team was relatively small and there was a resource limit internally.

Mr Brady referred to the MCA DoL audit outcome as worrisome when significant delays were being experienced from admission to the completion of assessment documentation. **Mrs O'Hagan** stated it was of interest that medical staff were not inclined to engage in this type of work and asked where that sat in terms of accountability of their own performance. **Mrs McCaw** explained initially it was considered GPs would take this work forward but they had not done so with the work now falling to hospital based doctors. **Dr Briscoe** asked if it was additional to their core work adding it did not augur well for patients if they were encountering delays at this stage of the process. **Mrs McKeown** replied it was largely a resource issue. **Dr Briscoe** acknowledged the Trust had completed a significant amount of work in terms of MCA legacy. **Mrs O'Hagan** stated the recommendation did not seem to match the intention behind MCA and the person centred care approach the Trust strives to deliver. **Mrs McKeown** replied her team had had detailed discussions on this aspect given there was no obligation to require medics to be involved with the aim being to maximise the number stepping forward for training and retaining them.

Mrs O'Hagan commented the process felt cumbersome. **Mrs McCaw** replied there had not been the engagement on a continuous basis with medics and a recommendation to re-engage had been agreed with the Medical Director. **Dr Briscoe** asked if there were any other healthcare professional who could complete a Form 6 such as a specialist nurse. **Mrs McKeown** advised it was their understanding it was limited to qualified registered doctors. **Ms Thompson** stated Management thought limited assurance was disappointing given the finite resource available but they were reviewing processes through the Action Plan with a view to re-engaging sustainable levels of medics. **Mrs O'Hagan** asked about the possibility for litigation arising from such delays. **Ms Thompson** advised

the Trust would continue to monitor this are closely and report through to DoH. **Ms Thompson** highlighted that because of progress made, EMT had recently re-assessed this risk down from the Corporate Risk Register to the Directorate Risk Register.

6.3 MID-YEAR ASSURANCE STATEMENT FROM HEAD OF INTERNAL AUDIT 2022/23

Members received, for discussion, **SET/AC/42/22 Mid-Year Assurance Statement from Head of Internal Audit 2022/23**.

Mrs McKeown advised the Statement provided an independent and objective assurance on the aspects of the system of internal governance reviewed and reported on by Internal Audit in the first six months of 2022/23 including the organisation's implementation of previous accepted Internal Audit recommendations. **Mrs McKeown** noted Internal Audit had reviewed the implementation of accepted outstanding Priority 1 and 2 recommendations where the implementation date had now passed which showed 78% of the outstanding 191 recommendations examined were fully implemented, a further 19% partially implemented and 3% not implemented.

6.4 SET MID-YEAR FOLLOW UP ON OUTSTANDING RECOMMENDATIONS REPORT 2022/23

Members received, for discussion, **SET/AC/43/22 SET Mid-Year Follow Up on Outstanding Recommendations Report 2022/23**.

Mrs McCaw stated of the 149 recommendations, 78% had been fully implemented, 16% partially and 6% not implemented at this stage. **Mrs McCaw** noted nine ICT recommendations connected to the 2018/19 IT Audit of Cyber Security had been removed as they sat more appropriately with DoH. **Mrs McCaw** concluded performance was consistent with other HSC Trusts. **Mrs O'Hagan** asked if Internal Audit were concerned about implementation looking forward to the end of the year. **Mrs McCaw** replied that they were not concerned given the on-going level of engagement across Directorates. **Mrs O'Hagan** added it was important work to implement recommendations with respect to ICT progressed.

6.5 BSO INTERNAL AUDIT SHARED SERVICE AUDITS 2022/23

Members received, for discussion, **SET/AC/44/22 BSO Internal Audit Shared Service Audits 2022/23**.

Mrs McKeown advised the recommendations were the responsibility of BSO Management to take forward and the final reports shared with Management as a customer of BSO Shared Services.

Mrs McKeown confirmed the following audits had been finalised since the last meeting:

- Accounts Payable Shared Services – **Satisfactory Assurance**
- Business Services Team – **Satisfactory Assurance**

7.0 REPORT FROM EXTERNAL AUDIT

7.1 FINAL REPORT TO THOSE CHARGED WITH GOVERNANCE 2021/22

Members received, for noting, **SET/AC/45/22 Final Report to Those Charged with Governance 2021/22**.

Mr Knox advised the Public Funds Financial Statements and Patients' and Residents' Monies accounts had been certified by the Comptroller & Auditor General and laid before the NI Assembly on 5 July 2022. **Mr Knox** also confirmed the Charitable Funds Financial Statements had been certified and laid before the Assembly on 5 July 2022. **Mr Knox** then introduced Mr Clerkin to discuss the Final Report to Those Charged with Governance.

Mr Clerkin provided an update stating the recommendations now had management responses against them which External Audit were content with. **Mrs O'Hagan** sought an update on the accrual position. **Ms Thompson** advised she understood this now to be resolved.

8.0 ITEMS FOR ESCALATION

No items for escalation were raised.

9.0 ANY OTHER BUSINESS

Ms Thompson advised the Mid-Year Assurance Statement presented earlier in the meeting formed part of the Trust's corporate Mid-Year Assurance Statement currently in draft form ready for EMT consideration at its next weekly meeting.

Ms Thompson advised she would circulate the Mid-Year Assurance Statement to Members of this Committee for information post approval.

10.0 DATE AND VENUE OF NEXT MEETING

Mr Brady advised the next meeting would be held on Thursday 1 December 2022 at 12 noon in the Boardroom, Trust Headquarters, Ulster Hospital, Dundonald.

Mr Brady thanked everyone for their participation and declared the meeting closed at 2.03pm.