MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 5TH JUNE 2023 - DAY 47

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THE INQUIRY RESUMED ON MONDAY, 5TH JUNE 2023, AS FOLLOWS:

MS. TANG: Good morning Chair, Panel. The Inquiry will hear evidence from Ms. Maureen Edwards this morning on behalf of the Belfast Trust, and that evidence will be regarding Module 2 which will be topics A and F, Trust Budget and Finance Including Capital Spend Post Bamford. She'll be speaking to June Champion's statement, which the reference for which is 0881, and she'll be dealing with some of the issues that Ms. Champion wasn't able to provide details about whenever she gave evidence. 09:59 09:59

CHAIRPERSON: Yes. And indeed Ms. Champion actually referenced this witness, of course, in relation to finance, when she was giving evidence. 09:59

MS. TANG: Yes. Yes, she did indeed.

CHAIRPERSON: That's very helpful.

MS. TANG: If there are no further issues, I could call the witness? 10:00

CHAIRPERSON: Yes, certainly. Can I mention - obviously there was legal argument last Thursday. As I indicated I will give my determination today, but I think it's fairer to get on with the witness and then I'll deliver it. We'll take a short break and then I'll deliver my determination. Yes, let's get the witness in. 10:00

MS. TANG: Yes. Thank you, Chair. Maureen Edwards, please.

MS. MAUREEN EDWARDS, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:

CHAIRPERSON: Can I just thank you - I'm sorry we haven't met, but can I just thank you very much for coming along to assist The Inquiry. We understand the circumstances in which you're here. You didn't of course make your own statement, but I think you did contribute to the statement of June Champion, and it's really to assist us specifically in relation to that module which Ms. Champion couldn't assist us with. So thank you for coming along. 10:00 10:01

1 Q. MS. TANG: Good morning, Ms Edwards. I'm Shirley Tang. You and I met a short time ago. I'm one of the counsel team to the Inquiry. As you know I'm going to be asking you a series of questions that will be related to The Trust budget and finance, including some of the capital spend programmes post Bamford. You've agreed to speak to that topic which was previously dealt with in the statement of June Champion. You have a copy of that in front of you, can I confirm? 10:01 10:01

A. Yes.

2 Q. I'm going to be specifically looking at paragraphs 13 to 53, which are on pages 6 to 16, and then I'm going to be looking at paragraphs 91 to 194, and that's on pages 24 to 52 of the statement. Does that include - is that part of the paperwork that you have? 10:01

A. Yes.

3 Q. Good. Can I check that you've had an opportunity to read through all of those paragraphs?

A. Yes.

4 Q. I'm not going to ask you to formally adopt the statement into evidence, because Ms. Champion has already done that, but if you could confirm that you're content to speak to the evidence that is contained within those paragraphs, that would be helpful? 10:02

A. Yes, I am content.

CHAIRPERSON: Can you keep your voice up. Sorry, Ms. Tang. 10:02

MS. TANG: Sorry. I'll speak up.

5 Q. I want to find out a little bit first about your current role and your background. So what is your current role with the Trust? 10:02

A. I am currently the Director of Finance, Estates and Capital Development in the Trust, a position I've held since June 2017.

6 Q. And what did you do before that?

A. Prior to that I was Co-Director of Finance in the Belfast Trust, and I held that role since the inception of The Trust in 2007. 10:02

7 Q. So you've worked for Belfast Trust since 2007?

A. Yes.

8 Q. Did you work for the previous legacy organisations in Belfast? 10:03

A. I worked - my immediate role before Belfast Trust was for a short period Director of Finance of the Royal Hospitals after a longer period as Deputy Director of

Finance in the Royal Hospitals.

9 Q. Okay. Thank you. That's helpful. Okay. Can I refer you then to paragraph 22 of the statement. It deals with the Trust's budget. And perhaps if that could be pulled up on the screen, please? I'll give you the page reference. It's on page 8. Thank you. See in the paragraph: 10:03

"The Belfast Trust receives the previous year's recurrent budget baseline uplifted for pay and price inflation and amended to reflect any new investments, savings or service changes." 10:03

Can you clarify first of all what's meant by "baseline"? 10:04

A. Well, the Belfast Trust has a budget of around £1.9 to £2 billion, and most of that budget - it receives most of its income from the Department of Health through the SPPG, the Strategic Planning Performance Group. That budget every year is rolled forward from the previous year, so most of the budget is just rolled forward year on year, but obviously each year there are new needs. For example, if a pay award is granted, or to account for non-pay inflation, or if there are agreed service developments, so if there's a new service or a service expansion. So whilst we have most of our budget is the year before budget rolled forward, it will be adjusted then for any new costs or pressures that are funded, or in previous years we've had money retracted for 10:04 10:04

savings.

10 Q. I was coming on to ask about savings actually. Can I check first of all before we leave, the things that are added into the budget. Is The Trust typically fully funded for pay awards and price inflation? 10:05

A. It is fully -- it has been until this year fully funded for -- because we haven't had a pay award for '23/'24 -- but up to this year, yes, we have had full funding for all pay awards, and also for -- we usually get an agreed non-rate for non-pay inflation, which will be 10:05 based roughly on the CPI, for example, but it can vary between years, between 1%, 2, 3%, but we would get specific increases, for example, for the minimum wage, and that would be built into the non-pay inflationary uplift so that we can pay our independent sector 10:06 providers, who will have increases in their costs due to, for example, the minimum wage.

11 Q. Would it be fair to say that cost pressures is an assumption as to what those are going to be? So if an independent sector provider, for instance, came along 10:06 to you and said "Actually our costs have gone up quite a bit", The Trust, in that scenario, might not have been given sufficient funding to meet new costs?

A. No, you're right. Likewise with the Trust, we have cost pressures and they are not always funded, and we 10:06 would then have to enter into discussions with SPPG to explain what the pressure is, and then they would validate or otherwise the pressure, and funding would follow. So, with others who provide service to the

Trust, the same process would follow. If there is a pressure that they feel is outside a normal pay or price uplift for which they will have already been funded, then they would have to discuss that with the Trust.

12 Q. Would there be scenarios when SPPG, or indeed yourselves, would have to go back to whoever is asked for increased funding and say "I'm sorry, we don't have it. We accept that there may be an issue, but we can't fund it." Does that happen? 10:07

A. Yes, it can happen, and usually our starting position will be we can pass on to you the funding that we've received for pay and price inflation. But, as I said, if there is a legitimate concern, so for example, during Covid, additional money was provided to us, and then we pass that on to independent sector or other service suppliers to the Belfast Trust.

13 Q. Kind of related to that I want to ask you about savings now and the arrangements that there have been for those. You mentioned that, I think if I am correct, that this year you haven't had a savings target applied but previously you would have?

A. In 2021, 2021/'22, the financial period that ended on the 31st of March, we did not have a general savings target applied. We are expecting a savings target for '23/'24, the current financial year. But, yes, you're right, we had savings targets every year until 2020/'21.

14 Q. And when you say "every year" is that right back to the

dawn of the Trust?

A. Since inception.

15 Q. So 2007, when you were in there?

A. Yes.

16 Q. How do those savings targets typically work? 10:08

A. There was -- the Department of Health agreed the savings targets to be applied to each Trust, and then SPPG - previously the Board HSCB - would have retracted money equivalent to that percentage savings target.

17 Q. A percentage target? 10:08

A. It was usually a percentage target, yes.

18 Q. And was it targeted at individual areas, perhaps certain programs of care, or was it just Belfast Trust X%?

A. No, it was a blanket general savings target, and then 10:09 The Trust decided how best to make those. So back at the inception of The Trust, the savings targets were based on RPA savings. So when the six legacy trusts joined, there was an expectation, for example, that there would be -- part of the savings was identified 10:09 specifically as a management cost savings, and then other more general savings targets were applied.

19 Q. So would there have been a situation where you had a roll forward budget, there would have been an element of uplift for new costs, or whatever those be, but that 10:09 might have been cancelled out by the fact that a savings amount had been withheld from the Trust. So you were effectively trying to do the same with less every year?

A. It would certainly. It depended on the rate of pay inflation and non-pay inflation, and the amount The Trust received for agreed inescapable cost pressures or new investments relative to the amount that was applied as a savings targets. I would have to go back and check, but I imagine every year -- well, I would be fairly certain that every year we had a net increase in income. But, yes, there would have been amount off-setting any new income in relation to savings. 10:10

20 Q. Yes. You used the word "inescapables" there. Can you explain what inescapables are? 10:10

A. Well, inescapables are cost pressures that we believe we could not control those cost pressures happening. So, for example, if you had a demand related pressure, or a re-settlement, for example, in Muckamore, where The Trust had no option but to incur that cost, we would deem that to be an inescapable cost pressure. 10:10

21 Q. So in terms of practical examples, just to help us understand. In a mental health or learning disability setting, an inescapable - you've mentioned re-settlement - is that the typical kind of inescapable cost for that programme of care, or what other types of inescapable costs might you have in that setting? 10:11

A. Yes. In learning disability, yes, re-settlements would be probably the most significant inescapable pressure every year, or other demand pressure. So we have more children over recent years transitioning into learning disability, so that, that increase in the demand every year we would deem as an inescapable cost pressure. 10:11

22 Q. For an area like Muckamore would savings targets have been applied to it throughout the period of time that we've spoken about, from 2007 onwards?

A. Learning disability, the directorate itself would have had a target and would have been expected, for example, in the earlier years, to make the management savings associated with bringing multiple services into one, so that would have reduced the management intake. But, if any other savings targets, each Directorate was asked to try to come up with ways in which they could meet the savings target of The Trust, but that had to be through safe service reductions where there had been, for example, improved productivity or efficiency. And obviously in the case of Muckamore, whilst it wasn't against those savings targets, we know, for example, there would have been an expectation in the hospital that there would have been reduced costs in wards provision, for example, and an increase in cost of community as people were resettled out of Muckamore into the community. 10:12 10:12 10:12 10:13

23 Q. So, just thinking about the hospital facility itself, if I'm understanding you correctly there would have been a level of savings target that ward managers or service managers covering that area would have been expected to deliver on. Is that correct? 10:13

A. Yes, they were certainly given targets. In reality those savings targets, the general savings targets were not achieved and, therefore, The Trust has a savings target gap that it has been building up over recent

years, because we were not able to safely make savings in some areas, and that would have included Muckamore Abbey.

24 Q. So are you saying Muckamore didn't make its savings targets? 10:13

A. No. No, it did make...

DR. MAXWELL: Can I just ask? Would that have been presented as a cost improvement plan by the Directorate?

A. If they had identified savings plans, yes, that would have been presented as a cost improvement plan. 10:14

DR. MAXWELL: And so would those documents be available from 2007 onwards, if the Inquiry wanted to see them?

A. Yes, if there had been any -- I'm not sure the extent to which there were cost improvement plans, but my understanding is that Muckamore Abbey would not have achieved much in the way of savings. 10:14

DR. MAXWELL: So the Directorate would have had a cost improvement plan that they were submitting to you.

A. Yes. If they are -- yes, if they had cost improvement plans that have been approved and savings made, yes, they would be available. 10:14

DR. MAXWELL: Thank you.

25 Q. MS. TANG: Can I ask you just in general, what kind of things might a service area, a mental health area, for instance, typically be expected to do to try and make savings? 10:14

A. Well I suppose it is much easier probably to explain in an acute ward, for example, but a mental health acute

ward would be similar. If, for example, it was deemed that the length of stay for patients in one of our hospital wards, when compared with peer hospitals in the NHS, for example, if it appeared that our length of stay was longer, then the Directorate would look at ways, they would look to explain why that might be the case. And, for example, it would look at ways at which they could improve the length of stay. So, for example, not bringing patients in ahead of need, having pre-assessment, for example, instead of bringing patients in before they needed to be in the hospital. Getting patients back home more quickly. Sometimes if patients then are delayed in hospital that would add to the length of stay, and that would obviously add to the cost and the number of beds needed. So if a Directorate identified that there was potential, there was opportunity to reduce the length of stay, then they would put that plan in place and then identify the savings that could be released from that. 10:15 10:15 10:15

26 Q. Would clinical areas be expected to carry a certain amount of staff vacancies perhaps to try and achieve savings? So maybe gapping how long it takes to fill a post? 10:16

A. Yes, and Directorates have made savings, usually fortuitously, where, for example, we know that a vacancy won't be filled for a number of months, even though you've tried to plan ahead, then there probably -- you know, in some cases, particularly in administration, for example, where a post wouldn't be 10:16

filled and you wouldn't necessarily bring in agency for maybe a number of weeks or months, then you will have, I suppose, fortuitous savings. But you wouldn't plan in a ward to not safely staff a ward. So if you have a vacancy, then ward managers would try as best they can, before a vacancy is filled substantively, to cover that vacancy with, for example, additional hours of part-time staff, or bank staff or, if necessary, agency. 10:17

27 Q. I could appreciate that would be a somewhat clearer decision to make in an acute setting where there might be safe levels of staffing already set, and rotas of how many people, or, you know, ratios of how many people you would need. An area like Muckamore where there may not have been a clear, a clear understanding of exactly how many staff were needed to have safe staffing levels, can you say would there have been a pressure at any point in time to try and allow a certain amount of vacancies to run to try and make sure they made some of their savings? 10:17 10:17

A. That would not have been The Trust's intention, and certainly that wouldn't have been a message The Trust would have shared with the Directorates. In any discussions in savings, the first principle was that services should be safe and patient safety and quality was the first priority. So it would not have been the expectation that people would not have -- would have avoided safely staffing areas to generate savings. 10:18

28 Q. Did we know, to your knowledge, how many staff it would

have required to safely staff Muckamore?
A. I'm probably not the best person to answer that, but I know in mental health wards, and certainly in acute wards, there are safe staffing levels, and wards and Departments are funded to those staffing levels. 10:18
DR. MAXWELL: But there would be an agreed establishment?
A. Yes, and that's why, whilst I'm not the best person to ask, I know that Muckamore, like every Department, would have had an agreed staffing level and funded 10:19
accordingly, and my expectation would be that that was based on clinical decisions on how many people were needed on each shift. So the ward budget is made up of - it starts with how many people are needed in the morning, afternoon and evening shift, how many staff 10:19
does that require on a 24-hour basis across the full week? How much do you add then for holidays, annual leave, et cetera? And that comes up with this is the number of staff that you need to fund that ward and Department. 10:19
DR. MAXWELL: And who signs off the establishment? Is there a professional input? For example, would the Director of Nursing sign that off?
A. My understanding would be that the Directorate and the ward manager, and right up to the Director of Nursing, 10:19
would sign off, or would certainly have oversight of the safe staffing levels.
29 Q. MS. TANG: Can I ask you then, looking down on to paragraph 26, which I think is just over the page. A

little section there reads:

"In recent years there has been an increasing gap between the level of recurrent funding provided and the financial needs of the Belfast Trust." 10:20

Can you tell me what the main drivers have been that have led to that mismatch between recurrent funding and the financial needs of The Trust?

A. Yes. Well in recent years I suppose there has been an acknowledgment that pressure on public sector funding, and including health, as that has increased then it has been more difficult to begin the year with what we believe is needed for the year, and some of that is because we are, as a Trust, carrying unfunded, inescapable pressures which have been funded maybe on a one-off basis in recent years, but have not got a recurrent funding associated with them yet, and as I said earlier, we have had some unmet savings targets which have become an underlying deficit for The Trust, and we haven't had the recurrent funding to match that in recent years. 10:20 10:21 10:21

30 Q. So is there a case that health needs have increased along with all of that or are health needs fairly static? 10:21

A. Health and social care needs rise every year. It varies across year because I suppose, depending on the various elements insight. So in a year when there is a significant pay award then the total cost of health and

social care will rise more. But it is considered generally that health and social care needs between 3 and 6% increase every year to keep up with growing demand. Demographic growth, as you know, would be a significant pressure in recent years because of the aging population, and that will apply as well in learning disability where, as I said earlier, we have more children transitioning into adult learning disability, and more demand per se. The aging population, people are living longer, with more complex needs, and that adds to the total requirements for The Trust every year. 10:22 10:22

31 Q. Are there inefficiencies in the system as well that you...

A. Well I think if -- you have a report, the recent fiscal report on health, and it really focused on health rather than social care, I mean there is suggestion in that report that there are inefficiencies in the Northern Ireland health and social care arena, and I suppose I don't think hand on heart any Trust could say that they were 100% efficient. Some of that is systematic, there are reasons why, maybe for economies of scale, for example, we can't be as efficient as maybe a Trust in the NHS, and there are, you know, always areas where we could do better. 10:22 10:23 10:23

32 Q. Can we go down to paragraph 27, following on from that one? I want to read you a little bit of that, which is:

"While to date the allocation of non-recurrent funding to the Belfast Trust each year has been sufficient to enable it to break-even, there is no budget certainty in respect of non-recurrent funding."

10:24

That does sound quite a precarious situation to be in, if I've understood it correctly. Is that in effect that the Trust gets a financial bailout at some point in the year to help it meet its financial targets, or have I not understood that correctly? 10:24

A. In the last few years The Trust has had to rely on considerable non-recurrent monies in year, usually during the year, to help it break-even, some of that Monday has come from monitoring rounds, departmental, monitoring rounds, for example, and some of it will 10:24 come from slippage. If we had, for example, money at the beginning of the year for a service development, and there was a delay in putting that in place, maybe, you know, lack of ability to get staff in as quickly as we'd wanted, then that gives us, I suppose, some 10:24 non-recurrent monies in year, and that has helped us to break-even. But, you're right, I mean that sentence is saying, that paragraph, that our recurrent budget has not been sufficient to allow us to break-even and we have needed those injections of non-recurrent cash. 10:25 But as I've said there, there is no budget certainty, because by its very nature some of that non-recurrent money is one-off in nature and can't be relied upon.

33 Q. You've referred to cost pressures in your evidence that

you have given. Would things like high levels of agency nurse staffing be considered as a cost pressure?

A. Yes, it is certainly a very significant cost pressure in the Trust at the minute, and that probably would fall more into category of escapable pressures; were we able to recruit staff and fill the vacancies? But we haven't been able to in all cases, and we've had to use agency nurses to allow us to provide safe levels of care. 10:25

34 Q. And would it be fair to say that for Muckamore particularly, agency nurse staffing would be a significant cost? 10:26

A. It has been a particular pressure, yes, in Muckamore, because we have had very significant rates of vacancies and we have had to employ agency staff, yes. 10:26

35 Q. And has The Trust had to allocate additional funding into the Muckamore budget to cover that, or had it been expected to manage that within what it has as a recurring budget?

A. No, we have allocated funding to match the costs in Muckamore, and then The Trust has held that deficit centrally, and that deficit in previous years had been covered by some of that non-recurrent money that I've referred to earlier. So we would have regular meetings your our commissioners, SPPG, and we would raise all of our pressures, including specifically the staff agency costs of Muckamore, and then we would ask them to fund those, and they have not been able to provide the recurrent funding at this point yet to meet all of 10:26 10:27

those pressures and we've had to rely on non-recurrent money for that.

36 Q. I would imagine The Trust would be keen to see the agency cost budget reduce over time, from what you're saying. Are you aware of anything strategic that the Trust is involved in to try and address some of the difficulties attracting staff to Muckamore? 10:27

A. Yes, I suppose, you know, before I come to Muckamore, more generally The Trust we had considerable nursing vacancies in the Trust, and you've probably heard maybe from nursing colleagues that we have had a very successful international nurse recruitment programme, which has had a significant impact on vacancy levels. Unfortunately we haven't really been able to use international nursing for Muckamore Abbey, for learning disability, although we have had some success in mental health. In Muckamore, the team there, you know, are continuously looking at ways to better recruit and to better retain staff. So, you know, that is a regular discussion at executive team and Trust Board meetings. 10:27 10:28 10:28

37 Q. From a financial perspective, is there any leeway that they could be given to pay enhanced rates or anything like that to try and relieve that problem, or is that something The Trust wouldn't be able to stand over?

A. The Trust normally is expected to comply with AFC, Agenda For Change, terms and conditions, and medical terms and conditions. But in Muckamore there has been additional payment made in recent years, which the Department of health approved, and that was a 15% 10:28

recruitment and retention were premium as a one-off specific mechanism to attract and better retain staff in Muckamore.

38 Q. Did it work?

A. I'm not sure the extent in nursing, we still have a significant vacancy level, so I'm not sure the extent to which it is deemed to have worked in recruiting staff, but I expect the service would be better placed to explain whether they believe the premium helped retain staff. 10:29

39 Q. Do you know when that took effect, what year, roughly?

A. No, I would have to check.

CHAIRPERSON: I think it is mentioned in the statement somewhere and I can't...

MS. TANG: Okay. I can check back on that. 10:30

A. Yes, I can certainly check.

40 Q. Okay. Going down to paragraphs 41 -- I am going to look at 41 to 43 now. And that is page 13. I want to ask you about budget holders and who might typically be a budget holder. Would anyone on the Muckamore site have been a budget holder? 10:30

A. Yes. I mean The Trust, as you'll see there in the budget pack in tab 9 on page 1305 I think, The Trust operates a devolved budgetary system, and that means we try to give budget responsibility to those who can have the most effect in managing the budget. So we would expect, and at Directorate level, for ward managers, for example, to oversee the budget for theirs. So a ward sister would get her budget, or his budget report 10:30

every month. They would also get a list of the staff in post so that they can check, for example, that everybody they are paying for is supposed to be paid, and that the hours they are paid are the expected hours and the hours that they work, and that will form part of the costs of their ward. They will have the annual and then the monthly budget, and they will have details of their spend and, therefore, if there is any variance, then they would be expected to understand that variance and do what they can in terms of action planning to try and manage that spend back within budget, if that's possible. 10:31 10:31

41 Q. You've mentioned that there was a savings target applied to the Trust. Would that savings target have been reflected in the budget statement that the ward manager, for instance, got? 10:32

A. Savings targets have generally been attributed to the Directorate and would be held at the Directorate at sort of the co-director. In their budget report they would see the line and they would only give it to, they would only allocate an element of that out to a ward if a ward had identified a plan by which to make those savings. So in a ward, the ward sister or the ward manager would not see that savings target, unless they had an identified plan to make those savings. 10:32 10:32

42 Q. Would it be fair to say that there must have been a degree of pressure within Directorates to try and come up with schemes from all the different areas to make savings?

A. Well they would have, as part of their budget responsibilities, shared The Trust's responsibility to achieve a break-even and, therefore, they would have had responsibility to seek opportunities to make savings, yes.

43 Q. So, as the Director of Finance, would you have expected directorate managers, for instance, or co-directors, to be having the conversations with the areas underneath them to probe where savings could be made and to come up with some ideas? 10:33

A. Yes, that's part of our budgetary framework. The focus usually is on spend against the budget, and ways in which you can get back into budget, but some of those conversation would also have been "Is there anything else we can do to contribute to Trust break-even?" Are there opportunities, looking at benchmarking, for example, looking at performance elsewhere, to do things better and more efficiently? 10:33

44 Q. Obviously some allegations of abuse came out in relation to Muckamore. Were you aware from that point in time of any change in attitude towards cost pressures or savings targets in relation to Muckamore? Was there -- did the Trust take a different approach from then on? 10:34

A. I'm not aware of any particular change in approach, because the approach has always been that people seek opportunities for savings with the underlying principle that anything, any of those savings must not compromise safety and quality. 10:34

45 Q. So was there anything by way of just saying "Right, we're not going to put any pressure on Muckamore. We'll just take our eye off them in terms of financial targets and savings", or do you recall any kind of conversations of that nature? 10:34

A. I suppose I don't believe there was pressure prior to that for them to make savings that weren't achievable, so not really.

46 Q. Okay. I want to talk now about re-settlement, and that will take us to paragraph 46, which would be page 14. 10:35 I just want to read a short bit from that one.

"A finance theme relating to Muckamore that has been prevalent from the Belfast Trust became operational in 2007 has been the increasing per capita spend. The 10:35 reality is that the fewer patients Muckamore has, as patients are resettled, the higher the required spend per capita within Muckamore. This has meant that as time has gone on, and resettlements have been successful, the cost per patient within Muckamore has 10:35 increased significantly because the costs of staffing and maintaining Muckamore do not decrease proportionately to each patient who is discharged."

Can you just explain why that is? 10:36

A. I suppose there are a number of elements there. If you have a ward, and I'm not specifically talking about Muckamore here, but if you had a ward of say 10 patients, and one patient is resettled, the staffing,

particularly, you know, the nurse supervision level, and the nurses per patient, wouldn't necessarily reduce at all with one patient, and it would take a cohort of patients to go before any real change to staffing levels occurred. So the fixed or semi-fixed costs of that ward would remain virtually unchanged until a number of patients had left, and that means the cost per patient has increased. Also, I suppose, over time in Muckamore the remaining patients tend to be the most complex patients. So, therefore, the patients left usually require more nursing per patient than when the hospital was fuller. 10:36 10:36

47 Q. Okay. Looking at paragraph 47, just following on from that. There's a reference there to funding pressures in 2007 due to full costs being removed when a Western Health and Social Services Board patient was resettled. Was the funding around a move like that not agreed upfront so that everybody would know how much money was going to come out of Muckamore to follow the patient back up to the west? 10:37 10:37

A. Well my understanding, and I wouldn't be as familiar with that specific case, but in terms of Muckamore re-settlement programme at that time, there was an agreement between the four Boards and the Belfast Trust that as patients were resettled out of Muckamore then the money would be retracted out of Muckamore to help fund those re-settlement packages, and the understanding would be, as I said earlier, you may not be able to close a ward or even reduce the staffing 10:37

levels until a cohort of patients left the ward, but there was obviously, at that time in the programme, an expectation that, for example, as a certain cohort of patients were resettled then a ward could be closed and the money would then be retracted. I expect from this that the Western Trust was going to use that for another purpose in their area. But what did happen, I know at that time, is that, yes, there would have been a plan to close a ward. What invariably happened, there were delays in resettling the patients. We weren't able to close the wards as quickly as possible, so the plan slipped, and I know from my experience that the Board, then we made bids to the Board for what we called bridging funding. So we said, yes, the money had to come out for that ward to fund the re-settlement programme, unfortunately there has been a delay so we bridging for, whether it was three months or six months, until the ward was able to be safely closed, and they gave that back as non-recurrent money until such times as we were able to close the ward. 10:38 10:38 10:39 10:39

DR. MAXWELL: Can I clarify the funding in 2007, because as I understand it Muckamore Hospital is a tertiary service funded by HSCB, but this seems to suggest that the other Trusts are purchasing services from the Belfast Trust. What is the funding source? 10:39

A. Well at a point at times, certainly in the Legacy Trusts, all of the Boards would have funded their patients, and then in the Belfast Trust, you're right, the Health and Social Care Board would have given us

the funding. But we would have still potentially had patients until the West and the Southern Trust had their own hospitals, we would have had patients on a regional basis.

DR. MAXWELL: So you still have patients from the Northern Trust, for example, because they don't have an in-patient facility. Are they paying a marginal rate for their patients on top of the money you're getting from HSCB, now SPPG? 10:40

A. No, we hold all of the funding for the patients in Muckamore and the other Trusts don't pay us. 10:40

DR. MAXWELL: So when did that change? When did it change from the other Trusts paying a marginal rate...(INTERJECTION)?

A. I believe that happened then when we became the Belfast Trust. I expect this - and I will certainly go back and clarify - I expect this maybe was when the Legacy Boards became one Board, and there was a need in a Trust in the Western area, that they were tidying up the funding before we all became Trusts. But I can certainly follow that up. 10:40 10:41

DR. MAXWELL: Okay. Thank you.

48 Q. MS. TANG: That's brought me on to a question more generally on re-settlement, which is: Whenever The Trust had re-settlement targets set, and they agreed that a certain number of people would hopefully move over a period of time, how did the funding of that get built into that plan? 10:41

A. Well we would have agreed those re-settlement plans

with the Board, and any retraction as the ward closes would have been part of that overall agreement. So we would have - at the beginning of the year we would have discussions with the Board, with the HSCB at the time, about how many patients were going to be planned to be resettled that year, their expected dates of re-settlement, and the estimated costs, and then throughout the year we would, on probably a monthly basis, would have revisited that with the Board, and if we didn't require all the money, because, for example, there had been a delay in the patient re-settlement, then the Board would just give us what we needed. Likewise, if the costs changed for legitimate reasons that are approved by, or were approved by the Board, then they would have increased the money that we needed accordingly. Most years I think there was a slip against the very initial. I suppose we try at the beginning of the year to make sure we have enough money set aside, but invariably there was a bit of slippage and we didn't require the whole lot. And, likewise, we didn't retract from wards as quickly as possible. 10:41 10:42 10:42 10:42

49 Q. What kind of things would make a re-settlement end up delayed or not work out?

A. A number of reasons. If the provider of the resettlement package was delayed, for example, either in getting the building ready for re-settlement or having adequate staffing, that would be delayed. Also, if the patient, the resident in Muckamore wasn't ready, so patient readiness, so whilst the clinical teams will 10:43

have agreed plans, you know, they will keep a very close eye on that, and if the patient, if the patient isn't ready, sometimes the patient would have - I can't think of the word - a tryout re-settlement, and if that doesn't work, you know, then the patient, that might delay the start date of the re-settlement.

50 Q. Can you ever recall a time when arguments over funding or issues getting funding or releasing funding would have contributed to a delay?

A. No, we would have -- we would have made sure that that did not delay the re-settlement of a patient. Those ongoing discussions with the Board around the costs of a re-settlement would have been done a long time in advance, and we certainly wouldn't have held back a re-settlement whilst we, you know, negotiated around the margins for a package.

51 Q. Associated with re-settlement, paragraph 49 further down - sorry, just over the page, noted there that there were large capital spends in 2007/2008, 2008/2009, and 2009/2010, of approximately £6 million. Whenever we know that the 1995 Review of Policy and Services for people with learning disability, and also Equal Lives 2007, had been recommending that re-settlement was the way to go, can you tell us why those large capital spends happened or what they were?

A. And I don't know the exact details of what those investments were at the time, but -- and I can certainly find out the detail -- but the re-settlement programme was over a number of years and it is very

important for The Trust to maintain buildings to a standard that are safe. So I fully expected those were inescapable capital spend decisions made to make sure that whilst patients were still in Muckamore that they were in a safe environment.

52 Q. Is that something you could give us some further detail about?

A. I can certainly get you detail on that.

53 Q. Thank you. Can we move down to paragraphs 51 and 52? Thank you. I'm just going to read a short bit from that as well:

"The costs of resettlement, however, are in many cases much more expensive. The Belfast Trust has regarded re-settlement as a significant priority. Consequently it has taken steps to ensure funds are available to allow re-settlement to take place. The SPPG has assisted through accepting re-settlement costs as inescapable pressures and providing non-recurrent funding to meet those pressures. This is not withstanding that dealing with matters in this way creates a significant accounting risk for Belfast Trust."

Can you clarify why re-settlement - obviously you've said it is a significant priority - why does that need to be bolstered up by non-recurrent funding?

A. The Trust hasn't been able to secure recurrent funding for the re-settlement, or enough money at the start of

the year, and by its nature I suppose re-settlements are -- sometimes they're not part of the recurrent baseline, and as they arise then we try to get recurrent funding for them. So there's a bit of a timing delay. But really it's we haven't had sufficient funds to have a recurrent break-even plan at the beginning of the year, and resettlements are one of those pressures that haven't been recurrently funded.

54 Q. Is that something that is discussed with SPPG, or in the former days Health and Social Care Board? Did they accept that these are significant costs pressures or what was their response? 10:47

A. Yes, they have accepted they were inescapable pressures but did not provide recurrent funding, were not able in those years to provide recurrent funding, and we would discuss that, it would be in our monthly reports, and we would discuss it regularly with SPPG. So they are very aware of all of the pressures associated with Muckamore Abbey. And as I said, where they have been able to secure non-recurrent money, they have provided non-recurrent money to address those pressures. 10:47 10:48

55 Q. And where they haven't been able to secure non-recurrent money, have there been times whenever the Trust just simply hasn't had enough money?

A. Well, we have broken even every year, so we have had, through non-recurrent money or from other non-recurrent measures in the Trust, for example, slippage, to be able to break-even in our totality. 10:48

56 Q. Is it your evidence that money has never delayed a

re-settlement, so is this an issue then?

A. As we've said there, it creates a significant accounting risk. The Trust would not normally invest ahead of funding being secured. So, if, for example, we wanted to implement a new service, we would not do that without recurrent funding confirmation from the Board, but we see resettlements as an inescapable pressure and, therefore, we have initiated those at financial risk and ahead of funding, but continue that dialogue with SPPG in order to recurrently fund them on a long-term basis. 10:49 10:49

57 Q. That's helpful. Thank you. Can I go down now to one of the exhibits in relation to Muckamore? It is at page 088902, please. And just at the top of that page, if you can see that okay: 10:49

"As the children on the Muckamore Abbey site are expected to move into the community towards the end of '08/'09, The Trust's first call in 2008/'09 in respect of re-settlement will be for the three people whose resettlement plans have been developing this year. They were identified as possible reserves for the '07/'08 targets. We believe that each of them will have a re-settlement cost of at least £120,000." 10:50 10:50

Can I ask, do you know what that figure covers, and is the fact that they will not be taking up a bed in Muckamore considered?

A. I'm sorry what do you mean by that?

58 Q. Do you know what that £120,000 would relate to for the re-settlement costs?

A. No. No, I would have -- I'm not familiar with that, but I expect that is the cost of those children, the re-settlement packages for those children that we would pay for their care. 10:50

59 Q. And would there be an offset in that, that the fact that they're leaving Muckamore, they're not taking a bed there, would that be released in to fund some of that? 10:51

A. Only if there were changes in staffing, for example, as a result of those children leaving. So if, for example, the staffing in a ward was able to be reduced, then the Board would have taken that money and helped to fund those re-settlement. I'm not sure in that case whether that was the case or whether indeed that money released funded other patients in Muckamore, or whether they couldn't be saved because you didn't get that economies of scale. But I can take that away. I'm not familiar with that paragraph. 10:51 10:51

60 Q. Yes. Yes, if you would. Thank you.

CHAIRPERSON: Just so that I understand. When you talk about a re-settlement cost, or as you do in the next -- sorry, not "you" -- as the document does in the next paragraph, requiring re-settlement packages. Is that talking about an annual cost? 10:51

A. Yes, that's an annual cost that we would pay to the provider of the re-settlement, the community package that the resident from Muckamore moves to.

CHAIRPERSON: Thank you.

61 Q. MS. TANG: I have a question relating to statement page number 934. If that could be called up, please? Thank you. It's from the element of this page which deals with the capital investment plan in 2008 and '09. You can see there, that there's Muckamore design fees. Can you tell me what might those design fees have related to? 10:52

A. Not at this stage. I suspect that was for the treatment and assessment unit in Muckamore, but I will take that away. That's usually the architect's fees. 10:52

CHAIRPERSON: So that would be the capital costs, obviously.

A. Yes.

CHAIRPERSON: Yes. Okay. 10:53

62 Q. MS. TANG: And if we could go down to 935, please, to the table that's within Section 3.2.3. You can see there that there is a further approved capital scheme for Muckamore of "Muckamore Phase IV Capital Project Spend" of just short of 5 million. Can you tell us what that was? 10:53

A. Likewise that would be, I imagine, the capital spend following the design phase. It's probably the same scheme, but I'll find out about both of those.

63 Q. Thank you. Back to the main body of the statement then to page 30 and paragraph 117. I want to look at the topics of risk and governance now. We had some conversation with Ms. Champion on that and she was able to give us detail on the management and clinical risk 10:53

systems. I wanted to talk to you about the financial governance and links between that and the governance systems that Ms. Champion was able to tell us about. Paragraph 117 refers to the development of integrated governance and then goes on to give some detail about how that has rolled out across the NHS elsewhere. Can you tell me what you understand by that term "integrated governance"?

A. This wouldn't be my area of expertise, but integrated governance brings together clinical, corporate and financial governance. So all of those governance structures required to ensure that the Trust provides, you know, safe quality care within the resources that it has.

10:54

10:54

64 Q. So in practical terms, as an Executive Board, how does that work as an integrated governance approach?

10:54

A. Well we have our governance framework, we have Assurance Committee that would deal with clinical governance and other elements of corporate governance, we have our audit committee, that would be around the financial governance, and all of those various committees report through into Trust Board. We would have a Principal Risk Register, and then at service level we would have service specific risk registers, for example, that would cover all the various strands of governance and risk.

10:55

10:55

65 Q. So, if I'm correct, if I'm understanding you correctly, there are tiers of risk registers going right up through the organisation. You mentioned the Principal

Risk Register. Is that the same as the Corporate Risk Register or is that something different?

A. It is -- again, others would be able to probably articulate this better...(INTERJECTION).

CHAIRPERSON: I was going to say, are we getting off your area? 10:55

A. Yes.

MS. TANG: Is this not your thing?

A. No. No, it wouldn't be my area of expertise.

66 Q. Okay. I understand. In that case can I go down to paragraph 183, which I think may be closer to your remit. That's where there is reference to the Corporate Risk Register. Sorry, I'll give you a page number for that. That is page 49 please. It's paragraph 183. That's picking up on the Principal Risk Register. There was reference elsewhere to the Corporate Risk Register. Is that a document that the finance function would use or is that something that... 10:56 10:56

A. No, it's not. It's not purely finance. That's a number of corporate risks would be in there, including finance would just be one of our corporate risks, the financial position, the ability to make break-even, for example, would be just one of the corporate risks. 10:57

67 Q. So what kinds of operational issues would be tracked using a Corporate Risk Register? 10:57

A. I mean various. In my own patch, for example, we would have fire safety, water safety, ventilation, in my estates world. But each Directorate or service division would have their own risks at their service

level that would feed into that. And, again, I'm not probably the best person to answer that.

68 Q. Okay. So if I'm understanding you correctly, it's a great big overview of all risks within the organisation, some financial, some service area or whatever it be...(INTERJECTION)? 10:57

A. Yes. Estates, clinical, yes.

69 Q. Okay. Is that a prioritised document? Does The Trust Board, for instance, look at it and go "Well here's the ones we really need to worry about. Here's the ones that are less likely." How does that happen? 10:58

A. Yes, it is prioritised, so that what's held at Directorate Risk Register that we're managing, we're managing a risk, then that wouldn't be on the Principal Risk Register because it is being managed and mitigated as well as possible. The Principal Risk Register highlights the risks that, I suppose, are of most concern, and that they are the ones brought to Assurance Committee and to Trust Board. 10:58

70 Q. Can I be clear, the Principal Risk Registers that highlight those concerns, are those purely service area ones or might there be a financial equivalent of that? 10:58

A. Yes, there would - finance would be also part of the -- we would have the ability to break-even.

71 Q. Okay. I understand. 10:58

A. And the lack of sufficient budget to predict the break-even would be considered as a principal risk.

72 Q. Okay. So in terms of the things that are typically on Principal Risk, is it like the top ten biggest risks

for The Trust or is it much more than that?

A. No, it's anything which needs to be raised at that level. So that can vary from year to year, and some of those risks, then once its established that there are mitigations in place, so if there is a particular risk that arises that can be addressed, we can get mitigations in place and then that comes off the Principal Risk Register. So it varies year on year. 10:59

73 Q. Would it be fair to say though that that is the priority list? Those are the things...(INTERJECTION)? 10:59

A. Yes. Yes, they would be the priority risks.

74 Q. And are those discussed at Trust Board or how are those managed?

A. They would be discussed at Assurance Committee which feeds into Trust Board, and then the Assurance Committee minutes, for example, which would highlight the key actions, the key priorities, would then be discussed at Trust Board. 10:59

75 Q. So, is there someone, for instance if there was a Muckamore related issue on the Principal Risk Register, is there someone that is tasked with an action plan or how do you ensure the risk is dealt with? 11:00

A. Well, that would be the director of the service, and I would say Muckamore is as -- it is a standing item at every Trust Board, and it's discussed at almost every executive team, and it would be discussed at length then in Assurance Committee. That would be with a combination of Director of Muckamore's Learning Disability, the Director of Social Work would also have 11:00

a key work, key role in terms of safeguarding and reporting, and then you'd have various other people for elements maybe associated with Muckamore, recent Muckamore issues.

76 Q. So you said that it was discussed -- it is a standing item at every Trust Board. Is there a plan or is there a...(INTERJECTION)? 11:01

A. Yes, there are detailed actions taking place. So, for example, there will be an update on the re-settlement programme, for example, and where that is. There would be an update on The Inquiry. There would be an update on CCTV and investigations, for example. So there would be very detailed plans and updates provided. 11:01

77 Q. Do you recall any discussion about staffing and staffing shortages? 11:01

A. Staffing would be one of the standing items in the update of the Muckamore Report, there would be an update on where we are with staffing, any impending recruitment, any particular challenges and updates on recruitment, for example, and numbers of nurses in post. 11:01

DR. MAXWELL: Presumably it only became a standing item after the revelations in 2017?

A. I've only been on The Trust Board since 2017, but it has been an item. It isn't one of our standing items per se on a Trust Board, but it tends to be. 11:02

DR. MAXWELL: It is because it is high risk?

A. Yes. It tends to be discussed at every meeting as an update because The Trust Board like an update.

DR. MAXWELL: But if all of the risks have been identified it wouldn't have been routinely discussed at the Board?

A. It would have been discussed, as with all other Directorates, if there were issues that needed to be raised with Trust Board. 11:02

78 Q. MS. TANG: I have -- I want to refer you now to a couple of the exhibits, the first of which is on page 1538. If that could be called up, please? That's the Assurance Framework, Board Assurance Framework. Can you explain what the main purpose of that document is, please? 11:02

A. Again, I think you've -- some of my colleagues will be here and will probably be able to articulate that better, but it does provide -- the intention of it is to provide Trust Board with assurance that the Trust has identified and has good oversight of key risks, mitigations and actions to address those risks. 11:03

79 Q. Can we go to page 1546, please? And I just wanted to ask you - I think Audit Committee is somewhere further down that page, please. There it is. Did this committee deal with purely financial audit considerations or would there have been other more general audit arrangements? 11:03

A. No, Audit Committee, we have reports from our internal audits who would do reviews, about a third of those are finance and the rest are risk and governance, and then they do also audits into various issues and services. They would look at, for example, they would do a fire 11:04

safety audit in an area of The Trust. So, no, they're not all finance.

80 Q. Okay. Thank you. Ms. Edwards, those are all my questions, but the Panel may have some questions, so I'm going to hand over to them. 11:04

MS. EDWARDS WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

CHAIRPERSON: Dr. Maxwell wants to ask you a question. 11:04
If it is outside your remit, then you'll just tell us of course.

A. Okay.

DR. MAXWELL: So I'm wondering about the management of patient finance and patient property, which I'm 11:04
suspecting ultimately comes under the Finance Department to set the policies, and also under internal audit, which I suspect also probably comes under your responsibility. So I wonder if you would be able to talk in general about how patient finance and patient 11:05
property is supposed to be managed?

A. Yes. Finance would set the policies around that, and internal audit is obviously an independent function who would do the audits on patient's property and patient's finances. But the role in managing the finances comes 11:05
under the care managers who report through obviously on the clinical side, so they wouldn't be finance staff.

DR. MAXWELL: So if patients had, who were in Muckamore for a long period of time, had accrued substantial

amount of cash, would that be managed on behalf of them by The Trust?

CHAIRPERSON: Sorry, Dr. Maxwell, I just want to understand. Do you mean in terms of Social Security payments or that sort of thing? 11:06

81 Q. DR. MAXWELL: Well, anything. Yes. It could be benefits. We've heard some of the families give evidence that, you know, there can be thousands of pounds worth of patient's money at Muckamore being managed on their behalf by The Trust, and I'm just 11:06 wondering how that works? And presumably that would be through some cash office or account?

A. Yes, there is a cash office, and residents of Muckamore can hold their cash in there. If they -- they're assessed as to whether they can operate their own 11:06 funds, or the family, and in some cases then I think there is - I don't know the terminology - Power of Attorney or whatever, and RQIA, we have to advise RQIA if any resident holds over I think it's £20,000. I can get information specifically on our policies and 11:07 procedures around that but, yes, the day-to-day, the Social Security, that is managed as part of the whole care manager's remit with the patient, but finance, we will ensure that the policies are followed and then internal audit will review and do testing to make sure 11:07 that everything is operated properly.

DR. MAXWELL: It would be helpful to learn a bit more about the process.

A. Yes, that's no problem. I can get you

some...(INTERJECTION).

82 Q. CHAIRPERSON: And, again, this maybe very basic, but if a patient has been in receipt of any form of Social Security or benefit, and they then come into the hospital for a long time, is there any question of The Trust, or indeed the DOH, being able to retain that benefit, or does it still always belong to the patient? And if you don't know, then obviously... 11:08

A. I would have to check that. I know what happens when somebody is care managed or when they go into a nursing home. I'm not sure what benefits residents in Muckamore are eligible for and what happens, so I will get you the detail on that. 11:08

CHAIRPERSON: Okay. That would be helpful. Thank you.

11:08

END OF QUESTIONING BY THE PANEL

CHAIRPERSON: Thank you. Can I thank you very much for coming along to help us on that very specific area that you have focused on. I don't think we'll be seeing you again, as far as I know. We will see. 11:08

DR. MAXWELL: Never say never.

A. And apologies some of the things -- I mean it is a very broad subject, and some of my colleagues will be able to provide me with the detail and I'll pass that on to you. 11:09

CHAIRPERSON: No, we understand that entirely, but thank you very much for your attendance today. Thank you.

A. You're welcome.

CHAIRPERSON: What we'll do is we'll take a short break now, and rather than make everybody wait until 12.00, I'll deliver the determination at 11.30.

11:09

SHORT ADJOURNMENT