Muckamore Abbey Hospital Inquiry

Organisational Module 9 – Trust Board

WITNESS STATEMENT OF GORDON SMYTH

I, Gordon Smyth, a non-executive Director within the Trust Board of the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 28 March 2024. The statement addresses a series of questions posed to me concerning my role as a non-executive Director of the Trust Board of the Belfast Trust and concerning my role as Chair of the Audit Committee for the Belfast Trust.

2. This is my first witness statement to the MAH Inquiry. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "GS1".

3. The 28 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

Qualification, Experience and Position of the Statement Maker

4. I am a non-executive Director of the Trust Board within the Belfast Trust between April 2016 to the present day.

5. I have been Chair of the Belfast Trust Audit Committee from 2016 to the present day. I also took up the role of Chair of the Assurance Committee from July 2023.

6. I am also a member of the Children Social Care Steering Group, and the Charitable Funds Advisory Committee.

7. I commenced my professional career in May 1977 in banking. I became an assistant branch manager in 1982, I obtained my Institute of Bankers examinations in 1983, I became a branch manager in 1988, and spent seven years in the Regional Office in Ballymena. In 2012 I took the opportunity to take advantage of an early retirement option from my then employer. In 2014 I was appointed as a Non-Executive Director on the board of the Norther Ireland Fire and Rescue Service. I was appointed as Chair of the Audit, Risk and Governance Committee and served approximately eight years. I was appointed to the board of the Belfast Health and Social Care Trust in April 2016 and currently Chair the Audit and Assurance Committees. In addition, I am Chief Executive of the Ulster Federation of Credit Unions and have responsibility for 38 credit unions across Northern Ireland. I have been in this role since April 2014.

Questions

Question 1

What is the composition and remit of the BHSCT Audit Committee?

8. The Audit Committee currently comprises four non-executive directors of the Belfast Trust. Given my professional background in finance, I have been Chair of the Audit Committee since April 2016. In addition to the members of the Committee, various other individuals attend committee meetings. These will generally include the Director of Finance and representatives from internal and external audit, although other people may attend Audit Committee meetings from time to time.

9. The Audit Committee was established and constituted to provide the Trust Board with an independent and objective review on its financial systems and internal control arrangements. The Term of Reference have been approved by the Trust Board and reviewed on a periodic basis and are available to the public on request. The Audit Committee's functions in relation to the Belfast Trust's financial systems relate to internal audit, external audit, financial reporting and Value for Money. The functions in relation to internal control are more concerned with internal governance arrangements.

Question 2

How often did the Audit Committee meet?

10. During the time I have been a member, the Audit Committee has met on at least four occasions per year.

Question 3

By what means (and at what intervals) did the Audit Committee report to the Trust Board?

11. The Audit Committee reports to the Trust Board after each of our meetings. As Chair, I report to the Trust Board on behalf of the Audit Committee. This report is provided orally at Trust Board meetings, and the minutes of the previous Audit Committee meeting are contained within the papers to be considered at Trust Board.

12. In addition to reporting to the Trust Board after Audit Committee meetings, I, as Chair of the Audit Committee, report annually to the Trust Board in June each year. At the June Trust Board meeting I present the annual Audit Committee report, which addresses the overall adequacy of the Belfast Trust's systems of internal control. The Trust Board is given an opportunity to scrutinise the report and to approve it at this meeting.

Question 4

Do you recollect MAH being on the agenda and, if so, how often?

13. I joined the Belfast Trust in April 2016, and I believe that MAH first appeared as an agenda on the monthly Trust Board in and around late 2017. From that point on it was an ongoing report at each Trust Board.

14. The agenda items on the Audit Committee follow a standard format, although the detail of what is discussed will vary from meeting to meeting depending on what work has been undertaken. I do not recall MAH ever appearing as a standalone agenda item on the Audit Committee agenda.

15. One of the routine agenda items considered at the Audit Committee relates to the work of the Internal Audit department. Internal Audit will carry out a series of audits on different areas within the Belfast Trust on a rolling basis, and the Audit Committee will consider those audits as and when they are finished. I recall that Internal Audit conducted two audits concerning MAH during my time on the Committee, and the content of those reports would have been considered at Audit Committee within the agenda item dealing with Internal Audit. I have set out more detail relating to those audits in my response to Question 5.

Question 5

Do you recollect the Committee receiving audits, reports or other material relating to MAH? If so, please give details and indicate how the Audit Committee dealt with such material?

16. The Internal Audit department may undertake reviews of individual service areas as part of its role. This department is part of the Business Services Organisation and is independent from the Belfast Trust. In accordance with the 2017/18 annual plan, Internal Audit carried out a directorate risk audit in the Adult Social and Primary Care Directorate. It is my understanding that, following discussions with

the Director and the Co-Director for Adult Social and Primary Care, it was agreed that the focus of the audit would be on Muckamore Abbey Hospital. Specifically, this review considered the management of complaints and incidents, patient supervision and the Facility's progress in achieving the Royal College of Psychiatry's quality network for inpatient learning disability standards of care. The Audit Committee would not have had a role to play in deciding what services should be audited, or what the subject of the audit would be.

17. The outcome of the Audit Report was that there was "Limited" assurance for Complaints, provided on the basis of information and data governance issues identified within complaints files.

18. The second element of the Audit Report found "Satisfactory" assurance for Incidents and Patient Supervision provided on the basis that Trust policy in relation to Patient Supervision / Observation is generally working effectively. Service users under supervision were found to follow policy and the actual costs for supervision were on target to meet budget provision.

19. The Internal Audit report was considered at an Audit Committee meeting on 24 April 2018 and its contents were noted. The Director of Adult Social and Primary Care was present at the meeting, and advised the Audit Committee that Muckamore Abbey Hospital was subject to on-going service review and that all recommendations made by Internal Audit would be addressed in due course.

20. It is probably important to understand that the level of Assurance that Internal Audit can provide is defined as follows:

    i. "Satisfactory" – overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

ii. "Limited" – There are significant weaknesses within the governance , risk management and control framework which, if not addressed, could lead to system objectives not being achieved.

iii. "Unacceptable" – The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

21. Following an audit inspection, the Internal Audit Team will evaluate their findings and will determine the appropriate rating, i.e. "Satisfactory", "Limited" or "Unacceptable".

22. In the event of the Audit Committee being presented with a "Limited" rating, the Committee will request the Director responsible to attend and answer members' questions. The Committee would expect the Director to explain the shortfalls identified by Internal Audit, and to have an appropriate action plan to address the issues, together with an appropriate timeline to see them addressed.

23. The Audit Committee will then expect a progress report at each Audit Committee meeting to ensure effective follow up. The Committee would also expect details of the learning to be shared by the Executive Team.

24. In accordance with the 2019/20 annual plan, Internal Audit carried out an audit of Patients' Private Property in Muckamore Abbey Hospital during February / March 2020. The audit focused on the management of property and monies held by the Belfast Trust on behalf of the patients. The outcome of the Audit Report was that a "Satisfactory" rating was given to Patients' Private Property in Muckamore Abbey Hospital.

Question 6

Did the Audit Committee have any role in the Trust's responses to inspections of MAH, including those carried out by RQIA? If so, please give details.

25. During the period under review, as detailed in question 5, the 2017/18 annual plan saw Internal Audit carry out an audit on two areas; Complaints and Incidents and Patient Supervision. "Limited assurance" was given for Complaints and the Incidents and Patient Supervision was rated as "Satisfactory".

26. The Audit Committee does not itself review compliance with RQIA inspections, but if an internal audit report draws on an RQIA inspection, which is what happened for the 2020 Internal Audit relating to patient finance, then Audit Committee would be aware of the RQIA inspection by that means. As part of its April 2020 work, Internal Audit reviewed Patients' Private Property in Muckamore Abbey and provided a "Satisfactory" rating. However, it noted that an improvement notice was issued by RQIA to the Trust on the 16th August 2019 in regard to its failure to ensure that a robust financial governance framework was in place for the effective management of patients' finances within Muckamore Abbey Hospital.

27. At the time of the April 2020 Audit carried out by BSO Internal Audit, sufficient progress had been made to provide a "Satisfactory" rating. It was noted by Internal Audit that RQIA recommendations should be fully addressed by the Belfast Trust.

Question 7

During your time as Chair, can you recall whether the Audit Committee raised any concerns in relation to MAH with the Trust Board? If so, please give details.

28. To the best of my knowledge the Audits in 2017/18 and April 2020 as detailed above were notified to the Trust Board after each audit had been completed. Furthermore, the internal audits would have been discussed by the Audit

Committee, whose minutes would have been presented to, and approved by, the Trust Board. This was a means of directly reporting the Audit Committee's findings to the Trust Board, although that reporting is done whether the internal audit report identifies areas of concern or not.

29. As to whether the Audit Committee raised concerns relating to MAH, that has not happened during the time I have been Chair of the Audit Committee. The only contexts in which the Audit Committee has come across the services provided at MAH during my time as Chair is as I have set out above, and on both occasions the Committee was sufficiently assured that the particular issues in question were being adequately dealt with. The Audit Committee therefore had not had cause to raise any concerns in relation to MAH to the Trust Board within the context of the Audit Committee's work.

Question 8

Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

30. For the assistance of the MAH Inquiry Panel I exhibit to this statement behind Tabs 2 – 7:

    i. An agenda for an Audit Committee meeting;
    ii. A set of minutes for an Audit Committee meeting;
    iii. A copy of the Audit Committee's Annual Report for 2017/18;
    iv. A copy of the Audit Committee's Annual Report for 2020/21;
    v. A copy of the Internal Audit report referenced above from 2017/18;
    vi. A copy of the Internal Audit report referenced above from 2019/20.

Declaration of Truth

31. The contents of this witness statement are true to the best of my knowledge and belief. I have, to the best of my ability, either exhibited or referred to the documents which, collectively, I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

Signed: *Gordon Smyth*

Dated: 7th June 2024

Gordon Smyth Organisational Module 9 Exhibit Bundle "GS1"		
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MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

28 March 2024

By Post
Mr Gordon Smyth
Former Non-executive Director
and Chair of Audit Committee BHSCT
25 Shanaghy Road
Ballymoney
Antrim
BT53 7NW

Dear Mr Smyth

Re MAHI Organisational Modules 2024: Request for Witness Statement

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006.

The Inquiry understands that you were a non-executive Director of the BHSCT Trust Board and also Chair of the Trust Audit Committee between 2016 and 2021.

You are asked to make a statement for the following module:

M9: Trust Board

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement is primarily concerned with the evidence of those in key positions of responsibility for

MAH, past and present, at Trust Board level.

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Given your role as Chair of the Audit Committee for BHSCT, the Panel would be assisted if you would address the following matters specifically in your statement:

1. What was the composition and remit of the Trust Audit Committee?
2. How often did the Audit Committee meet?
3. By what means (and at what intervals) did the Audit Committee report to the Trust Board?
4. Do you recollect MAH being on the agenda and, if so, how often?
5. Do you recollect the Committee receiving audits, reports or other material relating to MAH? If so, please give details and indicate how the Audit Committee dealt with such material?
6. Did the Audit Committee have any role in the Trust's response to inspections of MAH, including those carried out by RQIA? If so, please give details.
7. During your time as Chair, can you recall whether the Audit Committee raised any concerns in relation to MAH with the Trust Board? If so, please give details.
8. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

It would be helpful if you could address those questions in sequence in your statement. If you do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 10 May 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/zjeno4cq8rl617xmxb2er15db7n9xoue

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024: Organisational Modules 2024.pdf (mahinquiry.org.uk).
2. MAHI Terms of Reference
3. OM2024 Statement Format Guide

ORGANISATIONAL MODULES 2024 STATEMENT FORMAT GUIDE

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Sarah Jones
Date: [INSERT]

I, Sarah Jones, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of [INSERT] in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "Exhibit 1" (OR "There are no documents produced with my statement").

USE NUMBERED PARAGRAPHS

Qualifications and positions

1. I am a qualified [insert]. I hold a degree in [insert with date]. I hold a Masters degree in [insert and date].

2. I have held the following positions. From 2000 to 2005, I was [Assistant Director of A]. From 2005 to 2010, I was [Director of B].

Module

3. I have been asked to provide a statement for the purpose of [EXAMPLE: M1: Patient Advocacy and Representation].

4. My evidence relates to paragraphs 10 to 13 of the Inquiry's Terms of Reference.

5. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Q1. What responsibility did you have for the care of patients at the hospital?

6. In my role as [Director], I was responsible for ...

Q2. What steps did your organisation take to implement the recommendations of the Hospital Report in 2011?

7. On publication of the Hospital Report, my organisation took a number of steps to implement the recommendations of the report, including the following: ...

Etc ...

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: *Sarah Jones*

Date: [INSERT]

List of Exhibits (Sarah Jones)

Exhibit 1: Letter from X relating to MAH, dated X.

Exhibit 2: Memo re MAH, dated Y.

Exhibit 3: Organisational report, dated Z.

FORMATTING ADVICE

Please use the following formatting:

- Font: Arial.
- Point size: 12.
- Line spacing within paragraphs: 1.5.
- Spacing between paragraphs: double.
- Numbered paragraphs in sequence throughout statement.
- DO NOT insert a "header", as MAHI pagination will be applied at top of pages.

WITNESS CONTACT PAGE

NAME: SARAH JONES

PERSONAL INFORMATION BELOW NOT TO BE DISCLOSED

D.O.B: --/--/----

ADDRESS FOR CORRESPONDENCE:

E-MAIL ADDRESS:

TELEPHONE NUMBER:

IF LEGALLY REPRESENTED: LAWYER'S NAME AND CONTACT DETAILS:

NAME:

EMAIL:

TELEPHONE:

AVAILABILITY

I definitely could not give evidence to the inquiry on the following dates in April – June 2024, as I have booked to go away or I have medical appointments:

[DATES].

Belfast Health and Social Care Trust
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AUDIT COMMITTEE

24 April 2018 at 10.00am
Boardroom, A floor,
Trust Headquarters, Belfast City Hospital

AGENDA

1.0 Apologies

2.0 Minutes of Previous Meeting – 16 January 2018

3.0 Chairman's Business

3.1 Conflicts of Interest

4.0 Matters arising

4.1 Internal Audit Report Fire Safety – update
4.2 Internal Audit Report Catering – update
4.3 Internal Audit Report Contracts with Voluntary sector – update - *To Follow*

5.0 Report of Internal Auditor

5.1 Progress Report
5.2 Year-end Follow-up Report
5.3 Shared Services Report
5.4 Head of Internal Audit Annual Report 2017/18 – *To Follow*
5.5 Draft Internal Audit Strategy and Plan 2018/19

6.0 Draft Governance Statement 2017/18 – *To Follow*

7.0 Single Tender Actions 2017/18

8.0 Fraud Update

9.0 Any other business

10.0 Date of Next Meeting – 2.00pm on 5 June 2018

Belfast Health and Social Care Trust
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Minutes of the Audit Committee Meeting held on 24 April 2018 at 10.00am in the Boardroom, Trust Headquarters, A Floor, Belfast City Hospital

Present:

Mr Gordon Smyth, (Chair) Non-Executive Director
Professor Martin Bradley, Non-Executive Director
Dr Paddy Loughran, Non-Executive Director

In Attendance:

Mrs Maureen Edwards, Director Finance, Estates and Capital Development
Mr Aidan Dawson, Director Specialist Hospitals and Women's Health – *Min AC/15 a (ii)*
Mrs Maire Heaney, Director Adult, Social and Primary Care – *Min AC/15 a (iii) + (iv*)
Mrs Jacqui Kennedy, Director Human Resources/Organisational Development (Interim) *Min AC/15 a (i)*
Mrs Fiona Cotter, Co-Director Financial Services
Mrs Nicola Williams, Head of Governance and Client Accounting
Mr Roger McCance, Northern Ireland Audit Office (NIAO)
Mrs Catherine McKeown, Internal Audit (BSO)
Mrs Jenny McCaw, Internal Audit (BSO)
Mrs Pauline McCartan, Boardroom Apprentice
Miss Marion Moffett, Minute Taker

Apology:

Mrs Miriam Karp, Non-Executive Director
Mrs Nuala McKeagney, Non-Executive Director
Mr Martin Pitt, External Auditor Price Waterhouse (PwC)
Ms Claire Cairns, Head of Office, Chief Executive's Office

Mr Smyth welcomed everyone to the meeting.

AC12/18 Chairman's Business

a. Mrs McKeagney and Mrs Karp - Comments

Mr Smyth explained that Mrs Karp and Mrs McKeagney had submitted written comments, which he would cover during the meeting.

b. Conflicts of Interest

There were no conflicts of interest noted.

AC13/18 Minutes of Previous Meeting

The minutes of the previous meeting held on 16 January 2018 were considered and approved.

Proposed: Professor Bradley Seconded: Mrs Edwards

AC14/18 Matters Arising

a. Internal Audit Fire Safety Report – Update

Mrs Edwards presented an update report in relation to the Fire Safety Action Plan highlighting significant progress in relation to the recommendations outlined in the Internal Audit (IA) report.

In response to a comment from Professor Bradley, Mrs Edward advised that Floor Plans are available in all clinical wards and work was ongoing on remaining areas. She also advised that evidence of Evacuation Plans and Floor Plans were now included in the Director Safety and Quality Walkround Checklist.

In relation to mandatory training, Mrs Edwards advised that whilst there had been improvement in performance there continued to be a need for progress. She advised that there were difficulties in HRPTS reporting and the Statutory Mandatory Training Group had undertaken to assess the reporting function of HRPTS in an attempt to develop more meaningful reports for Directors.

Mr Smyth emphasised the importance of all staff undertaking mandatory training in respect of fire safety.

In terms of cladding, the Trust had received assurance from the regional group established in the aftermath of Grenfell, led by DoH that all necessary actions had been addressed. The Trust's review of buildings had identified two with ACM cladding, the Critical Care building (ED canopy) and the Cancer Centre. No action was required in relation to the Critical Care building. However, the Trust had taken the opportunity at the time to review all types of cladding and issues were identified in terms of external cavity barriers in RBHSC and in the McAuley Building at the Mater. A bid had been approved for remedial works in the Cancer Centre, RBHSC and the McAuley building and work was ongoing.

Following a question from Professor Bradley, Mrs Edwards advised that replacing the cladding on the Cancer Centre will be undertaken on a phased basis and will take some time to complete due to the busy clinical environment.

b. Internal Audit Catering including Contract Management Report - Update

Mrs Edwards presented a detailed update in respect of the Catering including Contract Management Audit recommendations.

Members noted that the majority of recommendations had been fully implemented with two partially implemented and work was o going to achieve full implementation.

Members acknowledged the significant work undertaken to address the issues raised by the audit and Mr Smyth wished to record appreciation to Miss Creaney and the Catering team for the excellent progress to date.

Mrs McKeown advised that IA were currently undertaking a follow-up audit in this area.

c. Internal Audit Contracts with Voluntary Sector Report – Update

Mrs Edwards tabled the action plan developed by Mrs Thompson to address the recommendations in the IA Contracts with Voluntary Sector report.

Members noted the Trust had commenced a review of how VFM is demonstrated across contracts. The issue is also being addressed at contract review meetings and joint work is being undertaken with the SEHSCT to identify common contracted services and costs/outcomes comparisons. Training has been delivered for Service Managers with responsibility for contracts in relation to roles and responsibilities and the need to evidence VFM. The guidelines and protocols, together with supporting documentation, have been updated.

AC15/18 Report of the Internal Auditor

Mrs McKeown presented the Progress Report summarising progress made against the 2017/18 IA Plan and summary of the audit reports finalised since the previous meeting. She pointed out that two reports would be presented to the next meeting.

Mrs McKeown explained that there had been resource issues within IA, which had impacted on the management of the audit process, and it was hoped this would be addressed to prevent similar issues in the future.

Mrs Edwards advised that Director colleagues had raised concerns regarding the audit process, including issues with timescales and apparent lack of clarity about information requirements in relation to management evidence. Mrs Edwards advised that the Trust would meet in the next couple of months to suggest improvements in the

process prior to meeting IA. She was also currently considering reinstating a post within Finance to co-ordinate the process.

Mr Smyth said he would welcome the opportunity to consider further at a future Trust Board workshop to ensure appropriate processes are in place.

Mr Smyth asked that reports with limited assurance be dealt with first to accommodate Directors attending for specific items.

a. Progress Report

(i) Payments to Staff

Mrs McKeown reported limited assurance in respect of Payments to Staff with 5 significant findings reported. Of the 15 previously reported recommendations only 1 had been fully implemented.

Mrs Kennedy acknowledged the report had been disappointing. She explained there were issues with HRPTS and resource, with a small team of staff working to tight deadlines. Additional training has been provided to staff in relation to EDRMS and champions nominated for each area to ensure improvement.

In response to a query from Mr Smyth, Mrs Cotter said that she would arrange a meeting with IA to review the outstanding recommendations, as there was evidence available to suggest that there had been more fully implemented than indicated in the report.

Mrs Kennedy advised that management were following up all recommendations.

In the discussion which followed, members expressed concern at the cost implication for the Trust and the need to ensure appropriate processes are in place to prevent further cases.

In noting the position, Mr Smyth stated that all recommendations accepted by management needed to be addressed.

(ii) Patient Flow – Trauma and Orthopaedics 2017/18

Mrs McKeown reported limited assurance in respect of Patient Flow 2017/18, in relation to the management of transfers of Trauma and Orthopaedics patients and records from RVH to MPH, with 1 significant finding.

Mr Dawson advised that he had included this service in the IA Plan knowing it would raise a number of issues, which would support service improvement. Management had accepted all recommendations outlined in the report and an action plan had been developed to ensure

they are progressed. He advised a new Service Manager had taken up post recently and was monitoring the action plan closely to ensure implementation of recommendations.

Professor Bradley and Dr Loughran expressed concern that separate records are held for individual patients by both the RVH and MPH.

Mr Dawson advised that whilst the preference would be for one record he understood there would be a need for significant investment. He undertook to follow up with Mrs Thompson, the Director responsible for records management.

In response to a question from Dr Loughran regarding patient safety, Mr Dawson advised that with additional beds and increased theatre capacity the need to transfer fracture patients will reduce. The fracture care pathway was currently under review and included considering a different use of the Fracture Clinic to run a 24-hour service.

Mr Smyth said it was reassuring to note implementation dates were April, May and June 2018.

Having considered the report in detail members noted the position.

(iii) Domiciliary Care 2017/18

Mrs McKeown provided limited assurance in respect of the Domiciliary Care Contract Management audit with 2 significant findings.

Mrs Heaney referred to the regional issues in respect of Domiciliary Care provision and acknowledged significant challenges in respect of the service. She advised that a pilot had commenced with three providers, which would be monitored and supported closely to ensure improved outcomes. In addition, a programme of engagement workshops has been scheduled with providers to work more collaboratively and develop an improved care model. Further work is being undertaken at regional level with the DoH and HSCB to stabilise the domiciliary care workforce.

In response to a comment from Mr Smyth regarding the significant number of people on the waiting list for Domiciliary Care, Mrs Heaney advised social workers continue to work closely with clients to consider an alternative pathway and provide additional support for families.

Members noted the report.

(iv) Adult Social and Primary Care Directorate – Muckamore Abbey Hospital

Mrs McKeown advised IA had undertaken an audit within Muckamore Abbey Hospital (MAH), on the management of complaints and

incidents, patient supervision and progress in achieving Royal College of Psychiatry's quality network for inpatient learning disability standards of care. She reported satisfactory assurance in relation to the management of incidents and patient supervision; however limited assurance was reported in respect of the complaints process.

Mr Smyth advised Mrs Karp had noted concerns in relation to the MAH complaints process.

Professor Bradley emphasised the importance of all complaints being processed through the formal complaints process.

Mrs Heaney referred to on-going service review in relation to MAH and advised that all recommendations would be addressed.

Following discussion members noted the report.

(iv) General Ledger 2017/18

Mrs McKeown reported satisfactory assurance in respect of the audit of the General Ledger, with no significant findings identified.

The Committee noted the report.

Mr Smyth asked that members' appreciation be extended to all staff involved.

(v) Risk Management 2017/18

Mrs McKeown reported satisfactory assurance in respect of the Risk Management audit.

The Committee noted the report.

Mr Smyth again asked that member's thanks be extended to all staff involved in positive report.

(vi) Patient Flow General Medicine Inter Hospital Transfers – Follow Up Review

Mrs McKeown reported satisfactory assurance in respect of the Patient Flow General Medicine Inter Hospital Follow Up Review.

Members welcomed the report, which indicated significant improvement since the previous audit.

(vii) Stocktaking 2017/18

Mrs McKeown reported satisfactory assurance in relation to the year-end Stock Take, with no significant findings.

Members welcomed the report.

(viii) Performance Management 2017/18

Mrs McKeown reported satisfactory assurance in respect of the Performance Management with no significant findings identified.

The Committee noted the report.

(ix) Controls Assurance Verification

Mrs McKeown reported that IA agreed with the Trust's "substantive" compliance self-assessment with Controls Assurance Standards in Governance, Financial Management, Risk Management, Emergency Planning and Human Resources.

Members were reassured by this report.

Mr Smyth said this was a very good result and asked that members' appreciation be extended to all staff involved.

b. IA Outstanding Recommendations 2017/18 – Year-End Follow Up

Mrs McCaw presented a report on the Year-End Follow-Up of Outstanding IA recommendations 2017/18, indicating 67% of the 685 recommendations assessed had been fully implemented; 28% were partially implemented; and 5% were yet to be implemented at the time of review.

Mr Smyth sought clarification in relation to Laboratory Procurement and Contract Management, Mrs Cotter advised that a proposal regarding the establishment of a Laboratory Procurement Group was with DoH for approval.

Mr Smyth referred to concerns noted by Mrs McKeagney and Mrs Karp regarding the number of outstanding recommendations.

Professor Bradley referred to the recommendations relating to the Complaints audit and advised that feedback had been provided to IA, which had not be considered prior to the report being issued.

Mrs Cotter advised that she would arrange to meet with IA to review the position as it was her understanding that evidence had been provided in respect of a number of recommendations, which would impact on the overall position.

Members noted the position.

c. Shared Services Report

Mrs McKeown presented a report of the BSO Shared Services Audits in respect of Payroll, Accounts Payable and Governance. Whilst Accounts Payable and Governance had received satisfactory assurance, Payroll received limited assurance (previously unacceptable).

Members shared Mr Smyth's concerns at the continuing issues with Payroll related to HRPTS.

Mrs Edwards advised that the Directors of Finance Forum continued to monitor the situation. She explained that there were workforce issues within BSO Payroll department, which need to be addressed. In the meantime, Trusts were releasing staff to support BSO.

In response to a question from Mr Smyth, Mrs Edwards advised that Ms Deborah McNeilly, DoH, was the SRO for the project.

Mr Smyth said that Trusts had a duty of care to staff and emphasised the importance of on-going issues with the system to be resolved.

Members noted the report.

d. Head of Internal Audit Annual Report 2017/18

Mrs McKeown advised the Head of IA Audit Report for 2017/18 was currently in draft and would be available for the next meeting.

e. Draft Internal Audit Strategy and Plan 2017/18 to 2019/20

Mrs McKeown presented the IA Strategy, incorporating the proposed IA Audit Plan for the period 2017/18 to 2019/20 for consideration.

Mrs McKeown pointed out the IA Plan for 2018/19 detailed the audits proposed to be undertaken during the period.

The Committee approved the IA Plan for 2018/19.

This concluded the IA reports and the Chairman sought acceptance of the report.

Proposed: Dr Loughran *Seconded: Professor Bradley*

AC16/18 Draft Governance Statement 2017/18

Mrs Williams presented the draft Governance Statement (GS) for 2017/18. In their consideration of the Statement, the Committee noted the following:

Prior Year Control Issue now closed:

- Radiation Waste

Prior Year Control Issues ongoing:

- Financial Position
- Business Services Transformation Project
- Hypernatremia Inquiry
- Serious Adverse Incidents
- Prompt Payment Performance
- Temporary Suspension of Paediatric attendances at Mater ED
- Single Tender Actions/Direct Award Contracts
- Radiation Waste
- Domiciliary Care Services
- Social Care Procurement

New Control/Other Issues:

- Critical Care Building

Mr McCance advised that the C&AG may reference the issues with the Critical Care building in his annual report.

Mrs Edwards advised that the GS would be finalised in line with the final accounts timetable.

Members noted the position and the Chairman sought acceptance of the draft GS.

Proposed: Dr Loughran *Seconded: Professor Bradley*

AC17/18 Single Tender Actions 2017/18

Mrs Cotter presented the summary report of the Single Tender Actions for the year 2017/18.

In response to a query from Mr Smyth regarding Estates Department maintenance STAs, Mrs Cotter explained that these were pending a formal tender exercise.

The Committee noted the contents of the report.

AC18/18 Fraud Update Report

Mrs Williams presented a summary of new and ongoing suspected/ actual frauds reported to the Governance and Audit Team.

The Committee noted the contents of the report

AC19/18 Any Other Business

a. Annual Accounts 2017/18

Mr McCance advised the annual accounts audit process is underway and audit opinion will be presented at the next meeting

AC20/18 Date of Next Meeting

Members noted the next meeting was scheduled for 2.00pm on 5 June 2018

Belfast Health and Social Care Trust

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2017/18 ANNUAL REPORT OF THE AUDIT COMMITTEE

1. Introduction

It is the responsibility of the Audit Committee to oversee the establishment and maintenance of an effective system of internal control to meet the Trust's objectives. In fulfilling this role, the Audit Committee must also safeguard public and other funds and the Trust's assets.

In turn, the Audit Committee must provide the Trust Board with assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are being met.

This annual report to the Trust Board covers, in the main, activity within the 2017/18 financial year.

2. Chairman's Foreword

In presenting this Annual Report of the Audit Committee of the Trust, I wish to place on record my thanks to all my Non-Executive Director colleagues for their support and effective contribution to the successful operation of the Audit Committee.

3. Membership

Membership of the Audit Committee for the year ended 31 March 2018 is set out below:

Mr Gordon Smyth (Chair) – Non-Executive Director
Professor Martin Bradley – Non-Executive Director
Mrs Nuala McKeagney – Non-Executive Director
Dr Patrick Loughran – Non-Executive Director
Mrs Miriam Karp – Non-Executive Director

All current Non-Executive Directors (with the exception of the Chair) were appointed in 2015 to serve on the Audit Committee for the period of their four year appointment as Non-Executive Members of the Board. On the recommendation of the Permanent Secretary, in October 2011 the Trust's Chairman separated the membership of the Audit and Remuneration Committees to ensure full standards of probity are met.

Servicing arrangements for the Committee are undertaken by the Head of Office.

4. Terms of Reference

The Audit Committee Terms of Reference were updated in April 2015 to align with the Department of Finance and Personnel (DFP) Audit and Risk Assurance Committee Handbook (NI) March 2014. The revised Terms of Reference were subsequently presented to Trust Board. The Audit Committee Terms of Reference are reviewed on an annual basis.

5. Meetings

The Committee is required by its Terms of Reference to meet not less than four times a year. During the year commencing 1 April 2017, the Audit Committee met on four occasions, as detailed below:

24 April 2017
6 June 2017(*)
9 October 2017
16 January 2018

(*) This meeting included a private meeting between the Audit Committee and the Internal and External Auditors. A further two meetings have been held since the end of the financial year, in April and June 2018 – these meetings focused primarily on consideration of the Financial Statements for the year ended 31 March 2018 and the Annual Report of BSO Internal Audit.

The attendance record for members was as follows:

Mr Smyth	4/4
Prof Bradley	3/4
Mrs McKeagney	3/4
Dr Loughran	4/4
Mrs Karp	4/4

In addition, the Committee is attended by the Director of Finance, representatives of the Northern Ireland Audit Office (appointed auditors), PricewaterhouseCoopers (PwC) (contracted auditors) and Business Services Organisation (BSO) Internal Audit staff.

In accordance with the Action Plan developed as part of the Effectiveness Review, the Trust's Chief Executive attended the meeting held on 6 June 2017.

6. Learning and Development

Non-Executive Directors attended a number of Trust Board Workshops during 2017/18. These Workshops included sessions on the Trust Boards Annual Work plan, Quality Improvement Strategy, Regional Performance Management Framework, Fire Safety, Safetember, O'Hara Report, Muckamore Safeguarding Issues and Major Capital Projects. The Trust Board development programme work streams regarding complaints, performance, stakeholder engagement and Board Redesign have now been completed and any ongoing matters are dealt with in the normal course of business. In June 2017 the Trust Board attended a Quality Improvement development programme to enhance the Trust Board's improvement journey,

7. Internal Audit

7.1 Provider

Internal Audit services for 2017/18 were provided by BSO through a Service Level Agreement with the Trust. BSO is the regional provider of Internal Audit services to all H&SC Trusts in Northern Ireland.

The primary objective of Internal Audit is to provide an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee on the adequacy and effectiveness of the system of internal control. The work of the Internal Auditor is informed by an analysis of risk to which the Trust is exposed and annual audit plans, approved by the Audit Committee, are based on this analysis. Planned inputs of 888 days were agreed by the Committee for 2017/18, which is in line with the previous year's plan.

During the year, the Committee considered reports from the Internal Auditor covering the following systems:

AUDIT ASSIGNMENT	OVERALL LEVEL OF ASSURANCE
Cash Handling in Social Services Facilities	SATISFACTORY - 4 of the 6 Facilities (including 1 Sure Start Scheme) LIMITED - 2 out of 6 Facilities
Nursing and User Experience Directorate Review - Catering inc Contract Management	LIMITED
Management of Tenant Monies by the Trust in ASL Facilities (Trust Run Facilities)	SATISFACTORY
Client Monies in the Independent Sector	SATISFACTORY – 8 homes out of 10 visited LIMITED – 2 homes out of 10 visited
Non Pay Expenditure	SATISFACTORY Non-pay expenditure (with the exception of Agency payments) LIMITED – Agency payments
Management of Contracts with Voluntary Sector (including Sure Start Schemes)	LIMITED
Financial Assessments (including Self Directed Support & Direct Payments)	SATISFACTORY – Financial Assessments LIMITED - SDS and Direct Payments
Payments to Staff	LIMITED
General Ledger	SATISFACTORY
Management of Contract Adjudication Groups (CAGs)	SATISFACTORY
Attendance at Stock Takes	SATISFACTORY
Fire Safety	LIMITED
Absence Management	SATISFACTORY – HR processes LIMITED – Directorate Level
IT Audit	LIMITED – IT incident management and secure configuration SATISFACTORY– Malware prevention
Recruitment within the Trust	SATISFACTORY
Performance Management & Reporting	SATISFACTORY

AUDIT ASSIGNMENT	OVERALL LEVEL OF ASSURANCE
Patient Flow	LIMITED
Adult Social and Primary Care Services Directorate Risk based Audit	SATISFACTORY – Management of Incidents and Patient Supervision at Muckamore LIMITED – Management of Complaints at Muckamore
Management of Consultant Medical Staff – Job Planning & Payments	LIMITED
Management of Domiciliary Care Contracts	LIMITED
Claims Management (Regional Audit)	SATISFACTORY
Licence Governance Arrangements	SATISFACTORY
Risk Management	SATISFACTORY

In addition, Internal Audit facilitated a self-assessment in seven HSCNI organisations which was designed to make Senior ICT Management assess ICT and wider organisation control environment against the National Cyber Security Centre's suggested controls. In particular, this was to provide coverage of the 10 Steps to Cyber Security which were not substantively tested by Internal Audit during 2017/18 (in the Cyber Security audit). The results were reported in a regional report issued in April 2018 and presented to the Trust's Audit Committee in June 2018.

7.2 Appreciation

The Committee wishes to take the opportunity, in its Annual Report, to express its appreciation of the commitment of Mrs McKeown and Mrs McCaw and their team. The Committee acknowledges the work undertaken by the Internal Audit team and appreciates the good working relationships between the Audit team and Trust staff.

7.3 Internal Audit Annual Report

Internal Audit is required to provide an independent and objective opinion on the Trust's risk management, control and governance arrangements based on the work performed in fulfilment of the Internal Audit Plan. The purpose of the annual opinion of the Internal Auditor is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Trust's own assessment of the effectiveness of the system of internal control.

The Committee has approved the Annual Report from BSO (Appendix 1) and has noted, in particular, that:

(a) By the date of the Annual Report, 23 audits had been completed. The audits undertaken were in line with the approved Operational Plan.

(b) Key issues identified during the year included:

- **The Nursing & User Experience Directorate Review**: Catering including Contract Management audit received limited assurance on the basis that Knockbracken Foods do not use E-Procurement to

order catering goods which may result in the regional contract not being used.

- **Management of Contracts with Voluntary Sector (including Sure Start Schemes)** received limited assurance on the basis that there is no evidence that contracts, including new contracts issued in 2017-18, have been procured in accordance with procurement regulations. In addition, the lack of transparency in the breakdown of costs and contract prices available for many of the Trust's current contracts makes it extremely difficult to determine if value for money has been achieved.

- **Payments to Staff** received limited assurance as significant issues were identified with the management of overpayments, the accuracy of the OM (Organisational Management) Structure, controls around additional payments, completeness of staff drill down/staff in post checks and the substitution rights on the system.

- **The Management of Fire Safety follow-up** report received limited assurance due to weaknesses remaining in relation to staff training, the completion of fire risk assessments and having appropriate evacuation plans in place.

- **Patient Flow** received limited assurance in relation to the management of transfers of Trauma & Orthopaedics patients and records from RVH to Musgrave Park Hospital. Internal Audit found that patient consent and decision to transfer patients as a result of escalation are not documented in patient records.

- **Management of Consultant Medical Staff – Job Planning & Payments** received limited assurance on the basis that a significant percentage (49%) of the Consultant workforce does not have an agreed, current job plan. Further, 12 out of 16 (75%) recommendations made in the 2016-17 audit report remain outstanding, half of these relate to the recommendation that the Trust should revise and issue Job Planning guidance.

- **Management of Domiciliary Care Contracts** received limited assurance as the Trust has limited means of assuring itself on an ongoing basis that care time commissioned and paid for is actually received. In addition, the Trust has continued to roll forward contracts for Domiciliary Care Services without any competitive tendering or market testing.

While the following seven reports received an overall satisfactory level of assurance, limited assurance was provided in specific areas, as set out below:

- **The Cash Handling in Social Services facilities** audit received satisfactory assurance for 4 out of the 6 facilities visited but limited assurance in respect of 2 facilities where there was insufficient evidence of controls around the management of cash handling.

- **The Management of Client Monies in the Independent Sector** audit received a satisfactory assurance for 8 out of the 10 facilities visited but limited assurance in respect of 2 facilities where there were insufficient controls around the management of resident's monies.

- **The Non-pay Expenditure** received overall satisfactory assurance with limited assurance in respect of agency expenditure as based on the sample selected there were no checks made on invoice rates to contract rates.

- **Financial Assessments (including Self Directed Support (SDS) & Direct Payments)** received satisfactory assurance in relation to Financial Assessment and limited assurance in relation to SDS and Direct Payments. Internal Audit reported a low level of compliance in terms of monitoring information being submitted to Finance by SDS and Direct Payment clients and there is a lack of regular, timely reviews of submitted monitoring information.

- **Absence Management** received satisfactory assurance in respect of HR processes but limited assurance at Directorate level due to the significant and frequent issues identified around non-compliance with Trust Absence Management protocol and accuracy of absence recording.

- **IT Audit** received satisfactory assurance in relation to Malware Prevention. Incident Management received Limited assurance based on the lack of integrated governance in respect of Incident Management across the HSCNI network, impacting on the effectiveness of the BHSCT local arrangements. Limited assurance was received in respect of Secure Configuration due to the volume and nature of significant issues identified around continued use of unsupported platforms and other identified security vulnerabilities.

- **Adult Social and Primary Care Services Directorate Risk Audit** received satisfactory assurance in respect of management of incidents and patient supervision at Muckamore. The management of complaints at Muckamore received limited assurance on the basis of the information and data governance issues identified with the complaints files.

(c) A 32 significant findings (weaknesses that could have a significant impact on the system under review) were identified during 2017/18. Internal Audit reported 57 Priority One findings in 2016/17 and 59 Priority One findings in 2015/16.

Overall, the Committee accepted the findings and recommendations of Internal Audit in its reports for 2017/18. The Committee concluded that it was satisfied with management responses to Internal Audit recommendations and the associated action plans to address the control weaknesses identified. The Finance Directorate's Governance and Audit Team has an established audit process which ensures that all Service and Corporate Directorates are aware of their responsibilities for effective internal controls.

Internal Audit also reviewed the Trust's self-assessment of compliance with Controls Assurance Standards. Internal Audit agreed that these were reasonable and that the Trust had achieved substantive compliance in all of the four standards examined in detail.

Internal Audit conduct formal follow-up reviews in respect of the implementation of the Priority 1 and 2 Internal Audit recommendations agreed in the Internal Audit reports. Internal Audit presented a full report which showed that 67% of agreed actions have been fully implemented 28% partially implemented and 5% not implemented. The Audit Committee expressed concern regarding the number of recommendations not fully implemented and management have agreed to arrange a workshop with Directors and review the follow-up process in conjunction with Internal Audit.

Based on the work undertaken by BSO in 2017/18, management has been provided with an overall satisfactory level of assurance in relation to the system of internal control. Internal Audit noted that Limited assurance had been provided in a number of areas including the payments to staff audit and elements of the cyber security audit.

Internal Audit reported that BSO Accounts Payable, Accounts Receivable and Recruitment Shared Services (APSS, SSAR and RSS) received satisfactory assurance however Payroll (PSSC) received limited assurance.

The Shared Service Centre for Payroll received limited assurance in relation to Payroll Function Stability, Payroll System Stability and Payroll Processing. The assurance level over Payroll Function Stability has been raised from unacceptable. This takes account of improvements in respect of overpayments identification, calculation, notification and reporting. However it is important to note that these issues have not been fully resolved and continue to impact on Payroll Function Stability.

BSO have provided the Trust with assurances that they will continue to address identified weaknesses and pursue continuing improvements to systems of internal control in operation within the organisation in 2018/19.

The Committee is of the opinion that the necessary action has been, or is being, taken in response to all matters identified by BSO.

7.4 Internal Audit Strategy incorporating the Internal Audit Plan 2017/18 to 2019/20

The Internal Audit Plan for 2017/18 to 2019/20 was presented to the Audit Committee for approval in April 2018 (Appendix 2). In addition to the finance audits, the plan also provides for corporate risk based and governance audits, including an assurance process post controls assurance standards. The Audit Plan is sufficiently flexible to allow for changes, where these may be required throughout the financial year e.g. emerging issues.

7.5 Performance of Internal Audit

The Committee is pleased to report that the work delivered by the BSO was to a high standard and delivered in a professional and effective way, with reports setting out in a clear manner any remedial action required. As advised in its Annual Report, BSO conducted all work in accordance with Public Sector Internal Audit Standards (PSIAS); is accredited with the ISO 9001:2008 quality standard; and is an approved ACCA Gold Status Employer for Training and Professional Development.

A self-assessment of the BSO Internal Audit Service's compliance with the Public Sector Internal Audit Standards (PSIAS) performed during February and March 2018 provided assurance that the Service complies satisfactorily with the requirements of these standards. The Unit is now due for an external assessment and this will be commissioned in the near future.

The Committee's overall assessment is that BSO Internal Audit provides a satisfactory service. During the year, BSO Internal Audit did not provide any non-audit services.

8. External Audit

8.1 Provider

The Northern Ireland Audit Office (NIAO) provides the Trust's External Audit service. The Comptroller and Auditor General (C&AG) has re-appointed PwC to undertake the audit on his behalf for a five-year period with effect from 2017/18.

8.2 Appreciation

The Committee wishes to take the opportunity, in its Annual Report, to formally record its appreciation for the quality and rigour of work undertaken by the Audit Partner, Martin Pitt, and the rest of the PwC team.

8.3 External Audit 2017/18

PwC presented the findings of the external audit of the Trust's Financial Statements for the year ended 31 March 2018, in the Report to those Charged with Governance, at the Audit Committee meeting on 5 June 2018.

The Committee is pleased to note that the External Auditor co-operates fully with Internal Audit to maximise overall audit efficiency and to minimise unnecessary duplication of work.

A meeting between the Audit Committee and the contracted Auditors, without the officers present, is considered good practice. This meeting took place on 6 June 2017 and raised no substantive issues.

During the year, PwC did not provide any non-audit services or value for money studies.

8.4 Performance of PwC

The Committee acknowledges, in this Annual Report, the independence and effectiveness of the External Auditors, PwC. The Committee is satisfied that the External Auditor possesses the requisite experience and expertise to manage the audit effectively. The Committee also recognises that the reports of the External Auditor presented to the Audit Committee are robust, comprehensive and of the highest quality.

9. Financial Reporting and Governance Statement 2017/18

The Committee has reviewed the Trust's Financial Statements for the year ended 31 March 2018 and has confirmed that these comply with relevant legislation, accounting standards and that there is agreement between the Auditors and the Director of Finance over accounting policies. The audit report from NIAO is an unqualified opinion on the truth, fairness and regularity of the Public Funds Financial Statements.

The mid-year Assurance Statement, as at 30 September 2017, and the Governance Statement for the year ended 31 March 2018, were reviewed by the Audit Committee for adequacy and completeness.

The Trust's Financial Statements for the year ended 31 March 2018 have been recommended by the Audit Committee to the Trust Board for approval.

The Committee also considered, in detail, the Report to those Charged with Governance from PwC/NIAO and the Trust's response.

The Committee has expressed its appreciation to the Director of Finance and her staff for their work during 2017/18 and the financial outcomes achieved.

10. Fraud

The Trust has in place a formal Fraud Policy and Fraud Response Plan together with a Whistleblowing Policy.

During the year, 10 new incidents of suspected or actual fraud, with a potential value of £17,157.11 were reported to the Committee. All cases have been thoroughly investigated with the assistance of PSNI and BSO Counter Fraud Services, where

appropriate. The results of investigations have led to improved and/or new controls and disciplinary action.

In addition, there were five anonymous whistleblowing allegations made via the HSC Fraud hotline – preliminary investigations were carried out and in agreement with CFS four of these cases were closed due to insufficient evidence to support the allegations. The remaining case is subject to an ongoing investigation.

The Committee concludes that the general framework established by the Trust for the prevention and detection of fraud is adequate.

11. Review of Effectiveness

The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. Each Audit Committee member was asked to complete the Checklist independently. The results of the Checklist were then summarised and the key findings presented in a comprehensive report.

A statistical analysis of the results highlighted that 83% of questions were answered in the positive, 9% were perceived to be not applicable, and responses to 8% were negative. This is the second self-assessment carried out by the Non-executive Directors and a comparison with the results of the previous self-assessment shows that the Audit Committee has become more assured in its role and performance has improved against most of the good practice questions. The results provide a good indication of the overall effectiveness of the Trust's Audit Committee and indicated that the Committee has formal and transparent arrangements for considering financial reporting and internal control principles and for maintaining appropriate relationships with the Internal and External Auditors. A small number of improvements were identified which have now been incorporated into an Action Plan (Appendix 3) which will address the issues identified through this assessment process.

12. Committee Statement of Assurance

The Committee has considered the Annual Report of BSO and has received the Report to those Charged with Governance from PwC/NIAO on its audit for 2017/18. The Committee has considered the response of the Trust's management to individual audit reports, both Internal and External Audit, and other guidance issued during the year.

On the basis of this consideration and the material available to it, the Committee is of the opinion that the Trust's systems of internal control are adequate and effective, as are its strategies and procedures in relation to internal control and governance. In general, the Committee is satisfied that appropriate steps are being taken to ensure economy, efficiency and effectiveness in relation to the operations of the Trust.

13. Submission of Annual Report

The Committee is of the opinion that the assurances available are sufficient to support the Board in the decisions taken by it and in its accountability obligations and that a sound system of internal governance is in place. The Committee recommends that the Annual Report for 2017/18 be approved and that it be submitted to the Trust Board and the Chief Auditor.

Gordon Smyth
Chairman
Audit Committee 5th June 2018

Belfast Health and Social Care Trust
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Item 9
Audit Committee – 21.6.22

2021/22 ANNUAL REPORT OF THE AUDIT COMMITTEE

1. Introduction

It is the responsibility of the Audit Committee to oversee the establishment and maintenance of an effective system of internal control to meet the Trust's objectives. In fulfilling this role, the Audit Committee must also safeguard public and other funds and the Trust's assets.

In turn, the Audit Committee must provide the Trust Board with assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are being met.

This annual report to the Trust Board covers, in the main, activity within the 2021/22 financial year.

2. Chairman's Foreword

In presenting this Annual Report of the Audit Committee of the Trust, I wish to place on record my thanks to all my Non-Executive Director colleagues for their support and effective contribution to the successful operation of the Audit Committee.

3. Membership

Membership of the Audit Committee for the year ended 31 March 2022 is set out below:

Mr Gordon Smyth (Chair) – Non-Executive Director
Professor Martin Bradley – Non-Executive Director
Mrs Nuala McKeagney – Non-Executive Director
Dr Patrick Loughran – Non-Executive Director
Mrs Miriam Karp – Non-Executive Director

All current Non-Executive Directors (with the exception of the Chair) were appointed in 2015 to serve on the Audit Committee for the period of their four year appointment as Non-Executive Members of the Board. On the recommendation of the Permanent Secretary, in October 2011 the Trust's Chairman separated the membership of the Audit and Remuneration Committees to ensure full standards of probity are met.

Servicing arrangements for the Committee are undertaken by the Head of Office.

4. Terms of Reference

The Audit Committee Terms of Reference were updated in October 2018 to align with the Department of Finance Audit and Risk Assurance Committee Handbook (NI) March 2018. The revised Terms of Reference were subsequently presented to Trust Board. The Audit Committee Terms of Reference are reviewed on an annual basis.

5. Meetings

The Committee is required by its Terms of Reference to meet not less than four times a year. During the year commencing 1 April 2021, the Audit Committee met on four occasions, as detailed below:

20 April 2021
8 June 2021(*)
12 October 2021
8 February 2022

(*) This meeting included a private meeting between the Audit Committee and the Internal and External Auditors. A further two meetings have been held since the end of the financial year, in April and June 2022 – these meetings focused primarily on consideration of the Financial Statements for the year ended 31 March 2022 and the Head of Internal Audit Annual Report.

The attendance record for members was as follows:

Mr Smyth	3/4
Prof Bradley	4/4
Mrs McKeagney	4/4
Dr Loughran	2/4
Mrs Karp	3/4

In addition, the Committee is attended by the Director of Finance, representatives of the Northern Ireland Audit Office (appointed auditors), ASM Chartered Accountants (contracted auditors) and Business Services Organisation (BSO) Internal Audit staff.

In accordance with the Action Plan developed as part of the Effectiveness Review, the Trust's Chief Executive attended the meeting held on 8 June 2021.

6. Learning and Development

Non-Executive Directors attended a number of Trust Board Workshops during 2021/22. These Workshops included sessions on Time Critical Surgery, Unscheduled Pressures, Outpatient Modernisation Programme, Workforce, Building effective teams to keep patients and doctors safe, Financial Management and Governance, Capital Schemes, CHKS regional benchmarking for RQIA and Assurance Framework.

7. Internal Audit

7.1 Provider

Internal Audit services for 2021/22 were provided by BSO through a Service Level Agreement with the Trust. BSO is the regional provider of Internal Audit services to all H&SC Trusts in Northern Ireland.

The primary objective of Internal Audit is to provide an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee on the adequacy and effectiveness of risk, control and governance

arrangements. The work of the Internal Auditor is informed by the organisation's assessment of risk and assurance needs (as per the Principal and Corporate Risk Registers and Assurance Framework), and the audit strategy and annual audit plans, approved by the Audit Committee, are based on this analysis.

The Internal Audit Strategy and Audit Plan 2020/21 to 2022/23 was reviewed and updated in April 2021. A total of 888 audit days were planned in the SLA for the year 2021/22.

All audit assignments included in the 2021/22 Internal Audit Plan have been carried out, with the following approved amendments as requested by Trust management:

- Management of Review Appointments be deferred to 2022/23
- Governance and Assurance Framework to be deferred until 2022/23 - given the ongoing review and amendments to the Assurance Framework
- Whistleblowing audit be deferred to 2022/23 - whilst a Whistleblowing Manager is currently being recruited there has not been sufficient progress made in implementing last year's recommendations to make a 2021/22 audit of value.

During the year, the Committee considered reports from the Internal Auditor covering the following systems:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
FINANCE AUDITS	
Payments to Staff (specifically Nursing and User Experience Directorate)	Limited: Trust wide processes Satisfactory: Payment to Staff processes in Nursing & User Experience Directorate
Non Pay Expenditure (specifically in the Specialist Hospitals Womens Child Health and Mental Health Directorate, excluding agency expenditure)	Satisfactory
Cash Management in Social Services Facilities (in 6 facilities visited)	Satisfactory
Client Monies in Independent Sector Residential Homes (including adult supported living services) *Conducted in 2 audits with separate audit reports*	Satisfactory: 5 out of 9 homes visited Limited: 3 out of 9 homes visited Unacceptable: 1 out of 9 homes visited
Adult Supported Living Client Monies (Trust run services)	Satisfactory: 4 out of 5 facilities visited Limited: 1 out of 5 facilities visited
Asset Management	Satisfactory

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Management and Use of Non-Medical Agency Staff	Limited
Attendance at Year End Stock Takes	Satisfactory
CORPORATE RISK BASED AUDITS	
Implementation of Phase 1 of the Mental Capacity Act	Satisfactory
IT Project Management	Satisfactory
Management of Domiciliary Care Contracts	Limited
Kinship Foster Care Placements (Childrens Community Services Directorate)	Limited
Management of Medical Devices	Limited
COVID-19 Processes - PPE Stock Management and Fit Testing	Limited: Respiratory Equipment Fit Testing Satisfactory: PPE Stores
GOVERNANCE AUDITS	
Quality Management System (QMS) – Corporate Process	Satisfactory
Quality Management System in Surgery Division	Satisfactory
Complaints Management	Satisfactory
Management of Whistleblowing *Note: Audit Opinion carried forward from 2020/21 audit given deferral of planned 2021/22 audit due to limited progress in addressing the recommendations from the 2020/21 audit report*	Limited: Governance and Reporting around Raising Concerns/Whistleblowing processes *(Opinion carried forward from 2020/21)*

A number of advisory/non-assurance assignments were also carried out during the year namely – Assurance Mapping and Post Payment Validation Work on Special Recognition Payments (SRP) to Independent Sector Staff.

7.2 Appreciation

The Committee wishes to take the opportunity, in its Annual Report, to express its appreciation of the commitment of Mrs McKeown and Mrs McCaw and their team. The Committee acknowledges the work undertaken by the Internal Audit team and appreciates the good working relationships between the Audit team and Trust staff.

7.3 Internal Audit Annual Report

Internal Audit is required to provide an independent and objective opinion on the Trust's risk management, control and governance arrangements based on the work performed in fulfilment of the Internal Audit Plan. The purpose of the annual opinion of the Internal Auditor is to contribute to the assurances

available to the Accounting Officer and the Board which underpin the Trust's own assessment of the effectiveness of the system of internal control.

The Committee has approved the Annual Report from BSO (Appendix 1) and has noted, in particular, that:

(a) By the date of the Annual Report, 17 audits had been completed. The audits undertaken were in line with the amended Operational Plan.

(b) Limited assurance was provided for four audits and partially unacceptable/limited assurance in a further four audits as detailed below;

- **Kinship Foster Care Placements** received limited assurance on the basis that kinship carer assessments are not consistently approved within the required timescale and subject to annual review.
- **Management of Non-Medical Agency Staff** received limited assurance on the basis of the significant reliance on off-contract agencies and prior approval not evidenced in half of the cases sampled.
- **Procurement and Management of Domiciliary Care Contracts** received limited assurance due to delays in procurement resulting in the rolling forward of contracts without a formal procurement process. In addition the standing down of key worker visits due to COVID-19 and delays in annual reviews was also reported.
- **Management of Medical Devices** received limited assurance as there is no complete central inventory meaning that there is limited assurance that designated equipment controllers are in place and appropriate servicing, maintenance and training are in place.
- **COVID-19 Processes - PPE stock management and Fit Testing** received satisfactory assurance in relation to PPE stock management and limited assurance in relation to management of fit testing on the basis that some sampled service areas could not identify all staff requiring fit testing and records had not always been maintained.
- **Payments to Staff** received satisfactory assurance in respect of processes within Nursing & User Experience Directorate and limited assurance in respect of Trust-wide processes due to not all budget holders confirming and returning their staff in post reports to financial management.
- **Cash Handling in Adult Supported Living Facilities** received satisfactory assurance for 4 Trust run facilities and limited assurance for 1 Trust run facility due to the large number of transactions for which supporting documentation could not be provided (32 transactions had no receipts with a total value of £1,735.42). Trust staff assisted tenants who are deemed to be financially capable and this resulted in a mixture of records being available.
- **Management of Client Monies in Independent Sector Homes** received satisfactory assurance for 5 Homes and limited assurance for 3 homes due to the lack of supporting documentation for expenditure and unusual cash transactions identified. For one client two transactions totalling £3,210 were paid out by the home to an individual - an adult

safeguarding referral was completed with no irregularities found. Unacceptable assurance remained in place for 1 home as limited progress had been made in respect of the implementation of outstanding Internal Audit recommendations.

(c) A total of 17 significant findings were identified during 2021/22. Internal Audit reported 8 significant findings in 2020/21 and 20 significant findings in 2019/20.

Overall, the Committee accepted the findings and recommendations of Internal Audit in its reports for 2021/22. The Committee concluded that it was satisfied with management responses to Internal Audit recommendations and the associated action plans to address the control weaknesses identified. The Finance Directorate's Governance and Audit Team has an established audit process which ensures that all Service and Corporate Directorates are aware of their responsibilities for the implementation of internal audit recommendations.

Internal Audit conduct formal follow-up reviews in respect of the implementation of the Priority 1 and 2 Internal Audit recommendations agreed in the Internal Audit reports. Internal Audit presented a full report which showed that 81% of agreed actions have been fully implemented and 19% partially implemented.

Based on the work undertaken by BSO in 2021/22, management has been provided with **satisfactory** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Head of Internal Audit noted that limited assurance has been provided in a number of areas and management action is required to address the significant issues raised.

Internal Audit reported that BSO Accounts Payable and Accounts Receivable Shared Services received satisfactory assurance.

Recruitment Shared Service received satisfactory assurance in respect of RSSC processing activities and limited assurance in respect of HSC recruitment processes.

The Shared Service Centre for Payroll received satisfactory assurance in respect of elementary or business as usual processes and limited assurance in relation to End-to-End Manual Timesheet Processing, SAP/HMRC RTI Reconciliation, Overpayments and Holiday Pay.

A Payroll Quality Improvement Programme (PQIP) was approved by the Business Systems Forum in August 2020 to deal with the outstanding Audit Issues and other identified priority tasks in Payroll.

Belfast Trust are working closely with other HSC customers to provide support to BSO in addressing the ongoing issues.

7.4 Internal Audit Strategy incorporating the Internal Audit Plan 2020/21 to 2022/23

The updated Internal Audit Strategy and Plan for 2020/21 to 2022/23 was presented to the Audit Committee for approval in April 2022 (Appendix 2). In addition to the finance audits, the plan also provides for corporate risk based and governance audits. The Audit Plan is sufficiently flexible to allow for changes, where these may be required throughout the financial year e.g. emerging issues.

7.5 Performance of Internal Audit

The Committee is pleased to report that the work delivered by the BSO was to a high standard and delivered in a professional and effective way, with reports setting out in a clear manner any remedial action required. As advised in its Annual Report, BSO conducted all work in accordance with Public Sector Internal Audit Standards (PSIAS) and is accredited with the ISO 9001:2008 quality standard.

An Internal Quality Assessment of BSO Internal Audit Service's compliance with the PSIAS was performed in March 2022 and provided assurance that the Service complies satisfactorily with the requirements of these standards.

Internal Audit Units are professionally required to undergo an independent External Quality Assessment (EQA) every 5 years. The Institute of Internal Audit (IIA) performed the most recent EQA of BSO Internal Audit during February/March 2019. They concluded that the BSO Internal Audit Service meet the vast majority (60 out of 62) of the applicable Standards, as well as the Definitions, Core Principles and the Code of Ethics, which form the mandatory elements of the Public Sector Internal Audit Standards and the Institute of Internal Auditors' International Professional Practices Framework, the globally recognised standard for quality in Internal Auditing. Work is progressing to implement the 2 EQA recommendations around assurance mapping and co-ordination of assurances.

The Committee's overall assessment is that BSO Internal Audit provides a satisfactory service. During the year, BSO Internal Audit did not provide any non-audit services.

8. External Audit

8.1 Provider

The Northern Ireland Audit Office (NIAO) provides the Trust's External Audit service. The Comptroller and Auditor General (C&AG) appointed ASM Chartered Accountants to undertake the audit on his behalf for a five-year period with effect from 2021/22.

8.2 Appreciation

The Committee wishes to take the opportunity, in its Annual Report, to formally record its appreciation for the quality and rigour of work undertaken by the Audit Director, Brian Clerkin, and the rest of the ASM team.

8.3 External Audit 2021/22

ASM presented the findings of the external audit of the Trust's Financial Statements for the year ended 31 March 2022, in the Report to those Charged with Governance, at the Audit Committee meeting on 21 June 2022.

The Committee is pleased to note that the External Auditor co-operates fully with Internal Audit to maximise overall audit efficiency and to minimise unnecessary duplication of work.

A meeting between the Audit Committee and the contracted Auditors, without the officers present, is considered good practice. This meeting took place on 12 October 2021 and raised no substantive issues.

During the year, ASM did not provide any non-audit services or value for money studies.

8.4 Performance of ASM

The Committee acknowledges, in this Annual Report, the independence and effectiveness of the External Auditors, ASM. The Committee is satisfied that the External Auditor possesses the requisite experience and expertise to manage the audit effectively. The Committee also recognises that the reports of the External Auditor presented to the Audit Committee are robust, comprehensive and of the highest quality.

9. Financial Reporting and Governance Statement 2021/22

The Committee has reviewed the Trust's Financial Statements for the year ended 31 March 2022 and has confirmed that these comply with relevant legislation, accounting standards and that there is agreement between the Auditors and the Director of Finance over accounting policies. The audit report from NIAO is an XXXXX opinion on the truth, fairness and regularity of the Public Funds Financial Statements.

The Governance Statement for the year ended 31 March 2022, were reviewed by the Audit Committee for adequacy and completeness.

The Trust's Financial Statements for the year ended 31 March 2022 have been recommended by the Audit Committee to the Trust Board for approval.

The Committee also considered, in detail, the Report to those Charged with Governance from ASM/NIAO and the Trust's response.

The Committee has expressed its appreciation to the Director of Finance and her staff for their work during 2021/22 and the financial outcomes achieved.

10. Fraud

The Trust has in place a formal Fraud Policy and Fraud Response Plan together with a Whistleblowing Policy.

During the year, 24 new incidents of suspected or actual fraud were reported to the Committee. A total of 37 cases, with an estimated value of £187k, are currently being investigated with the assistance of PSNI and/or BSO Counter Fraud Services, where appropriate. The results of investigations have led to improved and/or new controls and disciplinary action.

A paper outlining the Trust approach to NFI matches was presented to Audit Committee in October 2021 alongside the NIAO NFI self-assessment checklist. The completed checklist demonstrated BHSCT commitment to the NFI exercises and that matches are being reviewed efficiently and effectively. A number of actions have been identified which will be taken forward by the Trust NFI key contact.

The Committee concludes that the general framework established by the Trust for the prevention and detection of fraud is adequate.

11. Review of Effectiveness

The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. Each Audit Committee member was asked to complete the Checklist independently. The results of the Checklist were then summarised and the key findings presented in a comprehensive report.

A statistical analysis of the results highlights that 96% of questions were answered in the positive, 2% were negative and 2% were answered as unsure.

This is the sixth self-assessment carried out by the Non-executive Directors and a high-level comparison with the results of the previous self-assessment shows consistency with previous year's scores and demonstrates that overall the Audit Committee has the ability to achieve 96% of the good practice questions.

The results provide a good indication of the overall effectiveness of the Trust's Audit Committee and indicated that the Committee has formal and transparent arrangements for considering financial reporting and internal control principles and for maintaining appropriate relationships with the Internal and External Auditors. One improvement was identified in respect of members Digital Skills Gap and this has now been addressed through additional training.

12. Committee Statement of Assurance

The Committee has considered the Annual Report of BSO and has received the Report to those Charged with Governance from ASM/NIAO on its audit for 2021/22. The Committee has considered the response of the Trust's management to individual audit reports, both Internal and External Audit, and other guidance issued during the year.

On the basis of this consideration and the material available to it, the Committee is of the opinion that the Trust's systems of internal control are adequate and effective, as are its strategies and procedures in relation to internal control and governance. In general, the Committee is satisfied that appropriate steps are being taken to ensure economy, efficiency and effectiveness in relation to the operations of the Trust.

13. Submission of Annual Report

The Committee is of the opinion that the assurances available are sufficient to support the Board in the decisions taken by it and in its accountability obligations and that an adequate system is in place to manage internal governance. The Committee recommends that the Annual Report for 2021/22 be approved and that it be submitted to the Trust Board and the Chief Auditor.

Gordon Smyth
Chairman
Audit Committee XX June 2022

Belfast Health and Social Care Trust

Adult Social and Primary Care Services Directorate Risk audit – Management of Complaints and Incidents at Muckamore 2017/18

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Belfast Health and Social Care Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	14 March 2018
First Draft Issued On:	23 March 2018
Management Actions Due By:	13 April 2018
Management Actions Received:	16 April 2018
Final Report Issued On:	16 April 2018

Distribution List

Martin Dillon	Chief Executive (Final Report Only)
Cathy Jack	Medical Director
Marie Heaney	Director of Adult Social and Primary Care Services
Mairead Mitchell	Co-Director of Learning Disability
Claire Cairns	Co-Director for Risk and Governance
Maureen Edwards	Director of Finance
Fiona Cotter	Co-Director of Finance
Nicola Williams	Head of Governance and Audit

Introduction

In accordance with the 2017/18 annual plan, Internal Audit carried out a directorate risk audit in the Adult Social and Primary Care Directorate. Following discussions with the Director and Co-Director, it was agreed that the focus of this audit would be on Muckamore Abbey Hospital ("Muckamore" or "the Facility"). Specifically, this review considered the management of complaints and incidents, patient supervision and the Facility's progress in achieving the Royal College of Psychiatry's quality network for inpatient learning disability standards of care.

Muckamore provides in-patient, assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs or challenging behaviour. Wards at the Facility provide assessment and treatment planning for people with a learning disability and additional mental disorders, who cannot be effectively assessed or treated in the community. A complete range of services are available including, psychiatry, nursing, social work, psychology, day services, behaviour support as well as Allied Health Professionals, as required.

During the 10 month period, 1 April 2017 and 31 January 2018, there were a total of 4 formal complaints raised and 2,705 reported incidents within the Facility.

Scope of Assignment

There have been concerns raised in relation to the high frequency of complaints and incidents within the Facility and Trust management are seeking assurance that these are being dealt with appropriately and lessons learned from these cases. The audit also reviewed the Patient Supervision/Observation process and the possible impact this is having on service delivery, and the number of incidents/complaints arising. The audit also reviewed the Facility's progress to achieve the Royal College of Psychiatry's quality network for inpatient learning disability services standards of care.

The audit was based around consideration of the following risks:

- failure to adhere to applicable standards and guidelines and to improve processes in light of recent issues highlighted in the media and previous Trust incidents and complaints. Reputational loss as a result of poor incident and complaints management;
- that the resources used to facilitate the Patient Supervision process is necessary and also that staff and patient safety is not comprised within this process; and
- that the Facility fails to meet the Royal College of psychiatry quality network for learning disability standards of care.

The objectives of the audit were:

- to ensure that there are clear lines of accountability for the handling and consideration of complaints within the Service;
- to ensure there are appropriate processes & procedures in place to identify, record and report all incidents and complaints;
- to ensure that learning from complaints is integrated into governance and risk management arrangements;
- to ensure that all complaints however, or wherever received, are recorded, investigated, treated confidentially, dealt with in a timely manner and monitored;
- to ensure that all incidents however, or wherever received, are recorded, investigated, treated confidentially, dealt with in a timely manner and monitored;
- to ensure there are stringent policies and procedures in place to manage Patient Supervision;
- to ensure the Trust Policy is being applied appropriately; and
- to ensure that the Trust are striving towards providing the highest standards of care.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Complaints

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Incidents and Patient Supervision

Satisfactory

Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide Limited assurance on the Management of Complaints at Muckamore. Limited assurance is provided on the basis of the information and data governance issues identified with the complaints files. Internal Audit acknowledge that there have been just 4 formal complaints in this facility in the period April 2017 to January 2018.

Internal Audit can provide Satisfactory assurance on the Management of Incidents. While there continues to be a significant number of incidents reported, it is felt that changes in management practices at the Facility (i.e. reflective practice and introducing coping mechanisms) should contribute to a reduction in the severity of incidents being reported. Management are also taking steps to move to outcome based accountability where the reporting of incidents from the Facility, via the dashboards, can continuously improve and reflect relevant learning.

Internal Audit can provide Satisfactory assurance on the Management of Patient Supervision (within the scope of this audit), within Muckamore. Satisfactory assurance in provided on the basis that the Trust policy in relation to Patient Supervision/Observation is generally working effectively. Service users under supervision were found to follow policy and the actual costs for supervision were on target to meet budget provision. In respect of the Facility's progress in achieving the Royal College of Psychiatry's quality network for inpatient learning disability services standards of care, Internal Audit identified that Action Plans for the two remaining unaccredited Wards at the Muckamore Facility (i.e. PICU" and Sixmile Forensic) were in place, with the objective of successfully achieving accreditation by 31 December 2018. There was confirmation that these Action Plans were reviewed on a regular basis by the Director of Adult Social and Primary Care.

The significant findings in this audit, impacting on the assurance provided include:

1. Internal Audit identified the following issues in relation to recording and monitoring of complaints in accordance with the Trust's Policy:
    - Limited information is held on the Trust's central complaints files in respect of Muckamore complaints. Senior Management within the Directorate have instructed complaints information to be retained within the Directorate rather than forwarded to the Trust's Complaints department, as per Trust policy. Furthermore complete complaints files are not retained in Muckamore, instead information is held piecemeal by those officers involved with the complaint and is not easily accessible or held in a central location. In the event of an Ombudsman review or look back exercise etc. there is a risk that complete information may not be found and there is potentially an information governance risk too, Specifically, testing identified:
        - In 12 of the 17 instances, there was no evidence on the central complaints file as to the identity of the investigating officer.
        - In 16 of the 17 instances, investigation reports, statements from staff or investigation notes were not held on the central complaints file as required by the Policy. In these instances, there is insufficient evidence of a robust investigation retained on the central complaints file. However, we noted that our discussions with staff at the Facility identified that there is further information retained locally to support all investigations of complaints, but as stated above, this is held piecemeal. Internal Audit reviewed some of this information but not all.

The other key findings of the audit are:

2. Internal Audit identified the following issues in relation to the recording and monitoring of incidents in accordance with the Trust's Policy:
   - In 1 of the 27 instances reviewed, the incident was reported outside of the required 24 hours period;
   - In 3 of the 27 instances, our review considered that the description of the incident included opinion rather than just factually accuracy, as is required by the Policy; and
   - In 6 of the 27 instances, the approving manager did not approve the Incident Form within the 7 day target as set out in the Policy. The range of delays were between 8 and 18 days and in all instances the explanation provided were staff related (i.e. sickness absence, annual leave or staff shortages).
3. Internal Audit held discussions with 12 members of staff at Muckamore to discuss the culture of reporting incidents and complaints. Our discussions identified a view from several staff that there may be a level of "acceptance" in relation to working at the Facility that patient on staff violence is an expected part of their responsibilities. From discussion with Management and staff, there is a sense that incidents of wards within the Facility being understaffed are not always being reported when this is required. Concerns were also highlighted around the support provided to staff after an incident.
4. Internal Audit identified that there have been some complaints locally resolved during the period where Local Resolution forms have not been completed. We consider that the under reporting of locally resolved complaints means there are lost opportunities for learning and development. There is also a need to consider whether the Policy is correct for the types of locally resolved complaints at the Facility.
5. Internal Audit reviewed the Trust's Corporate Risk Register ("CRR") and the Adult Social and Primary Care Services Directorate Risk Register ("DRR"). We note that given the recent, negative, media attention of an incident at the Facility, along with the significant number of incidents reported in the year up to January 2018 (i.e. 2,705), we would have expected there to have been a related risk on the DRR in respect of how the Trust are managing incidents (e.g. reflective practice and coping mechanisms) and at a minimum, evidence of a discussion on whether the potential reputational damage to the Trust requires these matters to be considered on the CRR, which we did not see. In respect of complaints and incidents being recognised on the DRR, we consider there is further work required to articulate the risk in respect of patient on staff violence and staff on patient violence.
6. Internal Audit noted that in respect of the complaints and incident training compliance rates (for nursing staff): that 139 of the 305 nursing staff members at Muckamore (46%) have not yet completed Adverse Incident Reporting training; and that 84 of the 305 nursing staff members at Muckamore (28%) have not yet completed Complaints Management training. Our review also identified that similar training records are not maintained for the non-nursing staff working at the Facility (i.e. around 200 staff).
7. Internal audit interviewed a range of Clinician and Nursing Staff, to ascertain their views on the suitability and effectiveness of the current Levels of Supervision/Observations within Learning Disability Inpatient Services Policy. We noted the following issues in relation to the Policy: that there is no guidance documented on the application of the Two to One Policy; and that there is currently no requirement for structured training in respect of the staff discharging their responsibilities in respect of the Policy.

Other findings in the audit include:

8. In 10 of the 17 instances, the acknowledgement letter was not sent to the complainant within the required 2 working days. In 16 of the 17 instances, the complaint was not investigated and closed within the required 20 working days but there was evidence that the complainant was kept informed of the process. We note that in these instances, the times taken to close complaints ranged between 26 working days and 206 working days. We noted that the processing of obtaining consent has led to considerable delays in some of these cases.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Complaints Files	-	1	-

2.	Incident Reporting Process	-	1	1
3.	Reporting of Incidents	-	2	-
4.	Locally resolved complaints	-	1	-
5.	Risk Registers	-	2	-
6.	Training	-	3	1
7.	Supervision/Observation Policy	-	1	1
8.	Complaints Process Timelines	-	-	2

Detailed Findings and Recommendations

1. Complaints Files

Finding

Internal Audit reviewed the Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments to establish the processes in relation to managing a complaint. Internal Audit selected a sample of 15 formal complaints reported during the period 1 January 2016 and 31 January 2018 (there were just 4 complaints during April 2017 to January 2018) and reviewed the complaints file for compliance with the established processes. Our review identified that, in 2 of the 15 instances the complaint was closed and reopened in the period so the total sample considered was 17 complaints.

Limited information is held on the Trust's central complaints files in respect of Muckamore complaints. Senior Management within the Directorate have instructed complaints information to be retained within the Directorate rather than forwarded to the Trust's Complaints department, as per Trust policy. Furthermore complete complaints files are not retained in Muckamore, instead information is held piecemeal by those officers involved with the complaint and is not easily accessible or held in a central location. In the event of an Ombudsman review or look back exercise etc. there is a risk that complete information may not be found and there is potentially an information governance risk too,

We noted the following specific issues in relation to recording and monitoring of those complaints in accordance with Policy:

- In 12 of the 17 instances, specifically in relation to the information available on the central complaints file, we were unable to establish whether an Investigating Officer had been appointed. However, our review of the letter to the complainant provided evidence that some form of investigation had been undertaken;
- In 16 of the 17 instances, investigation reports, statements from staff or investigation notes were not held on the central complaints file as required by the Policy. In these instances, there is insufficient evidence of a robust investigation retained on the complaints file. However, we noted that our discussions with staff at the Facility identified that there is further information retained locally to support all investigations of complaints, but that this information is held piecemeal and not easily accessible or held in a central location. Internal Audit reviewed some of this information but not all;

Implication(s)

Complaints files may not record all of the relevant information relating to a complaint which may lead to data governance and retention issues. There is also a loss of audit trail to confirm the robustness of complaint investigations.

Recommendation 1.1	We recommend that the Trust ensure that all correspondence relating to any complaint i.e. statements from staff, investigation notes, investigation reports should be forwarded to the Complaints Department by the Investigating Officer for inclusion on the complaints file. This recommendation requires action by Muckamore Senior Management and also the central complaints department, who should have oversight of the management of all complaints.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Senior Manager Service Improvement/Governance & Senior Manager Complaints
Implementation Date	Commence April 2018

2. Incident Reporting Process

Finding

Internal Audit reviewed the Adverse Incident Reporting and Management Policy to establish the processes in relation to managing Incidents. Our review identified that during the period 1 April 2017 and 31 January 2018 there were 2,705 incidents reported. Internal Audit selected a sample of 27 incidents and reviewed those for compliance with the established processes.

We noted the following issues in relation to the recording and monitoring of those incidents in accordance with Policy:

- In 1 of the 27 instances reviewed, the incident was reported outside of the required 24 hours period;
- In 3 of the 27 instances, our review considered that the description of the incident included opinion rather than just factually accuracy, as is required by the Policy; and
- In 6 of the 27 instances, the approving manager did not approve the Incident Form within the 7 day target as set out in the Policy. The range of delays were between 8 and 18 days and in all instances the explanation provided were staff related (i.e. sickness absence, annual leave or staff shortages).

While there continues to be a significant number of incidents reported at the Facility, it is felt that changes in management practices at the Facility (i.e. reflective practice and introducing coping mechanisms) should contribute to a reduction in the severity of incidents being reported. Management accept that, given the nature of the Facility that there will always be incidents. Management are also taking steps to move to outcome based accountability where the reporting of incidents from the Facility, via the dashboards, can continuously improve and reflect relevant learning.

Implication(s)

The Trust has not, on occasions, adhered to timescales set for the investigation of incidents which could impact on reputational damage.
There is a risk that investigation of incidents may be led by opinion rather than fact.

Recommendation 2.1	We recommend that the Trust considers whether there is sufficient staff capacity at the required grade to ensure that the Incident Forms can be approved in a timely manner. We consider that all staff, at Band 6 and above, should be trained to have the authority to enable them to approve Incident Forms.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Nursing
Implementation Date	May 2018

Recommendation 2.2	We recommend that the facility remind staff on the appropriateness of language used in recording incidents in line with Trust policy, to ensure that fact only is recorded and to avoid to use of personal or other opinion statements.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Senior Manager Service Improvement/Governance
Implementation Date	November 2018

3. Reporting of Incidents

Finding

Internal Audit held discussions with 12 members of staff at the Facility to discuss the culture of reporting incidents and complaints.

Our discussions identified:

- A view from several staff that there may be a level of "acceptance" in relation to working at the Facility, that patient on staff violence is an expected part of their responsibilities. This brings a risk of under reporting of incidents, if staff members take the view that the incident is "minor" in nature (albeit it is recognised that a significant volume of incidents are being reported);
- While all incidents of wards within the Facility being understaffed are required to be reported as an incident, our discussions identified that staff are not completing incident forms in relation to this occurrence in every instance. There is a sense that staff feel this will not make any difference and will not lead to any action. Our review of 25 incidents identified that only 1 related to understaffing issues. Management recognise that this is an area of under-reporting; and
- A view from staff that there was not enough time, or support, provided to staff after an incident to ensure they were fit to continue to work and that there is limited follow up by senior staff to assess the wellbeing of the staff after an incident.

Implication(s)

A culture of acceptance may lead to under reporting of reportable incidents and the statistics provided to management may not be fully reflective of the issues occurring at the Facility.
Staff may become unfit to work and this may lead to further pressures on staff resources.

Recommendation 3.1	Staff within the Facility should report all incidents of violence on staff and instances of understaffing on wards, when required, to ensure that reported statistics represent the actual activity at the Facility and that the appropriate action can be taken, or appropriate learning shared.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Nursing
Implementation Date	April 2018

Recommendation 3.2	A protocol should be established to manage staff wellbeing following an incident. We consider that Occupational Health should be integral in any agreed protocol.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager/Divisional Nurse
Implementation Date	June 2018

4. Locally Resolved Complaints

Finding

Internal Audit reviewed the Trust's Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments, dated March 2017 ("the Policy"). We noted that the Policy states that "*where a concern, or complaint, is made locally, every attempt should be made to achieve local resolution. Where frontline resolution has been unsuccessful, the complainant should then be offered the option of contacting the Complaints Department*" and that "*all complaints raised with front line staff should be recorded on Local Resolution forms including details of any actions taken and the outcome of such. Completed Local Resolution forms should be forwarded to the Complaints Department for entry onto the Datixweb system*".

Our review identified that within the period 1 April 2017 to 31 January 2018, there were 2 Local Resolution forms completed by staff at Muckamore. Our discussions with management at Muckamore identified that in effect, there have been more complaints locally resolved during the period where Local Resolution forms were not completed, because it is considered impractical to do so in each instance. In these instances, a log is maintained locally at the Facility to record these matters. While some of these issues were not in respect of patient care they are still required to be reported, and approved, in accordance with the current Policy.

We consider that the under reporting of locally-resolved complaints in this instance means there are lost opportunities for learning and development as management may not be aware of what decisions, or level of complaint tolerance is being effected at an operation level, and if this is right.

Implication(s)

Opportunity for learning, or development, is restricted.
Potential under reporting of locally resolved complaints.

Recommendation 4.1	We recommend that the facility ensure Local Resolution forms are completed for all complaints and are subject to the correct level of review.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Senior Manager Service Improvement/Governance
Implementation Date	September 2018

5. Risk Registers

Finding

Internal Audit reviewed the Trust's Corporate Risk Register ("CRR") and the Adult Social and Primary Care Services Directorate Risk Register ("DRR"). We note that given the recent, negative, media attention of an incident at the Facility, along with the significant number of incidents reported in the year up to January 2018 (i.e. 2,705), we would have expected there to have been a related risk on the DRR in respect of how the Trust are managing incidents (e.g. reflective practice and coping mechanisms) and at a minimum, evidence of a discussion on whether the potential reputational damage to the Trust requires these matters to be considered on the CRR, which we did not see.

We note that while the DRR includes a risk in relation to the "*risk of abuse and injury to vulnerable adults in shared settings, from other patients/service users (including inpatients medically fit for discharge)*", we consider that there is scope for this risk to be expanded to also include the risk of abuse and injury to vulnerable adults by staff within the Facility and to ensure that actions and controls are articulated to protect both staff and vulnerable adults.

Internal Audit's review of incidents in the period 1 April 2017 to 31 January 2018 identified a large number of incidents in relation to patient on staff violence. Our review of the DRR identified no related risk to ensure there is a control environment articulated to protect the Facility's staff in these instances.

Implication(s)

The Trust's risk registers are not reflective of the ongoing risks within the Facility and controls operating are not subject to regular review.

Recommendation 5.1	We recommend that the Trust review the process of escalating issues and learning arising from incidents (and complaints) which need to be considered and documented within risk registers.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Manager/Service Improvement & Governance
Implementation Date	June 2018

Recommendation 5.2	We recommend that the DRR is reviewed to consider whether there is a need to recognise the risk of abuse and injury to vulnerable adults by staff within Muckamore and also the risk in relation to patient on staff violence and ensuring that an appropriate control environment is articulated.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co-Director ASPC
Implementation Date	May 2018

6. Training

Finding

Internal Audit reviewed the Trust's Statutory and Mandatory Training Policy ("Training Policy"), dated April 2015. We noted that the Policy states that "*Adverse Incident Reporting*" and "*Complaints Management*" training is to be completed once by all members of staff i.e. there is no requirement for regular or refresher training. Internal Audit obtained and reviewed the training records held in relation to the Nursing staff at Muckamore. We note that there were 305 Nursing staff at the Facility who required this mandatory training.

Internal Audit noted that in respect of the training compliance rates (for nursing staff):

- that 139 of the 305 Nursing staff members at Muckamore (46%) have not yet completed Adverse Incident Reporting training; and
- that 84 of the 305 Nursing staff members at Muckamore (28%) have not yet completed Complaints Management training.

Our review also identified that similar training records are not maintained for the non-nursing staff working at the Facility (i.e. around 200 staff). We understand that some of the non-nursing staff have completed the mandatory Adverse Incident Reporting training and the Complaints Management training.

We note that the Trust's Training Policy states that training can be "*variable*" (i.e. in respect of the timeliness of completion) and the "*requirement and frequency* [of relevant training] *is particular to your care environment needs*". We consider that, given the environment that staff at the Facility are operating in (i.e. working with vulnerable patients), and the number of incidents and complaints received, that the Trust may wish to revisit the frequency requirement for training staff at Muckamore on Adverse Incident Reporting and Complaints.

Internal Audit noted that further, specific, training is completed by the 305 nursing staff at Muckamore in relation to the Management of Actual or Potential Aggression ("MAPA"). We note that the Training Policy states that this training should be undertaken annually. Internal Audit's review of the training records identified that 14 of 305 staff members (5%) are recorded as not yet having completed MAPA training. We understand that staff who have recently joined Muckamore are currently awaiting the next available MAPA training and therefore we are not raising this as an exception at this time but it is a point that management should keep under review to ensure everyone receives the relevant training in an timely manner.

Implication(s)

Not completing timely training may lead to the non-disclosure of incidents and complaints or the mismanagement of incidents and complaints.

Recommendation 6.1	We recommend that due to the numbers of incidents being reported at the Facility that staff within the Facility should be expected to complete the Adverse Incident Reporting and Complaints Management training at the staff induction, or within 3 months of commencement of employment.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Nursing
Implementation Date	June 18

Recommendation 6.2	We recommend that all staff who have not currently completed the mandatory "Adverse Incident Reporting" and "Complaints Management" training should complete this mandatory training as soon as possible.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Manager/Service Improvement & Governance
Implementation Date	December 2018

Recommendation 6.3	Given the nature of the care environment that staff at the Facility operates within, we recommend that the Trust consider whether there is a need to increase the frequency of completing structured "Adverse Incident Reporting" and "Complaints Management" training from once to a more regular basis.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co-Director ASPC/Senior Manager Service Improvement/Governance
Implementation Date	June 2018

7. Supervision/Observation Policy

Finding

Internal Audit reviewed the Trust's "Levels of Supervision/observations within Learning Disability Inpatient Services" Policy. It is noted that this Policy was last reviewed and approved for re-issue on 8 November 2017. The Policy has been developed to supersede any previous supervision/observation policies and to ensure a standardised approach across all its Learning Disability facilities as outlined in the Regional Guideline on the Use of Supervision/observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011.

Internal audit interviewed a range of Clinician and Nursing Staff, to ascertain their views on the suitability and effectiveness of the current Policy, as follows:

- Consultant Psychiatrist, Muckamore;
- Assistant Co-Director, Learning Disability Services;
- Operational Nursing Manager, Muckamore;
- Ward Manager, Erne Ward, Muckamore;
- Ward Manager, Cranfield Ward 2, Muckamore;
- Deputy Ward Manager, Psychiatric Intensive Care Unit, Muckamore;
- Band 6 Nurse, Sixmile Forensic Ward, Muckamore; and
- Band 5 Nurse, Donegore Female Ward, Muckamore.

We noted the following issues in relation to the Levels of Supervision/Observations within Learning Disability Inpatient Services Policy:

- the Two-To-One supervision/observation protocol is a term used to describe the assignment of two members of nursing staff to one patient, as part of the enhanced supervision/observation procedures. While there was consensus among those staff interviewed that the Two-To-One protocol was an effective measure, Internal Audit identified that there is no guidance on its application documented within the current Policy;
- Internal Audit identified that there is currently no requirement for structured training in respect of the staff discharging their responsibilities in respect of the Policy, except for the requirement to confirm that they have read the Policy at induction. Internal Audit identified a view from the interviewees that structured training, both at induction and as refresher exercises as the Policy is reviewed would be helpful; and
- Internal Audit noted that the Trust's implementation of the Policy is expected to be reviewed on an annual basis. We note that this Policy review is not completed formally, but rather is deemed to be done through the Ward Manager and Staff observing practice on a day to day basis, and identifying and addressing any non-compliance matters as they occur.

Implication(s)

Areas of expected control not documented, or identified to relevant staff, may lead to inconsistent practices emerging across the Trust.

Recommendation 7.1	The Trust should ensure that guidance on use of the Two-To-One supervision/observation protocol and a requirement for structured training should be included within the "Levels of Supervision/observations within Learning Disability Inpatient Services" Policy.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Service Manager/Divisional Nurse
Implementation Date	June 2018

Recommendation 7.2	The Trust should ensure that there is a full walkthrough of the Trust's ability to implement each requirement of the "Levels of Supervision/observations within Learning Disability Inpatient Services" Policy on an annual basis.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Co-Director ASPC
Implementation Date	June 2018

8. Complaints Process Timelines

Finding

- In 10 of the 17 instances sampled, the acknowledgement letter was not sent to the complainant within the required 2 working days;
- In 16 of the 17 instances, the complaint was not investigated and closed within the required 20 working days but there was evidence that the complainant was kept informed of the process. We note that in these instances, the times taken to close complaints ranged between 26 working days and 206 working days. We noted that the processing of obtaining consent has led to considerable delays in some of these cases.

Implication(s)

The Trust is not complying with the key performance indicators set for the investigation of complaints which could impact on reputational damage.

Recommendation 8.1	We recommend that the receipt, or notification, of a formal complaint received by staff must be appropriately escalated to the Trust's Complaints Department and the Directorate Governance Manager, in a timely manner to ensure that the Trust can meet the 2 day notification target.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Senior Manager Service Improvement/Governance
Implementation Date	April 2018

Recommendation 8.2	We recommend that Management at the Facility explore why complaints are taking longer than 20 days to complete and identify any lessons to be learned to make the process more efficient. We consider that the process of obtaining consent has led to some delays in some of the cases reviewed and may be one of the areas to consider.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Service Manager & AD Nursing
Implementation Date	June 2018

Appendix A - Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1 Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.

Priority 2 Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.

Priority 3 Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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Belfast Health & Social Care Trust

Patient's Private Property
Muckamore 2019/20

Contents

Acknowledgement

Internal Audit wishes to thank Management and staff at the Belfast Health Social Care Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	25 March 2020
Working Draft Report Issued On:	20 March 2020
First Draft Issued On:	27 March 2020
Management Actions Due By:	**10 April 2020**
Management Actions Received:	08 April 2020
Final Report Issued On:	09 April 2020

Distribution List

Cathy Jack	Chief Executive
Maureen Edwards	Director of Finance
Brenda Creaney	Director of Nursing & User Experience,
Bernie Owens	Director of Neurosciences, Radiology & Muckamore Abbey Hospital
Gillian Traub	Co Director Muckamore Abbey
Fiona Cotter	Co Director of Finance
Nicola Williams	Head of Governance and Audit

Introduction

In accordance with the 2019/20 Annual Internal Audit plan, BSO Internal Audit carried out an audit of Patients Private Property in Muckamore Abbey Hospital during February/March 2020.

The audit focused on the management of property and monies held by the Trust on behalf of the patients.

An improvement notice was issued by RQIA to the Trust on the 16th August 2019 in regard to their failure to ensure that a robust financial governance framework was in place for the effective management of patients' finances within Muckamore Abbey Hospital. The Trust had failed to comply in relation to Standard 4.1 criteria 4.3 of the Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006). This requires an organisation to ensure appropriate financial management achieves economy, efficiency and probity and accountability in the use of resources. Under this enforcement notice the Trust were required as a minimum to ensure:

- The Trust is appropriately discharging its full responsibilities in accordance with Articles 107 and 116 of the Mental Health Order 1986.
- In respect of patients in receipt of benefits for whom the Trust is acting as appointee, that the appropriate documentation is in place and that individual patients are in receipt of the correct benefits.
- The implementation of a robust system including:
    - Appropriate records of patients property are maintained
    - Staff with responsibility for patients income and expenditure have been appropriately trained
    - Audits by senior managers of records at ward level are completed in line with Trust policy.
    - There is a comprehensive audit of financial controls relating to patients receiving care and treatment at Muckamore Abbey Hospital.

The Trust has an action plan in place to address these issues, with 15 actions listed to be completed - 9 of which the Trust advise are complete as at January 2020.

At the time of the audit, there are 55 patients in Muckamore Abbey Hospital and the Trust collect benefits and is appointee for 14 patients. The Trust has 66 patient property accounts including discharged patients with a value of £438,000 held. Patients can be divided into those where the Trust is corporate appointee; patients who have a PPP account where the Trust is not appointee; patients with personal bank accounts; and patients whose family member is appointee. Patients will be professionally assessed in relation to mental capacity and financial plans are being put in place for each resident. Trust involvement in some patients monies is the management of day to day spend at a ward level and the completion of patient ledgers.

Scope of Assignment

The scope of this audit was to review processes within Muckamore Abbey Hospital, to manage patients' private property. Internal audit reviewed the records of 24 inpatients and 1 resettled patient across all 6 wards.

The risk in this area is reputational and loss or theft of patient monies and property if not appropriately controlled.

Detailed objectives of this audit are summarised as follows:

- To ensure there are appropriate governance arrangements in place for the management of patients' property and monies within Muckamore Abbey Hospital.
- To ensure that patients property/monies is appropriately controlled in Mental Health wards.

We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Satisfactory

Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide satisfactory assurance in relation to the Management of Patient Private Property at Muckamore Abbey Hospital. Satisfactory assurance has been provided on the basis that the Trust have updated their financial procedures in relation to the management of client monies. Whilst procedures require finalisation and embedding across all wards and some areas of the enforcement notice remain work in progress overall controls at a ward level and at a higher governance level appear to be operating effectively. Ledgers are completed and signed by two members of staff and monthly governance checks have commenced.

Internal Audit Observations against the RQIA Enforcement notice.

The Trust needs to ensure that the policy continues to be fully implemented and embedded at ward level. All governance checks should continue to be undertaken across all wards. Internal Audit have not duplicated any RQIA recommendations and would encourage the Trust to fully address all issues identified.

- **The Trust is appropriately discharging its full responsibilities in accordance with Articles 107 and 116 of the Mental Health Order 1986**

  An assessment of financial capacity is required to be undertaken by a Medical Officer. In a sample of 24 patients 1 capacity assessment was not signed off electronically on PARIS.

- **In respect of patients in receipt of benefits for whom the Trust is acting as appointee, that the appropriate documentation is in place and that individual patients are in receipt of the correct benefits.**

  On 46% (6 out of 13) of occasions, there was a BF57 on file. Internal Audit noted that on all occasions there was evidence that the Trust were in fact appointee through correspondence with the Benefits Agency.

- **The implementation of a robust system including**
  - **Appropriate records of patients property are maintained**
    This is now included within the Trust policy and is beginning to be embedded across wards on the site. Issues were identified in relation to the recording of valuable property for safekeeping.
  - **Staff with responsibility for patients income and expenditure have been appropriately trained.**
    Training has been developed and is included in induction for all staff. E learning packages continue to be developed and training will be supported by the appointment of the financial liaison officer. Training was run by the Trusts finance department in October 2019 but formal records of attendance weren't maintained.
  - **Audits by senior managers of records at ward level are completed in line with Trust policy.**
    This is included in the Trust policy and is operating in practice. Audit testing found non-compliance at 2 wards in 1 month.

- **There is a comprehensive audit of financial controls relating to patients receiving care and treatment at Muckamore Abbey Hospital.**
  This was carried out in February/March 2020.

There are no significant findings impacting on the assurance provided:

The key findings of the audit are:

1. In respect of the 13 patients for whom the Trust are appointee:
   - On 7 out of 13 occasions, there was no BF57 on file. Internal Audit did note that on all occasions there was evidence that the Trust were in fact appointee through correspondence with the Benefits Agency.
   - In 1 case where the patient has a balance of over £20,000, there is no evidence that the RQIA had been informed or that consent had been requested to hold these balances.
   - Internal Audit identified that one patient did not receive their benefits for three months. This has now been followed up and arrears of £1,600 have been received.
2. The Patients' Finances and Private Property policy is not being adhered to, in relation to the recording of patients property. In 4 (66%) of the 6 Wards visited, staff were not using the Patients / Clients Private Property' Private Property form as required, with purchased items such as games consoles and rings not recorded as property. In 4 (66%) of the 6 Wards visited, staff were not routinely recording items of property lodged with the Ward for safekeeping in their patients' property drawer. Specifically, it was noted that the records of items lodged for safekeeping by 14 patients differed to that actually held in their property drawer including a gift card (£15), tobacco and a passport. Quarterly reviews of patient property had not been carried out as per Trust procedures.
   Staff make purchases for patients during their own time i.e. after their shift has been completed. The timely recording of these purchases in the patients' cash ledger depends on when a staff member returns to work and often requires staff having to make a number of purchases over a period of days and expenditure may not be recorded on a timely basis.
3. Internal Audit visited 6 wards and reviewed a sample of 120 financial transactions relating to the sample of 24 patients' selected for review. The following was noted.
   - In 4 (3%) from 120 instances the change was not re-lodged to the patients' cash record / drawer as required. Amounts not re-lodged ranged from £1.65 to £36. Ward staff were unable to provide any reasons for these shortfalls.
   - On 4 (3%) from 120 instances, receipts (up to value of £41.55) could not be located for expenditure.
   - Internal Audit noted 1 occasion and contrary to policy, staff purchased goods online for a patient.
   - One staff member used their personal debit card to make 6 purchases against one withdrawal of £420.
4. An assessment of financial capacity should be undertaken for all Patients and a financial plan/agreement should be in place for all Patients. All patients are noted as having an assessment completed. Out of the sample of 24 Patients, 7 patients did not have a financial plan / agreement in place. The Trust are currently working through these.
5. Formal records were not retained for financial training for all staff in October 2019. E Learning training continues to be developed

The other findings in the audit are:

6. Practice is not in line with the documented policy in the following areas:
   - Policy requires staff to record any new belongings of significant value acquired during the patients stay, even if not handed in for safekeeping. However, it was established during audit testing that such items are actually on occasions recorded in a Patients / Clients Private Property Record (Ledger) or not at all.
   - As part of there is a new process receipts are attached to cash ledgers, this is not documented in the policy.
   - The Patients Finance & Private Property policy is under continuous review and has not yet been finalised although the policy has been issued to wards.
7. Assistant Service Managers complete a monthly audit as part of their monthly checks. There were no monthly audits completed in December 2019 in 2 wards.

Summary of Recommendations

Recommendations		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Appointee Requirements	-	2	-
2.	Patients Property	-	2	-
3.	Patient Monies	-	2	-
4.	Capacity and Financial Plans	-	1	-
5.	Training	-	2	-
6.	Policy	-	1	-
7.	Monthly Audits	-	1	-

Detailed Findings and Recommendations

1 Appointee Requirements

Finding

Where a patient is in receipt of benefits, and lacks capacity, under Social Security Regulations, an Appointee can be appointed. The Trust is currently appointee for 13 inpatients (1 in process of relinquishing) and 1 patient who is currently on resettlement. (This patient out in the community although BHSCT are still the appointee) Where authority is sought to be appointee, a BF57 form should be requested and retained from the Department of Works and Pensions. Internal Audit noted the following:

- On 7 out of 13 occasions, there was no BF57 on file. Internal Audit did note that on all occasions there was evidence that the Trust were in fact appointee through correspondence with the Benefits Agency.

A reconciliation between the notification of benefits received to benefit amounts actually received via the Patients Private Property Accounts should be carried out by the Appointee. Internal Audit noted the following:

- Internal Audit identified that one patient had not received their benefits from October 2019. Internal Audit queried this with the Finance Liaison Officer and this has since been followed up. The benefits agency had a query over who was appointee and the patient has since received arrears of £1660.
- One patient held a balance of £250.30 as per the cash office system although it was being reported that the patient had a balance of zero in their Patient property account. Internal Audit were advised that this was an oversight and manual error. .
- Transactions are not posted onto the system in real time which may result in patient balances going into negative balance. On 7 occasions patients balances were recorded as being negative between November 2019 to January 2020. Interest accrued on patients balances was not posted to their accounts until December 2019 for the previous 6 months.

The Trust holds Patient Property accounts for a total of 66 past and present Muckamore patients. When a patient's balance reaches over £20,000, the Trust must request consent from the RQIA to hold the monies. Internal Audit noted that 7 patients had a balance of over £20,000, on 1 occasion there was no evidence that the RQIA had been informed and consent had been requested to hold these balances.

Implications

There is a risk that the Trust is not acting legally and not undertaking all its responsibilities in relation to the management of patient monies.

Recommendation 1.1	Patients accounts should be proactively managed and reconciled to ensure all benefits are received.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Head of Governance & Audit
Implementation Date	30 June 2020

Recommendation 1.2	The Trust should ensure that for all balances over £20,000 that RQIA are informed and that consent is given to retain the balance.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Head of Governance & Audit
Implementation Date	30 June 2020

2 Patients Property

Finding

The Patients' Finances and Private Property policy requires that staff record assets belonging to a patient that are of significant value on their 'Patients / Clients Private Property' form (Appendix 1). This form should then be retained in the patients file. Every patient can also avail of a property drawer in which the ward will keep any items if requested by a patient. In these instances a Patient's Property Record form (Appendix 2) must be completed to evidence the transfer of the asset for safe keeping. This form should then be retained centrally in a file.
The policy requires staff to record any new belongings of significant value acquired during the patients stay, even if not handed in for safekeeping. However, it was established during audit testing that such items are actually on occasions recorded in a Patients / Clients Private Property Record (Ledger) or not at all.

Internal Audit visited 6 wards and reviewed a sample of 24 patients' records to assess compliance with guidance. The following was noted

- In 4 (66%) of the 6 Wards visited (Ardmore. Cranfield 1 and 2 and Six Mile Assessment), staff were not using the Patients / Clients Private Property' Private Property form as required (Appendix 1). e.g. 3 patients, based at Ardmore Ward had acquired items of significant value ranging from £70 (watch) to £280 (gaming console) and two rings valued at £199 were not recorded.
- In 4 (66%) of the 6 Wards visited (Ardmore. Cranfield 1 and 2 and Six Mile Treatment), staff were not routinely recording items of property lodged with the Ward for safekeeping in their patients' property drawer. It was noted that the records of items lodged for safekeeping by 14 patients differed to that actually held in their property drawer. In all cases the property was in the drawer and not recorded on the ledger.

The Patients' Finances and Private Property policy requires staff to complete quarterly reviews of the Patients Property Record (Appendix 2). Internal Audit noted that, over the 6 wards, 20 patients had property being held in their property drawers. There was no evidence of quarterly checks being completed for the 20 patients however on 12 of these occasions, the property records had only been put in place recently i.e. within 3 months. Internal Audit noted these should have previously been in place.

Implication(s)

Absence of robust control over patients property could result in property going missing. Where proper procedures are not adhered to, the integrity of staff may be called into question.

Recommendation 2.1	A review should be undertaken to ensure that property actually held both by the patient and the Ward is accurately reflected in supporting records for all patients. This should include all valuable items.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	31 December 2020

Recommendation 2.2	Quarterly Checks of the Patients' Property Records should be completed in line with the policy
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	31 December 2020

3 Patient Monies

Finding

The Patients' Finances and Private Property policy requires that staff obtain receipts for all expenditure for patients who lack capacity. If there are any monies left, it should be returned and recorded on the cash sheet ledger. Receipts should be produced within 1 week of issue of cash.

Internal Audit noted during testing and through discussion with staff that staff are often tasked with making purchases for patients during their own time i.e. after their shift has been completed. In such instances, monies advanced are appropriately signed out of the patients' cash ledger. However, the timeliness of returning change and submitting receipts for expenditure is affected by when the staff are next on shift and whether multiple purchases are made over a number of days.

Internal Audit visited 6 wards and reviewed a sample of 120 financial transactions relating to the sample of 24 patients' selected for review. The following was noted:

- In 4 (3%) from 120 instances, the change was not re-lodged to the patients' cash record / drawer as required. Amounts not re-lodged ranged from £1.65 to £36.
- On 4 (3%) from 120 instances, receipts could not be located for expenditure incurred. Amounts not supported by receipts ranged from £7.35 (washing power) to £41.55 (Christmas Dinner).

The Patients' Finances and Private Property policy states that staff are not permitted to make online purchases for goods on behalf of patients. Internal Audit noted that on 1 occasion staff committed online expenditure to the value of £170.99 for a patient.

Internal Audit also noted that one staff member used their personal debit card to make 6 purchases against one withdrawal of £420.

Implication(s)

Absence of robust control over patient's monies, increases the risk of misappropriation and where procedures are not followed the integrity of staff may be called into question.

Recommendation 3.1	The Trust should review the above exceptions and ensure that all monies due are returned and all receipts retained. The ASM should ensure higher value expenditure is reviewed as part of their monthly check.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	30 June 2020

Recommendation 3.2	The Trust should ensure that all monies (change) and receipts are returned and recorded on ledgers within one week of withdrawal as is stated in Trust procedures.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	30 September 2020

4 Capacity and Financial Plans

Finding

The Patients' Finances and Private Property policy require that an assessment of financial capacity should be undertaken by the Medical Officer and be recorded on the Learning Disability Financial Capacity Assessment and the electronic patient record. Internal Audit noted that 1 patient from a sample of 24 reviewed did not have their capacity assessment signed off electronically.

A financial plan or financial agreement should be in place for all patients (Capable, Temporarily Incapable & Incapable). Internal Audit noted that 7 patients from the sample of 24 reviewed which did not have a financial plan / agreement in place. Internal audit appreciate the Trust has risk assessed all patients and are currently working through these in line with the risks.

Implications

Mismanagement of patient's monies may occur and the integrity of staff may be called into question.

Recommendation 4.1	All financial plans should be completed as soon as possible. The Trust should review the assessment of financial capability for all Muckamore patients and confirm that this is recorded on the Learning Disability Financial Capacity Assessment and the electroinc patient record.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	30 June 2020

5 Training

Finding

Training is included in induction for all staff which requires staff to read and sign as confirmation that they have read and understood the policy. E learning packages continue to be developed and training will be supported by the appointment of the financial liaison officer. Training can also be provided on ad hoc basis by finance at the requirement of Assistant Service Mangers if there is an identified need.

E learning has not yet been developed and the training provided by finance in October was not a formal process and no records (sign in sheet) were kept of attendance. It is therefore difficult to ascertain if all staff had attended the training.

Implication(s)

Appropriate robust training may not be received by staff.

Recommendation 5.1	E learning training should be developed and the policy should be updated to reflect current processes.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service Head of Governance & Audit
Implementation Date	31 December 2020

Recommendation 5.2	The Trust should ensure all staff have attended training and formal records of this training are retained.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	31 December 2020

6 Policy

Finding

Internal Audit noted the Patients' Finances and Private Property policy does not reflect actual practice e.g.:

- There is a new process underway whereby receipts are now attached to cash ledgers and not as previously to withdrawal forms, this is not documented in the policy.

The Patients Finance & Private Property policy is currently undergoing review and has not yet been finalised although the policy has been issued to wards.

Implication

Staff may not be aware of the correct policy to be followed.

Recommendation 6.1	The Trust should review current policy and update where necessary. The policy should then be finalised and reissued to staff.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	30 September 2020

7 Monthly Audits

Finding

Assistant Service Managers complete a monthly audit as part of their monthly checks. Internal Audit noted that there were no monthly audits completed in December 2019 in the Six Mile and Erne Wards however audits were completed in November and January.

Implication(s)

Appropriate scrutiny over patient's finances may not be achieved.

Recommendation 7.1	Assistant Service Managers should ensure audits are completed in line with guidance to ensure appropriate management of patients finances.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Co Director Learning Disability Service
Implementation Date	30 June 2020

Appendix A- Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1 Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.

Priority 2 Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.

Priority 3 Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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