MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 1ST JUNE 2023 - DAY 46

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BRONA SHAW, HAVING ALREADY BEEN SWORN, AND BRENDAN McCONAGHY, HAVING ALREADY AFFIRMED, WERE EXAMINED BY MR. McEVOY AS FOLLOWS:

MR. MCEVOY: Good morning, Chair, good morning, Panel. 09:59

This morning, then, we are continuing with the evidence of Ms. Shaw on behalf of the Belfast Trust on the Module 4 topics. As outlined yesterday then, Ms. Shaw is joined at the witness table by Mr. Brendan McConaghy. 09:59

CHAIRPERSON: Mr. McConaghy, of course, affirmed yesterday and you are still bound by that affirmation. Of course, Ms. Shaw, you are still bound by your oath. Thank you. 09:59

MR. MCEVOY: Mr. McConaghy, as you know, my name is Mark McEvoy. We met yesterday. It might be helpful, Mr. McConaghy, just by way of introduction, noting that unlike Ms. Chambers and Ms. Forrest who are specifically named in Ms. Shaw's statement, in the body of the statement, you're not, so it might be of some assistance to the Inquiry if you could give an outline of your current role and responsibilities, please. 09:59

MR. MCCONAGHY: Thank you. 10:00

My name is Brendan McConaghy, I am a co-director within the directorate of Human Resources & Organisational Development within the Belfast Trust. I have a remit over occupational health, attendance management,

organisational development, learning and development, and workforce modernisation.

CHAIRPERSON: Mr. McConaghy, it is not uncommon in this jurisdiction but you speak very fast. I wonder if you could just slow down a little bit, both for me and also for the stenographer. 10:00

MR. MCCONAGHY: I'll do my very best.

MR. MCEVOY: Mr. McConaghy, you are by no means alone so don't worry about that.

10:00

You have been proposed by the Trust as a witness who may be able to assist Ms. Shaw and the Inquiry generally with three particular topics then, being measures - this is Topic E - relating to staff retention and support; Topic F being an induction programme for new unregistered staff and temporary workers; then K, which is a question of exit reviews, management and analysis. Are you content that you feel able to assist on those topics then? 10:00

MR. MCCONAGHY: I am. 10:01

MR. MCEVOY: If we can turn first to Topic E, which is that of measures relating to staff retention and support. You'll be able hopefully to turn this up at paragraph 287 on page 116.

10:01

Here, Ms. Shaw has said - Ms. Shaw, of course you can contribute as you feel necessary - in her statement that she has had the assistance as well of Jackie Kennedy, who is the director of Human Resources &

Organisational Development, and Alison Kerr, Senior Manager Human Resources. Are measures in relation to staff retention and support something then that you would have familiarity with in your day-to-day roles and responsibilities? 10:02

MR. MCCONAGHY: I would. To give some clarity around -- I know I described my remit. I suppose to give clarity around that question, there are two co-directors within HR&OD. So my --

MR. MCEVOY: What's OD? 10:02

MR. MCCONAGHY: Organisational development. My side of the house, as it were, is best described as HRD or HR Development. That's all matters pertaining to the health and wellbeing of staff and the development of staff. There are, however, at the other side of the 10:02 house, which is the more traditional HR management side of the house, that's where a lot of the employee relations, resourcing, recruitment, employment law, medical HR, those types of things, that most people would maybe associate -- when they think of HR, most 10:02 people would think of HRM. My side of the house is HRD, which is very much related to the support and development of staff.

MR. MCEVOY: So you might be termed sort of the policy side or the kind of the soft side of it, if you like. 10:03 Then the other side would be the hard-edged side where you are dealing with employee relations and those day-to-day issues that crop up.

MR. MCCONAGHY: That's quite often the way it's

defined, although the policy -- the policies would be fairly equally distributed between sides. I suppose mine would certainly be the more strategic development side of the house, that's true.

MR. MCEVOY: That's very helpful. That's very helpful. 10:03
Okay.

In terms of staff retention and support measures specifically then, which side of the house would that fall within or does it cross-cut, as it were? 10:03

MR. MCCONAGHY: I would say it definitely cross cuts. It's probably true to say that most of the support mechanisms, as most people would think of them, would sit more with me. Again, I can speak to -- I'm sure we'll get into the detail as to what they might be. 10:04
That said, we have a very strong collective approach within our senior management team. Whilst I use the term "sides of the house" to describe where the work sit, we do lots of cross-working and, you know, collaborative work so it doesn't really sit... That's 10:04
how the work is aligned and how staff report, but it is much more shared than that.

MR. MCEVOY: You're not in silos, as it were?

MR. MCCONAGHY: We're definitely not in silos.

MR. MCEVOY: Just on the topic of policies, the 10:04
subtopic of policies, if I can put it that way. Beginning at paragraph 290, if you can turn to it, please, on 119. The statement sets out under a heading of "Belfast Trust Policies Relevant to Staff Retention

and Support" a number - a suite, if I can put it that way - of policies which I'm not intending to open because they cover everything, I think, from induction, equality, diversion and inclusion right through to work-life balance, breastfeeding, conflict, bullying, harassment, stress, health and wellbeing. It is quite comprehensive. Can you help the Inquiry understand whether there is underlying set of principles or a philosophy which one might find common to all of those policies? 10:05

MR. MCCONAGHY: I suppose the best way to address that question would be to give some kind of more general context around the question that has been posed to the Trust around support and retention. Hopefully that isn't a digression, hopefully it provides the context that will help me answer that. 10:05

I suppose the policies sit within an overall framework to support and retain our staff, and some of those are through our formal documents, like strategies and approaches that have been developed centrally by executive team and by HR and so on. Others then fall within recognition and reward. Within recognition and reward, you have formal and informal mechanisms. A subcategory of that would be the policies then that we provide for our staff to best support them in their employment. Some of them are kind of reward in nature, you know, they are perks of the job; access to the childcare, breastfeeding policies and so on, some of 10:06 10:06

the others you have named.

MR. MCEVOY: Okay. Over the course of the evidence yesterday, which hopefully you were able to follow, the Inquiry heard quite a bit about attrition rates and vacancies, and vacancies in particular at Muckamore Abbey Hospital. How do those sorts of trends, particularly where, for example - in fact, the most glaring example at Muckamore of a vacancy rate of some 75% - how do those sorts of vacancy rates feed into, presuming that they do, the development of processes and policies around staff retention and support? 10:06 10:07

MR. MCCONAGHY: They do feed in to our policies and our approach. More latterly, we have described the type of information that you're referring to there as people and culture metrics. Previously it was probably more people metrics or HR metrics. They involve the things that we can count in the organisation in people metrics typically relating to vacancy rates, turnover, recruitment rates, and the culture metrics more around staff experience, engagement scores and so on. All of that kind of broad spectrum of data would all feed into centralised corporate plans then that are developed and then distributed and actioned through the directorates and through services. 10:07 10:07 10:08

In so doing then, in the collection of that data, the idea then is that hotspots or warnings signs are flagged or triggered whenever there's spikes in

turnover, for example. That will then cause more targeted support and action for that ward, service or department.

MR. MCEVOY: Can you maybe break that down by way of an illustration in terms for the layperson, in terms that the layperson may be able to understand. Naturally, in a situation that you have just described, there is an inevitable amount of management kind of speak and conversation. It's no criticism; legal professionals are just as guilty of it in our own framework and world. It might be helpful if you can just give us an illustration of where a vacancy rate or where there is, as you say, a hotspot, how then that feeds into, you know, your processes and this suite of policies. 10:08 10:08

MR. MCCONAGHY: Okay. Probably if I refer to the turnover rate as one of those subcategories of a people metric. We have in the organisation a turnover rate that sits typically below 10% across the organisation. So, whenever that data is then presented through the directorate lines, through our assurance framework, there would be cause for concern if that was to jump above that. 10:09 10:09

CHAIRPERSON: Sorry, if the turnover relates to people either retiring, leaving to go and do something else, dying, whatever it is, and the rate is an average of 10% for all of that across the service? 10:09

MR. MCCONAGHY: That's correct. Across the organisation, that's correct.

I've just lost my train of thought.
MR. MCEVOY: You were giving us an illustration just of how then that builds into your assessment.
CHAIRPERSON: You were saying whenever that data is then presented through the directorate lines through our assurance framework, there would be cause for concern if there was a jump on that. 10:10
MR. MCCONAGHY: Thank you.

One practical example of that - and I can look at my source here to find the date in just a second - but there was a cause for concern around the increasing turnover within Muckamore. The question was asked then of the Workforce Modernisation Team to help explore that in a bit more detail through the exit interview questionnaires, which maybe relates to a later topic but it all spreads across, if that's okay. 10:10
MR. McEVOY: Absolutely, yes.
MR. McCONAGHY: I think it exemplifies what you're asking. 10:10

In so doing then, the modernisation team looked and saw that the uptake of exit interview questionnaires was not sufficient for them to really understand what was happening there or the cause for the increased rate of turnover. 10:11
MR. MCEVOY: A low number - sorry to interrupt - but a low number of responses in the exit interviews wasn't a sufficiently broad evidence base; is that it?

MR. MCCONAGHY: That's correct, yes. As is a trend; we have not really ever been able to get significantly high numbers of responses with our exit interview questionnaires. The best practice would be there for a bit more of a targeted and bespoke piece of work for that team. On that occasion, it required interviews and surveys with staff who were exiting the organisation and existing staff to better understand what their reasons were for on a one-to-one basis - anonymously of course - to provide much more detailed intel around reasons for absence and what may be going on. That's one example of how those kind of hard metrics are translated into some actions.

10:11

10:11

DR. MAXWELL: Can I just ask, in some organisations all leavers are asked to do exit interviews. Is that not the policy at Belfast Trust?

10:12

MR. MCCONAGHY: It is. There's a leavers' checklist that the manager is asked to go through. However, it is not mandatory for the exiting employee; we can't make them do it. The manager is directed to ask to direct the --

10:12

DR. MAXWELL: I understand it's a choice.

From that routine exit interview, even if it is a small response rate, how is that information collected and collated, rather than waiting until you've noticed that the turnover is high and then starting to look for the reasons?

10:12

MR. MCCONAGHY: I can speak to how the numbers are

gathered. The exit interview uptake would be presented back through the directorate line, so the amount of exiting employees who have completed the exit interview would be counted and reported.

10:13

With regard to what is done with the data --

DR. MAXWELL: What they're saying.

MR. MCCONAGHY: -- that isn't handled, the content isn't handled by HR. That would be provided to the directors and the service manager would have access through the HRPTS system for them to be able to act on what the findings are. 10:13

DR. MAXWELL: So, the HR corporate function doesn't know the content of the exit interviews, it just knows whether any were conducted? 10:13

MR. MCCONAGHY: We do have access -- I would need to check that back with the team who handle it. I am not sure what level off -- they certainly would have access to it but I'm not sure what level of responsibility they have to collate and present back to the service or the director. So, I'm not quite sure how that information is fed beyond the counting of the numbers. Just the content, I would need to come back on that. 10:13

MR. MCEVOY: We'll come back to exit interviews in a few moments but if I can spin back to the start and the question of induction then. If I could take you just to paragraph 320, 134. If you could turn that up, please. Specifically there was some discussion about induction yesterday for registered nurses. This 10:14

morning the Inquiry would just like to hear a little bit, if possible, about the induction programme for new unregistered staff and temporary workers.

Now, if you look across at what is said, in fact at 320 is a little bit of definitional work around what unregistered staff and temporary worker is or could be interpreted as. The statement defines unregistered staff as a reference to nursing assistants. Would you, in general terms, agree with that definition? 10:14 10:15

MR. MCCONAGHY: I would.

MR. MCEVOY: Then the term "temporary worker" - I suppose again that's from a HR perspective as opposed to maybe a professional perspective - the term "temporary worker" could conceivably incorporate three categories of staff. Those are staff who are temporarily employed by the Belfast Trust, staffing on the nursing and midwifery bank, and then agency workers. So, are you content then to use that or employ that broad definition then in relation to those three categories? 10:15 10:15

MR. MCCONAGHY: I am.

MR. MCEVOY: There was, as I say, some discussion yesterday about what is done in relation to registered nurses. Looking across then to paragraph 326 on 136, the statement talks about the Trust's induction policy and management guideline, and tells us that it applies to staff who are new to the Trust and to staff who are new to a particular role or department. It applies to 10:16

various professionals groupings of staff within the Belfast Trust, including medical and dental, nursing and midwifery, and social services. It does not apply to agency staff or medical and dental staff in training. 10:16

What's the position then there? If there's no induction for what might be determined unregistered or temporary workers, what's the provision? Either witness can assist us with that. 10:17

MS. SHAW: Agency staff receive mandatory training and things like that through their agency. When they come to work in the Belfast Trust, they undergo -- they don't undergo the corporate induction package that The Trust offers but they would undergo a local 10:17 induction in the ward or the area that they would be providing the work to.

MR. MCEVOY: That's consistent with what you said yesterday in terms of how the expectation around registered nurses is that the agency will ensure it. 10:17 The same is true for unregistered staff, that is to say nursing assistants.

MS. SHAW: So, agencies ensure mandatory training. Any upskilling then that we require as a Trust, we provide. But in regards to induction, the agency don't receive 10:17 the corporate package but they receive a local package. So when they come in, depending if they're doing a one shift, they will undergo the emergency induction. That would be things like what we would do in a fire; they

would be given access to the patient care plan and talked to about the positive behaviour supports and things like that for patients that they would be providing care to that day. So, they would be inducted to the area for the day. 10:18

MR. MCEVOY: Okay. I presume then when you're giving us that example, you're talking about Muckamore?

MS. SHAW: Yes.

MR. MCEVOY: When you mention the positive behaviour training and so on. 10:18

MS. SHAW: Yes.

If they are providing more than one shift or coming in on a block booking, which sometimes happens, they would receive a more robust induction where they would go 10:18 through a bundle of induction and their attention would be brought to relevant policies and guidance that they would apply while working in that area.

DR. MAXWELL: Can I ask how they get access to the policies, because we heard from other witnesses that 10:18 your policies are on your intranet for which you need a staff ID and a password. So, how would agency staff have access to policies if they weren't on a block contract and hadn't been given access to the intranet?

MS. SHAW: If they're working in an area and they need 10:19 access to a policy, another registrant who has a Trust ID and login would be able to provide that to them. In Muckamore there is a special arrangement for those agency staff members who are working on block bookings,

that they have been given a Trust ID and password, and they have access to the loop so they can access the policies directly.

DR. MAXWELL: If you're a spot purchase agency, you don't have direct access to the policies? 10:19

MS. SHAW: No. No.

CHAIRPERSON: Just on that same topic. You mention that the agency, obviously, provides their own training.

MS. SHAW: Yes. 10:19

CHAIRPERSON: Do you assess what that training is?

MS. SHAW: The agencies are all subject to certain standards and they are accredited by the RQIA. The RQIA do regular checks on the agencies to ensure that their standards are met. We would receive notification 10:20 about agencies who are not performing at that level or who are not completing the arrangements that they need to do to provide us the staff.

CHAIRPERSON: But in terms of somewhere like Muckamore, by way of example, which is a very specific patient 10:20 group, does the RQIA assess the agency for their training in relation, for instance, to LD patients?

MS. SHAW: The Muckamore staff that we are using have been obtained through an English agency, I understand, so I'm not sure what the arrangement is for that 10:21 oversight. That would be part of the SLA, the Service Level Agreement. I would need to come back with information about that for you, about how that's monitored.

CHAIRPERSON: Yes. Okay. Thank you.
MR. MCEVOY: Can we look across then to paragraph 348, which is on 143. There's some discussion then in the paragraphs from 348 through to 352 about induction for nursing assistants employed by the Trust. I suppose we've heard a bit about induction you've certainly helped us there in terms of the types of induction training that might be given at a local level. This is again a question for either witness but presumably, Ms. Shaw, one better directed to you: Can you give us an indication of the sorts of roles that a nursing assistant at Muckamore might be required to undertake? 10:21 10:22
MS. SHAW: The nursing assistants working in Muckamore would be very involved in patient care. They would be assisting the patients with maybe activities of living, so dressing and washing. They would be maybe supervising the patient eating and drinking, for maybe where there are safety issues with the patient like choking, things like that. They would be involved in the daily activities for the patient, perhaps any sort of therapeutic interventions. They may be involved in some assessment of the patient in and around maybe doing weights and measures like that, where the patient is on certain medications that those activities need to happen. They would be very much part of the patient's care and the patient promoting their independence as well. 10:22 10:22 10:23
MR. MCEVOY: All right.

In terms of regulation, there are distinct regulators for each of the clinical professions and the allied health professions across the Trust, of course, but in terms of nursing assistants themselves, is it correct to say there isn't a regulator for nursing assistants within the Trust?

MS. SHAW: No, there's not.

MR. MCEVOY: Do you know whether that would contrast with the position in the private sector?

10:23 MS. SHAW: No, not that I'm aware of in the private sector. In the UK there are nursing associates, and they would be linked to the Nursing & Midwifery Council, but we don't have nursing associates in Northern Ireland.

10:24 MR. MCEVOY: Moving on then. If I can ask you, please, to look at paragraph 360 which is on page 147. Here the statement talks about an induction in mandatory training working group, which was set up in 2018 to review the existing arrangements for Band 2 and Band 3 nursing assistants. It was a working group chaired by Ms. Eilis McDougall, who is the senior manager for education, regulation and infomatics, and co-chaired by Ms. Ward. Its purpose was to ensure that the nursing assistant induction programme was in line with the 2018 Nursing Assistant Standards and the 2018 Nursing Assistant Pathway.

Is this something that was in train already at 2018 or -- well, you answer that question first. When was

the decision to embark upon this sort of review and institute this group taken?

MS. SHAW: This came about following the change to delegation around the NMC. The NMC set out guidance where registrant nurses would delegate duties to nursing assistants. Okay.

MR. MCEVOY: Specifically set out in the code of conduct, and I think your statement talks about that. We'll come to that.

MS. SHAW: Yes. On the back of that this framework, this document, was published then by the Department in 2018.

MR. MCEVOY: So the driver then was the change to the NMC Code of Conduct?

Further on then at paragraph 513, this is just picking up Mr. McConaghy on the question of exit reviews and that topic more generally.

CHAIRPERSON: This is page 201?

MR. MCEVOY: It should be 200, sir, actually.

CHAIRPERSON: Did you say 513?

MR. MCEVOY: I beg your pardon, page 200 is the beginning of the topic, which is Topic 4K.

513 takes us to some examples of the exit interview questionnaire. We will look at that in a moment. Mr. McConaghy, you tell us at 509 - if we just look back at that for reference - that:

"In order to address the topic, I have drawn on the assistance of Stephanie Reed, who is a HR services manager and business partner, and Jackie Kennedy, Director of Human Resources and Organisational Development." 10:27

Relative to you, Mr. McConaghy, those two persons are where?

MR. MCCONAGHY: Jackie Kennedy, up until yesterday, was the HR Director. She started a new job today. She was my direct report. 10:27

MR. MCEVOY: In other words, you reported to her?

MR. MCCONAGHY: I report to her. Stephanie Reed reports to me.

MR. MCEVOY: Okay. That's very helpful. 10:27

Just briefly, you referred, I think, a little bit earlier to a leaver's checklist. In answer to a question from Dr. Maxwell, you said that this is something that's employed but not something that's always necessarily responded to by employees leaving. I made reference, I think, a moment or two ago to a copy of the questionnaire, and hopefully that can be found at 11299, please. 10:28

10:28

Do you recognise that as being the questionnaire?

MR. MCCONAGHY: I do.

MR. MCEVOY: Is that still the format in use at present?

MR. MCCONAGHY: It is.
MR. MCEVOY: When was that implemented? I think just in ease of your position, at 511 - and there's no need to go back to it but I'll let you have it - you say that the HRPTS is a database that has been used throughout the health and social care system in Northern Ireland and has been used by the Trust since 2013. Does that help you? 10:29
MR. MCCONAGHY: It does to an extent. When HRPTS was launched, it didn't have a provision for exit interview questionnaires. It actually Stephanie Reed, through an improvement project, that instigated the embedding of the exit interviews into HRPTS regionally, so for all Trusts -- 10:29
MR. MCEVOY: That's been rolled out across Northern Ireland? 10:29
MR. MCCONAGHY: In 2016.
MR. MCEVOY: Thank you. That's the format then that has been in use for the past number of years since 2016. Can you talk us through it and the theory and the principles behind it? It might be helpful for the Inquiry to understand what the theory was in constructing it? 10:29
MR. MCCONAGHY: I can't speak to all the details behind, the drivers behind in bringing it forward at that time. That was before my time in HR. However, it is recognised as best practice to provide exiting staff with an opportunity to offer feedback in an anonymous way regarding their experience in the organisation, so 10:30

that information can be gathered and better understood on how to improve the culture or any issues that are being raised.

MR. MCEVOY: Okay. Turning over then to 515, which is on 202. Dr Maxwell asked you a few moments ago about completion rates. You've set some out there at 515 which are Trust-wide; is that correct? 10:30

MR. MCCONAGHY: That's correct.

MR. MCEVOY: Is there any way of being able to break down what the figures might be for Muckamore in particular. 10:31

MR. MCCONAGHY: Yes, that would exist in the organisation. It's not within the pack but I could certainly find that out.

MR. MCEVOY: It's something that can be produced. 10:31

Then if we could go back, please, just to that. In fact, it is down at 1132. If you can find that, please. I beg your pardon, 11312. It's my mistake. 10:31

Mr. McConaghy, this is, there's probably a better term for it, but a Word Cloud type of document which shows some quotes from staff interviewed as a result of the exit interview process. Then down on the next page then, 11313, which is just the very next page, you can see there just at the top of the page then: 10:32

"From the findings of the exit interviews, it is clear that an action plan needs to be developed to address

some of the concerns cited as the reasons why staff left. Based on the findings to date" -- sorry, what does that abbreviation stand for, if you can just help us with that?

MR. MCCONAGHY: It is the Modernisation and Workforce Planning Team. 10:32

MR. MCEVOY: "...recommend the following actions be implemented", and there are a number of actions listed.

Do you know whether or not those actions were followed up? 10:32

MR. MCCONAGHY: If I can refer you to paragraph 528?

MR. MCEVOY: Okay.

MR. MCCONAGHY: So, the summary report was compiled and provided to the interim director and divisional nurse at that time for them to distill the information and then to develop an action plan. 10:33

MR. MCEVOY: Okay. So this is from -- I think this document, is this the 2019 one?

MR. MCCONAGHY: The document on the screen currently? I would need to see maybe a bit more. 10:33

MR. MCEVOY: Can we maybe go back a page or two. It is not a long document. Maybe to 11310.

MR. MCCONAGHY: There were two in fairly quick succession. 2018, the latter half of 2018 and into 2019, from memory. 10:33

MR. MCEVOY: If you can maybe scroll up another page or two, please. Maybe the page before that. No, it's a blank page.

This is a summary report for -- the date on that one is 16th August 2018. We have just been looking at a report for 2018; would that be right? Then if we can move to what should be 11327. Maybe the previous. Try 11325, please. The numbering is slightly out of sequence. Is this the 2019? Maybe the page before that, forgive me. Try 11320, please. There we go. Thank you. 10:34

This is the report then for 2019. There's a date at the bottom, then of 31st December 2019. Is this the one that was in quick succession then? 10:35

MR. MCCONAGHY: Yes.

MR. MCEVOY: Then, if we can then move down to where I was, please, 11327. These are again some quotes from staff. Was there an action plan, or do you know whether action points were similarly drawn up or whether there's a review about what the 2018 actions were? 10:35

MS. SHAW: Might I come in there? Thank you.

MR. MCEVOY: Of course. Of course.

MS. SHAW: The first pilot on the exit interviews happened in August 2018.

MR. MCEVOY: This was a pilot? 10:36

MS. SHAW: Yes, this was a pilot activity. On the first occasion they looked at 11 leavers; okay. This coincided with the commencement of the first arrests and the investigation. So, this was all in and around

the time that Muckamore... This was the issues within Muckamore started to come to light. With that, there was an increased sense of concern and, I suppose, fear among staff. So when we look at some of the feedback that was given in that first round of exit interviews, you know, staff do tell us about stress and about morale being low, investigations and safeguarding, lack of support; things like that. We can see that there is, I suppose, elements of what was happening on the ground coming out in those conversations with staff. 10:36 10:37

At that time, the MWP team recommended that an action plan was put in place. You can see that they have - on page 205 - they have actually listed a number of, I suppose, suggestions that should be taken forward as part of that action plan. So, when we look through those -- 10:37

MR. MCEVOY: Sorry. That page that you have just given us, is that in the body or are you talking about --

MS. SHAW: That's in the body of the statement on page 205. 10:37

MR. MCEVOY: All right. Thank you.

DR. MAXWELL: Can I just ask? You seem to be implying that these negative comments were a result of the arrests. Did you compare those comments with comments in previous exit interviews to see if, in fact, they were new findings? 10:37

MS. SHAW: No. I suppose what I'm suggesting is that this coincided with what was happening on the ground.

I'm not aware that there was any comparative work done to look at what previous --

DR. MAXWELL: So it might be because of arrests but it might be have been things that people were saying before the arrests. 10:38

MS. SHAW: Exactly, yes.

DR. MAXWELL: We don't know because the comparison wasn't made?

MS. SHAW: Yes, that's correct.

MR. MCEVOY: So the Inquiry is clear then, the collation of this data in '18 and again then in '19 was brought about by reason of the revelations, if I can put it as broadly as that, and then the consequences for the workforce, and for some of them in particular? 10:38

MS. SHAW: I think it possibly came about that at that time there was a high attrition rate, there was people leaving, and they wanted to establish causes why people were exiting Muckamore. This is why the pilot happened. It coincided with -- 10:38

MR. MCEVOY: You say that. I was to say that to you, I was about to ask you about that. You use the term "coincide." I suppose, is that "coincide" in the incidental sense, in other words it just so happened, or was there a broader plan -- 10:38

MS. SHAW: No. 10:39

MR. McEVOY: -- driven by what was going on at the Hospital?

MS. SHAW: It's not my understanding that that's why it was conducted, on the back of what was happening that

this was done. Okay. So, the action plan that was set out on page 205, or the suggestions for action plan, many of those actions would have been taken forward as part of the ongoing work. There was a number of action plans in Muckamore happening. So, you know, looking at 10:39
the induction programme to newly qualify Band 5s coming into Muckamore was most definitely something that was looked at and how we would support any registrant coming into Muckamore Abbey, what training they needed, and I suppose what preceptorship they had and what 10:39
senior staff we had in Muckamore to support these registrants. Preceptorship in a timely manner, review of staff, quarterly interviews, all of those things, and the supervision from senior staff in the service as well. All of those would have been taken forward as 10:40
part of that pack for staff coming into Muckamore.

MR. MCEVOY: Okay. Then we're told, Ms. Shaw, at the end of paragraph 528 on page 207, that the response to concerns identified within both summaries, the 2018 and 2019 summaries, form part of a wider response to 10:40
workforce stabilisation. We'll go on to look at that in a moment or two. Before we do, can you explain what the approach was going to be if one was to cite it on arising from the information that you had then? Was there an agreed approach that the Trust was going to 10:41
adopt in terms of addressing some of the pressing matters that were coming out of what staff were telling you, staff leavers were telling you?

MS. SHAW: No. I mean, to review, you know, the

finding of 2018 following the completion of actions and the work that was happening in Muckamore, you know, it would follow that you would do another, I suppose, temperature check of how staff leaving are talking. That would give you a comparison, as Dr Maxwell was talking about. I would imagine that is one of the reasons why the 2019 exit interviews happened. 10:41

Then the second part was --

MR. MCEVOY: So we don't have anything beyond 2019? 10:42

MS. SHAW: No. No.

MR. MCEVOY: Is there a reason for that?

MS. SHAW: No, not that I'm aware of.

MR. MCEVOY: What we do know is that in the time since 2019, there has been an increased use of agency staff? 10:42

MS. SHAW: Yes.

MR. MCEVOY: Can the Inquiry take it that with the 2018 and 2019 data to hand and everything that staff leavers were telling you, the response was to use more agency staff? 10:42

MS. SHAW: I would have to come back to you on that. I haven't reflected on that for today.

MR. MCEVOY: I guess, if I can, maybe in fairness to you put it this way, rather than drill down into the reasons why -- and you had the data, you had the tools in the form of the exit interview, you had the data directly from Muckamore Abbey leavers, what use was made beyond just simply engaging more agency workers, or do you know? 10:42

MS. SHAW: I think yesterday we discussed, you know, the different initiates that the Trust had taken to seek substantive filling of the vacancies in Muckamore. I think that, you know, it's acknowledged that that was difficult given the ongoing issues in Muckamore. 10:43

DR. MAXWELL: Can I ask, some of the issues are about the number of people but some of them are actually about culture and ways of working. I'm wondering what the organisational development response was both at that time and earlier. We've heard that staff found it very difficult as beds were closing and wards were merged and two teams were coming together. I'm imagining as an expert in organisational development, you can give us some indication of what sort of things could be done in those scenarios and whether they were done? 10:43 10:44

MR. MCCONAGHY: I don't have sight of what specifically was done to address the cultural issues within Muckamore at that time. I can speak to what our general approach is with regards to collecting information from staff and providing actions on --

DR. MAXWELL: I was thinking more about organisational development rather than data collection and monitoring.

MR. MCCONAGHY: The point I was then going to make, I suppose, was to say our organisational development efforts are informed by the information that we gather and that the exit interview questionnaires are only one part of that. We have been working much harder in recent years to gather staff experience information 10:44

from our existing workforce to help understand what the culture is like now. That informs the organisational development efforts at a corporate and a local level, which I can speak to.

DR. MAXWELL: One of the things that I have seen in other NHS organisations is work on team building. Some of the comments we have seen that have been thrown up was that there was a challenge from the substantive staff having to manage a large number of agency nurses and then finding that stressful. Was there any team building work conducted with the staff at Muckamore Abbey? 10:45

MR. MCCONAGHY: I'm not sure. I would have to -- I know that the provisions are there and on offer to Muckamore staff in the same way they are for all staff in the organisation. As to whether or not they availed of any, I would need to come back on that. 10:45

MS. SHAW: May I come in, Dr Maxwell? Thank you.

I suppose at that time there was a focus on stabilising the workforce to maintain a service in Muckamore and to maintain patient safety. There was also the acknowledgment that staff were feeling very at sea with what was happening, and there was a spirit of fear in Muckamore at the time. There were a number of listening exercises carried out with staff to give them the opportunity to discuss how they were feeling and to share that experience. There was a lot of kind of rumour and suspicion and speculation as well, and those 10:45 10:46

listening exercises were designed to assist staff in a very open and candid way about what was happening and the plans that were going forward in the Trust, and to understand how best we could support the staff and how they were feeling at the time and bring them together. 10:47

Our psychology service was engaged with us at that time as well, and we were offering staff support through psychology, that they could -- there was an onsite psychologist available to staff. We were sign-posting 10:47 into occupational health as well, and sign-posting staff to other services that could possibly be of use to them. We also had a point of contact for staff in the Central Nursing Team. Her role was she was available to staff to call her should they have any 10:47 queries or any concerns, and she would then signpost them to the correct person within the organisation who could help them directly.

The issue of leadership was very, very crucial as well 10:47 because one of the comments that comes out in the exit interview is the visibility of leadership. We know that at that time, there was a change in the leadership. Some of the -- some people had retired, some people weren't there any more. The Trust worked 10:48 very hard putting in senior people with excellent leadership skills who were very able to provide that visibility and work with staff. There was increased walkarounds at that level, and very much an open door

policy for staff. The team that went up to Muckamore worked very, very diligently to get to know staff at a personable level, understand who they were -- as compassionate leaders, I suppose, to understand each individual, where they were in the story of Muckamore, what was happening, and how they as individuals needed to have support. That was facilitated as best as we could.

So, there was a number of things going on and a number -- frequent conversations happening. The leadership, the divisional nurse who was working in Muckamore at that time on an interim basis, was frequently in conversation with myself and my colleagues in Central Nursing, establishing ways that we could assist the team in providing different support, different training, and different, I suppose ways, to increase the resilience of the staff who were working and were turning up every day because they were committed to their patients and the care that they were giving. So, it was very important for us to continue to try and support them and to try and protect them at that time, and help them with that fear that they were experiencing. 10:49 10:49 10:49 10:49

PROF. MURPHY: Could I just ask you to clarify what you mean by "fear"? Was it fear about the resettlement programme going on or fear about how to manage very difficult individuals on the ward? 10:50

MS. SHAW: It was the fear with regard to the

investigation. So, this was a situation that nobody had faced before and it was a very fast-moving situation. You know, we started off uncovering some issues and very quickly that was growing, daily. Staff were -- because we weren't able to, because of the memorandum of understanding with the police, we weren't able to share exact detail of why people were being suspended and things like that. So, people didn't know what was going on who worked there, so there was this level of fear. They didn't know if they were going to be called to the office next. You know, they would come into work and their colleagues weren't coming in that day and they then were hearing that they were suspended. 10:50 10:51

They were being -- the staff members who worked in Muckamore, many of them were from the same families and same community, and they were experiencing isolation from their communities because they worked -- there was an association with Muckamore. So, it was a very challenging time. You know, it was important for us, as managers and senior leaders in the organisation, to try and work with those staff and protect them as best as we could. 10:51 10:51

PROF. MURPHY: Thank you. 10:52

MR. MCEVOY: When you say protect them, what do you mean?

MS. SHAW: Protect them by providing them with compassion while at work; giving them skills and

opportunities through training; making sure that things like their inductions and things like that were all in place to ensure they were as resilient as possible; giving them the open door policy where they could come and speak to a senior leader and getting to know them so that we could identify if there was specific things for each individual that we could help with. Just to make life a little bit less stressful.

MR. MCEVOY: When you say "getting to know them," I suppose an outsider might express surprise at that because an outsider might think someone looking at the Hospital from the outside might say well, sure, senior leaders and management should know their staff.

MS. SHAW: This was a new team of senior leaders. At that time that level had kind of dispersed and a new team was brought into Muckamore to oversee the action plans being put in play and ensure that the service was stabilised as quickly as possible.

MR. MCEVOY: Was there in any sense a sort of gathering together of the staff? Even as crudely as getting them into a room together to provide reassurance and provide clarity around what was going to happen next, and as far as you could so far as circumstances allowed?

MS. SHAW: That was one of the first things that happened, really, because there was a real rumour mill, if you like, and people, you know -- rumour is never helpful. So, it was fundamental to get staff into a room and, you know, do listening exercises with them, you know, talk to them about what their fears were and

what was happening, and be open with them. That has continued, and there's now fortnightly meetings with staff and the divisional nurse and co-director at Muckamore, where there's information sharing and staff are being kept informed about what's happening all the time.

MR. MCEVOY: And presumably that's all documented?

MS. SHAW: Yes.

MR. MCEVOY: Under what sort of framework or policy?

MS. SHAW: I don't know. I would have to come back with that. 10:54

MR. MCEVOY: Chair, I don't have any further questions with which Mr. McConaghy can assist but I do have some further matters. They're not lengthy. I suppose the fair thing to be may be to ask Mr. McConaghy whether he is content to remain where he is for quite a short time. 10:54

CHAIRPERSON: You have a bit more to do with Ms. Shaw, haven't you? About how long do you think?

MR. MCEVOY: 20 minutes, half an hour, he said. 10:55

CHAIRPERSON: Can I just confer with my Panel to see if there are questions?

In relation to the question of delegation, which is the best witness to assist us? 10:55

MR. MCEVOY: Those were items that I was -- that's a topic that I was going to cover with Ms. Shaw alone, given that it is a nursing topic, but it may be that Dr. Maxwell feels it is something that Mr. McConaghy

can add.
DR. MAXWELL: That's what I was wondering, whether through an HR perspective that there are aspects of that because it goes to the scope of the role and extending the scope of somebody's job description, which would be HR. 10:55
CHAIRPERSON: Could we ask both to remain?
MR. MCEVOY: That may be the best course. Then if Mr. McConaghy has something to contribute, or there are Panel questions which it is felt he may be more appropriate to answer, we can approach it on that basis. 10:55

Looking at paragraph 253 then, please. Hopefully on page 101. 10:56

Ms. Shaw, this is where we are picking up on the topic of the training recruitment and deployment of I suppose what are sometimes called the AHPs, the learning disability psychiatrists, psychologists, speech and language therapists, occupational therapists, and physiotherapists. This is dealt with, as I've indicated, at 253 and following through to 288. The more general and the broader question, I suppose, is how does the Trust know how many of such professionals it has and how many then it needs? 10:56 10:57
MS. SHAW: I'm not confident that I would be able to answer that with great clarity.
MR. MCEVOY: Okay. Is there a colleague within the

Trust who may be able to help us with that?
MS. SHAW: The Executive Director of Nursing has directorate responsibility for AHPs. However, there is a co-director then for AHP professionals who would be maybe more across the detail of the numbers. 10:57
DR. MAXWELL: Is there an internal workforce plan? Would that be something you could answer?
MR. MCCONAGHY: Relating to?
DR. MAXWELL: An overall workforce plan for the Trust.
MR. MCCONAGHY: There's no one global document that relates to all of the entire organisation, but there would be for the different professional groups. 10:58
DR. MAXWELL: So do you do the workforce planning by directorate or by profession?
MR. MCCONAGHY: There would be a bit of a combination. My understanding is there would be a combination of work there, because there's a dual kind of reporting structure for staff through the professional lines and through the directorate lines. Ultimate responsibility for the workforce planning within the organisation would sit with the Director, but it would be in consultation and collaboration with the professional lead. 10:58
DR. MAXWELL: So, the directorate within which Muckamore Abbey sits would have a plan which would say how many staff of each profession it felt it needed, how many vacancies it had against that plan? 10:58
MR. MCCONAGHY: That is what I would expect to be the case, yes.

DR. MAXWELL: That actually might go in a workforce report to the board every month?
MR. MCCONAGHY: I wouldn't have sight of that, I'm sorry, but that's something I could check for you.
MS. SHAW: Mr. McEvoy, if I could draw attention to page 15 of the statement that outlines the workforce plans for different AHPs from the Department of Health. 10:59
MR. MCEVOY: Yes. This is something that we looked at yesterday, this list of documents. Was there something... 10:59
MS. SHAW: No. It is just Dr Maxwell had asked about overarching workforce plans. There are per profession, but not that Trust approach.
DR. MAXWELL: But they must be translated into an operational plan for the Trust somewhere? I suspect it's report. Every board I've ever sat on, there's been a report that goes to the board every month that has by directorate the establishment and the fill rate. 11:00
CHAIRPERSON: Is that your understanding?
MS. SHAW: No. We'd have to follow up on that and come back to the Panel. 11:00
CHAIRPERSON: Right, okay.
MR. MCEVOY: Ms. Forrest, who gave evidence about workforce yesterday, her specific remit is about nursing workforce? 11:00
MS. SHAW: Yes.
MR. MCEVOY: Within the discussion in the statement around related clinicians and clinical professional and allied health professionals, there's mention at 236, if

you could turn it up, please, at 105. The specific issue this paragraph raised the Inquiry would like some assistance with is the shortage that you discuss around -- the shortage of practitioner psychologists regionally and nationally. 263, hopefully you have it.

MS. SHAW: Yes.

MR. MCEVOY: What you say then is that "Dr. Meakin informs me that she understands"... Dr. Meakin, she has oversight of.

MS. SHAW: Psychology.

MR. McEVOY:

"Informs me that she understands that the reasonable vacancy level for psychologists stands at approximately 30%. The lack of a workforce plan in Northern Ireland with regard to workforce needs for practitioner psychologists contributes to poor knowledge and data of workforce availability and demand. The position in Northern Ireland stands in opposition to that in Scotland and England."

What is the answer, if you're able to give us one, to that problem? What's the Trust's thinking about what the solution may be?

MS. SHAW: I note that Dr. Meakin has also told us that in Northern Ireland, we're the only country that doesn't have a chief psychology officer. Very often when you have a chief nursing officer, chief medical officer and things like that, there's a driver there, there's like an oversight of the department. We also

heard from Dr. Meakin in the statement that there is an increasing demand for psychologists. I suppose that where you see that demand, having a chief psychology officer at department level might influence an upturn in, I suppose, a workforce -- having a framework for a workforce for psychology. 11:03

MR. MCEVOY: The Trust's position is that a chief psychology officer may assist in the shortfall and may meet the demand then. That's one answer?

MS. SHAW: Mhm-mhm. 11:03

MR. McEVOY: Has the Trust -- and I know you're indicating that to the Inquiry today but do you know whether The Trust has communicated that to the Department or --

MS. SHAW: No, I don't know. 11:03

MR. MCEVOY: -- or to the Executive.

MS. SHAW: I don't know. I can't answer that.

MR. MCEVOY: Okay. Moving on then to the question of delegation. If I can take you, please, just to paragraph of 387 on page 154. If you can just scroll up slightly so we can see the heading. 11:04

Starting at 386, really:

"Nursing assistants undertake aspects of nursing care delegated by the nurse or midwife. It is the responsibility of a registered nurse or midwife to ensure delegation is appropriate." 11:04

As we see then, there's definition set out by the NMC, which you have included.

"The transfer to a competent individual of the authority to perform a specific task in a specific situation." 11:05

Then as you note, "The registered nurse or midwife remains responsible for the delegated care." 11:05

Specifically looking at 387:

"A registered nurse or midwife is accountable for the decision to delegate care and should only delegate a duty to a nursing assistant whom the registrant deems to be competent to carry out the duty in question. Accountability is defined by the NMC as the principle that individuals and organisations are responsible for their actions and may be required to explain them to others." 11:05 11:05

I suppose if we look across to the code of conduct, which is on 390, if you look across to it just on this particular point that you have helpfully extracted from the NMC Code of Conduct. I'm sorry, paragraph 390. I beg your pardon, that's my mistake. It is paragraph 390 on page 155. 11:06

If you look across, you have helpfully extracted the

NMC Code, in particular Section 11 which deals with delegation.

CHAIRPERSON: Sorry, can we just hold on a second while we find it on the screen. It is page 155 that we're looking for. 11:06

MR. MCEVOY: 390.

We have it there. You have extracted the relevant section, which is 11.1: 11:07

"Only delegate tasks and duties that are within the other person's scope of competence making sure they fully understand your instructions."

Then 11.2:

"Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care." 11:07

As far as the Trust is concerned, how does that concept of delegated care work when there is, in the case of Muckamore in particular, such a significant reliance on agency staff?

MS. SHAW: The agency staff that we are using are, in the main, block booked, so they have been working in Muckamore for periods of time, some up to 18 months, working within those teams. I suppose whenever those agency staff are coming in first of all to Muckamore, 11:07

they are coming in with the understanding and the assurance that they have completed required mandatory training, and then upskilling is provided by Muckamore, so we know to the level that these staff are trained and have any knowledge, skills or experience. Then working within teams, the registrant will know the staff she is working with or they are working with, and with that knowledge they will be able to delegate duties appropriately. 11:08

DR. MAXWELL: The NMC is very clear that delegation to unregistered staff is situational. 11:08

MS. SHAW: Yes.

DR. MAXWELL: There's not a list of tasks that unregistered staff can do; it depends on the situation and the patient. When I asked Paula Forrest yesterday about the model of allocating work, she talked about the desire to be person-centred but in practice it had to be task allocation sometimes. I suppose what I'm wondering is how Belfast Trust can be confident that registered nurses are making those individual assessments about patients and not just defaulting to the culture that, well, the healthcare assistants do these tasks? 11:08 11:09

MS. SHAW: So, I suppose the nurses working in the Belfast Trust as registrants, you'll know that we are all bound by the NMC Code and, within that, the four principles of preserving safety, practising effectively, prioritising people, and promoting professionalism and trust. Within that code, the 11:09

nurses would be very clear about what they are able to delegate to nursing assistants working with them.

DR. MAXWELL: You're taking it on faith?

MS. SHAW: Well, we provide -- through our supervisions and through our support to staff and the supervision of the ward sister or charge nurse, we would be confident that our nurses are adhering to the Code. 11:10

CHAIRPERSON: And just to help me because, as you know, I'm not a medical person. When you talk about the delegation and the nurse will have the responsibility for the delegated task, does delegation occur on a daily basis? Can you delegate a task for a week? How does it actually work in practice? 11:10

MS. SHAW: It will basically most often be on a daily basis because every day a person's care will change or will flex; it's situational, as Dr Maxwell has pointed out. As you are planning that person's care for that day and what is important to that person on that day and what I suppose the aims and goals for that person are on that day, then the tasks or the work that needs to happen will be decided at that time. 11:11 11:11

Teams change as well, so it is not always the same staff on duty every day. It wouldn't be that one staff member would have a responsibility to carry out specific actions for a period of time. 11:11

CHAIRPERSON: This may be absolutely obvious but, presumably, if the delegator had reason to believe that the person to whom the task was delegated was not

actually functioning appropriately, the continued delegation would not be appropriate?

MS. SHAW: It would be stopped immediately. I mean, part of the delegation is that you are asking another member of staff to do something on the understanding that person has the competence and the experience and knowledge and ability to do that, but that doesn't mean the registrant walks away and allows that to happen -- 11:12

CHAIRPERSON: No, that's what I mean. Of course.

MS. SHAW: -- there's oversight. Then the registrant is responsible for ensuring and evaluating the outcome of that action. 11:12

CHAIRPERSON: Yes. Thank you.

DR. MAXWELL: Is the decision-making about what can be delegated for an individual patient in individual circumstance documented anywhere? 11:12

MS. SHAW: Well, the patient records would be documented regularly. I'm not sure I would have to --

DR. MAXWELL: Will it include -- we may be coming to this but obviously NIPEC produced a very helpful decision on support, and it is very clear about the decision process the registered nurse should go through in making that decision. 11:13

MR. MCEVOY: You might find that set out at 394 actually. If you look at 158, you'll see what Dr Maxwell is referring to, hopefully. 11:13

DR. MAXWELL: Would those sort of assessments of patients' needs be found in the nursing records?

MS. SHAW: I don't know. I wouldn't be able to answer

that. I don't know if it would be set out in that way is what I mean, in that there wouldn't be -- it wouldn't be set -- I don't know if it would be set out in that way or if the decision-making would be captured in that way. 11:13

DR. MAXWELL: I'm just wondering, if I came on duty and I didn't know this patient and at the start of shift I'm deciding how to delegate care, would I find enough information documented somewhere to assist me in my decision about how to delegate? 11:14

MS. SHAW: I don't know. I would have to come back to you on that.

DR. MAXWELL: On the other side of the coin, do the healthcare assistants understand that their work maybe variable with different patients on different days; is 11:14 that made clear to them? And that actually to undertake a similar task with a different patient may be exceeding their scope of work?

MR. MCCONAGHY: I can speak to a part of the nursing assistant induction which sits within the learning team 11:14 would be clarification. This is in general terms across the organisation. Part of that induction would be description of the professional roles and responsibilities of nurses and, within that, how work may be delegated to them. I don't have the detail as 11:15 to what level of discussions are a part of that induction, but those things are covered as part of the mandatory nursing assistant induction programme.

DR. MAXWELL: So there's no formal monitoring of what

is being delegated and whether it is consistent and thought to be consistent with safe care?

MS. SHAW: I'm not aware of anything. I haven't looked at that for today, sorry.

MR. MCEVOY: I suppose just to close that topic off, as it were - and I'm following on from what Dr. Maxwell asked - once a decision to delegate work or a task to a healthcare assistant is made, how does a registered nurse assure her/himself that it has been completed adequately and in accordance with the Trust's own policies. 11:15 11:16

MS. SHAW: The registrant is responsible for evaluating the outcome of the action that has been delegated, and that would be depending on what that was. If it were -- I suppose for an example, I suppose a set of observations ensuring that they were completed on time, ensuring paperwork was completed, ensuring that any deviations away from normal had been reported to them, things like that. 11:16

MR. MCEVOY: So you are relying to an extent on an on-your-feet judgment on the part of the registered nurse; is that fair? 11:16

MS. SHAW: Well, the registered nurse shouldn't delegate a task or an action to anybody unless they were capable and competent of doing it themselves. So they should be able to evaluate that. 11:17

MR. MCEVOY: All right. Then obviously we see what the consequences of a failure around delegation, where it may lead. At 396, just at the top of page 159.

"Any failure to uphold any part of the NMC Code by a registered nurse may result in action being taken... both by the Trust and of course in terms of referral to the NMC." 11:17

Specifically, can you help us on the question of whether following the revelations at Muckamore, do you know whether the Trust made any referrals to the NMC specifically arising from potential issues or 11:17
inappropriate or improper delegation?

MS. SHAW: No, I'm not aware that they did.

MR. MCEVOY: Looking down the same page then to paragraph 397, just looking at the supervisory role of the ward sister or charge nurse. As you say earlier in 11:18
your statement, you have provided a definition of the role and the discussion around the role of a ward sister and charge nurse. You recap, obviously, by telling us it is a leadership role which encompasses elements of clinical practice, management, leadership, 11:18
education and teaching.

"While accountability for the delegation of care to a nursing assistant lies with the registered nurse, the charge nurse or ward sister should ensure appropriate 11:18
oversight of the delegation of care to nursing assistants. The ward sister or charge nurse is responsible for the oversight of the safety and quality aspects of all care in their ward and department."

There is an onus, obviously, on the ward sister and the charge nurse, and it`s quite a significant one. How then does that person assure themselves that healthcare assistants are working to Trust policies and, 11:19
therefore, that the care they are providing is safe?
MS. SHAW: The role of the ward sister or charge nurse is a supervisory role, and so that allows for their time to be spent on the ward overseeing nursing standards are being maintained. That would be having 11:19
that oversight of everything that's happening on the ward, ensuring that -- I suppose checking on paperwork, making sure that the staff are carrying out activities as they should be doing, and providing patient care as it should be. Then we have our Datixes and our 11:19
different audits that happen across our wards as well. The ward sister or charge nurse has access to ClickView or datasets that shows performance on the ward, that demonstrates how that ward is operating and how it is maintaining its standards as well. Then assurance 11:20
around those things is provided to the divisional nurse. So there's, I suppose, a line of governance. Then the divisional nurse provides that assurance then up to the Director of Nursing and the director for the division. 11:20
DR. MAXWELL: Are the ward sisters supernumerary or are they counted in --
MS. SHAW: They are not counted in the numbers but we avoid using the term "supernumerary" because they

are supervisory.
DR. MAXWELL: Okay. They wouldn't be included in the calculations about the number of staff needed to provide direct care?
MS. SHAW: No. 11:21
MR. MCEVOY: Okay. Then finally then, Ms. Shaw, if I can turn, please, just to one of the items again. It's towards the back of the exhibits at 10462, please. Hopefully I have the numbering right this time. 10462. Hopefully on screen what you can see is the adverse 11:21
incident reporting. We talked about adverse incident reporting yesterday.

If we can just look on the right-hand side of the page there. You can see the approval date is June 20th, 11:21
that it supersedes - just below that then, just below the review date of June 25th - it supercedes a version 4 from January '18 to January '23. Hopefully we can see that a bit more clearly now. Can you see it okay? You have some familiarity with this policy before I go 11:22
any further; is that right?
MS. SHAW: Yes.
MR. MCEVOY: Well then, can you help us with the extent of supersession. In other words, to what degree did this document differ from and replace its predecessor? 11:22
MS. SHAW: I wouldn't be able to comment on that. Could we scroll down just to see the top of that page? Okay. So, this policy is owned by the Medical Director's office, okay. So they would be -- and the

authors of that are staff from within the Medical Director's office who have been responsible for any changes or amendments that had been made to the policy. Now, the policy will have been amended and then it will have been brought to the policy committee where those amendments will have been discussed in detail and the rationale for any amendments made given to the policy committee, where the policy will then have been ratified before it goes up on the Trust loop. 11:23

MR. MCEVOY: But it is a Trust-wide policy? 11:23

MS. SHAW: It's a Trust-wide policy.

MR. MCEVOY: I suppose maybe it's a question to either/or both of you as senior officials within the Trust, there would be an onus on you to be familiar with it and its implications, and also then, as a consequence of that, cascading the message down throughout the divisions and so on for which you are responsible? 11:24

MS. SHAW: Absolutely. I mean, there's a range of different policies that at a senior level you have to have understanding of and awareness of. But yes, this would be a policy that we would be familiar with and we would be -- we would support staff to use where an incident or any reporting had to happen. 11:24

MR. MCEVOY: On that particular score then, if we can just move down to 10472, please. 11:24

CHAIRPERSON: Sorry, just before we come off this page, since we're there, can I just ask, the earliest policy or guidance listed I think seems to be about 2016.

Would that be because before 2016 they weren't called "adverse incidents", or would there have been a policy to deal with whatever it was before it was an adverse incident?

MS. SHAW: I would have to come back to you on that. 11:25
I'm sure that there was a policy but what it was called and why that name change happened, I don't know.

MR. MCEVOY: The "serious" appears to have fallen off the start of the policy and we move to just "adverse incident" and reporting. 11:25

CHAIRPERSON: We've just got to remember the terms of this Inquiry go back to 1999 and we seem to have stopped short in 2016, so we need to see the rest.

MS. SHAW: That's something we can come back on.

MR. MCEVOY: Do you think then, in fairness to you and 11:26
so the inquiry know where to direct their questions if they do arise, you've indicated that that's something -- this overall policy, it's devising and discussion would sit within the Medical Director's office, and therefore presumably sort of the history of 11:26
this adverse incident policy-making, including the specific issue that the Chair has raised, would be something that his office would be best placed to deal with then?

MS. SHAW: That's correct. 11:26

MR. MCEVOY: That's very helpful.

MR. MCCONAGHY: If I could just add? At page 133 there's a list of some policies that predate the formation of the Belfast Trust from North and West. At

the top of that page there is a serious adverse incident policy and procedure June 2005/2006. It's not a complete picture but.

CHAIRPERSON: That's very helpful.

MR. MCEVOY: That's very helpful. Thank you. 11:27

Okay. If we could look across then, just going back to that same exhibit, please. It's 10472.

CHAIRPERSON: How much longer have you got? This is the last? 11:27

MR. MCEVOY: This is possibly the penultimate if not the ultimate question, Chair. Sorry.

Here we're into the body of the policy, Ms. Shaw, and it's on that specific question of how to report. You 11:27 have given us some of your understanding around that. You can see then that the Trust, in two very succinct sentences, says:

"All incidents should be reported using the 11:27 organisation`s adverse incident reporting system accessed via the Trust intranet."

DR. MAXWELL: What would happen if there were agency staff who have no access to the hub? Sorry, were you 11:28 coming to --

MR. McEVOY: That's exactly what I was going to ask.

MS. SHAW: So there are some staff who don't have access to IT because they don't require it. That would

be perhaps be our patient/client service team of portering staff and people like that. So agency staff then, we would assume, would be similar. Where there is an incident that needs to be reported, they would either provide that verbally and they would be assisted to do the report, or in writing and then it would be transcribed then on to the digital. 11:28

DR. MAXWELL: So, do you keep a paper form for people who don't have access to be able to complete?

MS. SHAW: That would be kept locally, where the incident happens. 11:28

MR. MCEVOY: Ms. Shaw, finally from me - and I'm not sure if this is the same question being asked in a different way, so indulge me if you can - in terms of what is said just in bold type there in respect of incidents involving service users: 11:29

"Please note that adverse incident reports are not health records and copies of any electronic reports (or paper forms) should not be filed in the service users' records. However, details of the incident (including the incident reference number, if available) that are relevant to the treatment and care being provided to the service user should be added separately within the service user's healthcare record." 11:29 11:29

I've just read the entirety of that out so that we understand whether or not an incident reported in Datix will also be kept in the patient notes?

MS. SHAW: No. There won't be a copy of that Datix held in the record but there will be a reference to the Datix.
CHAIRPERSON: Right. So, there won't necessarily be any reference to the incident in the patient notes other than a Datix reference? 11:29
MS. SHAW: No. For example, if there were a slip or trip or fall or something, that would be absolutely recorded in the patient's record. It would state that the patient had had a fall and then Datix reference number, so there would be a link back. But what happened to the patient and the subsequent treatment and outcome would also be recorded in the patient's record. 11:30
CHAIRPERSON: Right. I just wonder. The first part says: 11:30

"In respect of incidents involving service users ... adverse incident reports are not health records."

11:30

The adverse incident report itself would not form part of the record?
MS. SHAW: No.
CHAIRPERSON: Would you expect there to be a narrative of the event, whatever it was, in the note? 11:30
MS. SHAW: Yes.
CHAIRPERSON: And that is how it works?
MS. SHAW: That's correct.
MR. MCEVOY: Ms. Shaw, you will be pleased to know

that's the end of the questions that I have for you.

MS. SHAW: Thank you.

MR. MCEVOY: Now it is possible that the Panel will have some more.

CHAIRPERSON: No, I don't think we do. 11:31

Can I thank you both very much for coming to assist the Panel and giving the evidence that you have. There are obviously a couple of things that you will want to come back to us on. I know you are represented today so no 11:31 doubt a note of those has also been made. In the meantime, thank you very much.

MS. SHAW: Thank you.

CHAIRPERSON: We have legal argument at two o'clock, and I don't think anything until then. 11:31

Can I just mention, I think that the Trust submissions have been uploaded to the CP box file so you can see what this is all about. Thank you very much.

11:31

THE INQUIRY THEN ADJOURNED