MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 31ST MAY 2023 - DAY 45

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CHAIRPERSON: Good morning. Just before we start with the Trust witnesses today, I just want to mention the schedule for tomorrow afternoon when there is going to be some legal argument. This, as you all know, is a public inquiry and it is important that the public, so far as is possible, and particularly interested parties, are kept informed, not only about the evidence which the Inquiry intends to call but also any legal issues which may affect the progress or the timing of the Inquiry. It is in that regard that I want to mention there will be legal submissions made by the Trust, the Belfast Trust, on Thursday, 1st June, which of course is tomorrow. That will be after the conclusion of the evidence of Brona Shaw. Currently, we are going to list it for two o'clock. 10:05 10:05 10:05

It has come about in this way. In line with the Inquiry's often-stated approach in relation to patient notes, the Inquiry wrote to the Trust on 2nd March this year. Enclosed with that letter was a request to the Trust to produce a number of patient notes which related to patients about whom the Inquiry heard in the sessions between June and December last year.
As I've said on a number of occasions, we will be making targeted requests for specific patient notes identified as being of particular interest to the Panel. That is what has happened. 10:05 10:06
The request was issued under Rule 9 of the Inquiry Rules. Back in 2021, at the Trust's request, I issued

a notice under Section 21 of the Act to compel the Trust to produce any document requested of them under Rule 9. This recent request for patient notes made in March was covered by that Section 21 notice.

10:06

The Trust has indicated in correspondence that although it wishes to produce the material to the inquiry, there is concern that the Section 21 notice doesn't cover requests in relation to patient documents, and they suggested that the Inquiry should approach the High 10:07
Court, jointly with The Trust, to seek an order from the High Court to produce the documents. My view so far, as has been indicated to the Trust, is that Section 21 does cover such material and there is no necessity to apply to the High Court or anywhere else. 10:07
In my view, the order under Section 21 - and this is, of course, subject to submissions from the Trust, which may alter my view - is sufficient to compel the Trust and any other organisation to produce such material.

10:07

There is an exception provided for by Section 22, which is where the nature of the material requested could not be ordered to be produced by the High Court. My present view is that that doesn't apply to the material we have requested. 10:08

The Trust has produced written submissions, which will be made available to Core Participants, and they have asked for an oral hearing. I have given counsel to

the Trust a maximum of 45 minutes to put forward any oral submissions that he wishes to. As I've said, that will be scheduled tomorrow at two o'clock.

This is an issue between the Inquiry and the Trust and I don't need or wish to hear from any other Core Participant on this issue, although, of course, anyone who is interested is welcome to listen to the submissions. 10:08

Mr. McEvoy, I think we are now ready for the witnesses. I think there are -- is it four witnesses accompanying Brona Shaw?

MR. McEVOY: There are.

CHAIRPERSON: There are four accompanying Brona Shaw? 10:08

MR. McEVOY: Yes.

CHAIRPERSON: What is the proposal in relation to swearing them in?

MR. McEVOY: What is proposed is that at the outset, the principal statement maker Brona Shaw and she is accompanied today by a Ms. Paula Forrest, Ms. Carol Chambers and Mr. Brendan McConaghy. It is proposed by those representing the Trust that they are, as officials, potentially in a position to assist the Inquiry if there are matters arising from Ms. Shaw's statement where they may, where appropriate, be able to add evidence on areas within their areas of responsibility and knowledge. 10:09 10:09

What is proposed at the outset is that the four persons, Ms. Shaw, Ms Forrest, Ms. Chambers and Mr. McConaghy come in and be sworn; Ms Forrest will remain with Ms. Shaw and the other two will then go with the Inquiry Secretary back to the witness waiting room and when, then, we reach the end of that aspect or those sections of the statement with which Ms. Forrest is able to assist, Ms. Chambers will then come in and so on. Mr. McConaghy will then come in at the conclusion of Ms. Chambers. 10:09 10:10

CHAIRPERSON: But at any one time, I want to make it clear, I don't want any more than two witnesses at the table.

MR. McEVOY: There will be no more than two. As has been the approach previously adopted, it is proposed, Chair, that you would indicate that there are two principal ground rules - a clear indication for purposes of the transcript as to who is speaking, and no over-speaking. 10:10

10:10

Ms. Shaw is the statement-maker and the contributions, the ancillary contributions then come from those other persons.

CHAIRPERSON: Okay. Well, that's fine. All right. Let's get the witnesses in. 10:10

Could you give your name before you give the oath?

MS. SHAW: Brona Shaw.

BRONA SHAW, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

CHAIRPERSON: Thank you.

MS. FORREST: Paula Forrest. 10:11

PAULA FORREST, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

MS. CHAMBERS: Carol Chambers. 10:12

CAROL CHAMBERS, SWORN

CHAIRPERSON: Thank you.

MR. McCONAGHY: Brendan McConaghy. 10:12

BRENDAN McCONAGHY, SWORN

CHAIRPERSON: Right. Could the two witnesses who are not going to assist us immediately go back to the room. 10:12

Can you just confirm, Mr. McEvoy, that the witnesses in the witness waiting room can watch and hear proceedings?

MR. McEVOY: There is a facility for those two witnesses to follow along. 10:12

CHAIRPERSON: Just so that everybody knows, as it were, they are not in purdah, they can listen to the evidence and, I suppose, in due course could comment on it if

necessary.
MR. McEVOY: That's right.
CHAIRPERSON: All right. Thank you very much.
MR. McEVOY: Thank you, Chair.

10:13

First of all, good morning, Ms. Shaw and Ms. Forrest. We spoke briefly earlier. My name is Mark McEvoy, I'm one of the Inquiry counsel. Thank you for coming along today.

10:13

Ms. Shaw, we have a very extensive statement from you of some 223 pages. If I could ask you to go to the last of those, if you have it before you. There is no handwritten signature but your name appears at the bottom of the page and there is a date of 6th April 2023. Do you wish to adopt the statement as the basis of your evidence to the Inquiry?

10:13

MS. SHAW: Yes, thank you.
MR. McEVOY: As the Inquiry has heard indication, you are joined by Ms. Paula Forrest then.

10:14

So we are clear, there are two other individuals who are also sworn in and will be assisting you in giving evidence in due course. Can you give some idea of the where the other three persons sit relative to you in The Trust hierarchy, so to speak? That might be a slightly out of date word but you get the idea. If you can indicate for us where they sit relative to you.

10:14

MS. SHAW: Okay, certainly. So, myself, Ms Forrest and

Mrs. Chambers are all members of the Central Nursing Team. Paula Forrest and I are both Deputy Directors of Nursing. I'm responsible for Safety Quality and Patient Experience, and Ms. Forrest's remit is Workforce Informatics and Education. Mrs. Chambers then is the Lead Nurse For Education in the Central Nursing Team. Mr. McConaghy works in the human resources team as the Co-Director For Human Resources. 10:14

MR. McEVOY: That's very helpful. As you know, there are three topics for discussion this morning with the assistance of Ms. Forrest, Ms. Shaw. Those are workforce plans relating to disability care in the period from 1999, which is the outset of the Inquiry's terms of reference, and 2021, which is their end. Then a discussion around an overview of turnover and vacancy rates in wards, if you can help us with that. Also then, thirdly, the impact of and response to suspensions and the increased use of agency staff. Those are the three matters which hopefully the two of you will be able to assist, as far as you are able to, the Inquiry this morning. 10:15 10:15 10:15

If I can just turn then to the substance of the issues the Inquiry is looking at. If I can ask you, please, to go to paragraph 32, which appears hopefully on page 15 of your statement. That will also come up on the screen. Page 15, please. 10:16

The Inquiry would like to know, arising from some

reasonable workforce reviews carried out following the 2015 framework what the position is in relation to psychology and psychiatry. The reason for that is, looking at paragraph 32, your statement sets out a number of workforce reviews. One can see them there listed, A through to J. There's one for domiciliary year care, one in relation to prosthetics, dietetics, physiotherapy, speech and language therapy, podiatry. Overleaf then, occupational therapy, social work, pharmacy. Also then at J, music, art and drama therapies. 10:17 10:17

The Inquiry would like to know what the position is around clinical psychology, firstly. Also then if you can help us in relation to psychiatry. What's the position -- 10:17

CHAIRPERSON: I'm sorry, before you do that, can you just set the scene as to what the purpose of a workforce review is and how it is conducted?

MR. McEVOY: For the uninitiated. 10:17

CHAIRPERSON: Well, this is a public inquiry so the public need to understand in broad terms what the evidence means.

MS. SHAW: Paula will take that. Thank you.

MS. FORREST: The workforce reviews are carried out by the Department of Health. They are often aligned to the strategic direction of other documents or other pieces of work. For example, the Transform Your Care or other aspects of work that would be ongoing by the 10:18

Department of Health in relation to a number of the documents are already referred to within the topic around Transforming Your Care, Delivering Together. To enable those to be implemented and put into place, the Department would look at workforce reviews to ensure that we had the appropriate trained, skilled workforce in place to deliver on the strategic direction.

CHAIRPERSON: Right. So that's the essence of it, it is to try to identify what is needed --

MS. FORREST: Yes. 10:19

CHAIRPERSON: Of the nursing workforce, is it, and the other sort of disciplines for a coming year, for a coming five years? What sort of period did they cover?

MS. FORREST: It can vary, so it can be three years, it can 10 years. There are documents that have been produced that would cover various sort of time scales. I think it's important to note that they would need to be revisited and looked at if they were for a prolonged period of time. For example, some of the reviews referred to in the statement are for 10 years. Our population health and the need of our population may change within that time, so that would need to be revisited on a regular basis. 10:19 10:20

CHAIRPERSON: Right. Who receives the workforce review? Who is supposed to act upon it? 10:20

MS. FORREST: So, the workforce reviews are undertaken by the Department of Health. It would be usual then for -- there may be an action plan that would be developed associated with the workforce review by the

Department of Health. That may then come to the Trust in relation to implementation of workforce reviews. There are a number of workforce reviews that have been listed here. I haven't prepared any information for you and I wouldn't be over the detail of those reviews today, but if you require them --

CHAIRPERSON: That's fine. I'm sorry to interrupt, Mr. McEvoy, you obviously know this material very well and sometimes there's a temptation to launch into the particular, and I just needed a broad overview. That has been very helpful. Mr. McEvoy, over to you.

MR. McEVOY: Thank you, Chair.

In light of that, you have indicated then -- I'll give them back to you in some of the examples that you have given us, and indeed the reviews have been included in your exhibits, but one can see that there are reviews in relation to a range of specialisms and professions, health professions; allied health provisions as we'll hear more about. The Inquiry is keen to know what is the position, if you can help, in relation to both clinical psychology and psychiatry. It is possible that you don't know but if you are able to help us, please do.

MS. FORREST: Sorry, I would not be able to -- I haven't considered that as part of my remit in relation to the statement.

MR. McEVOY: We don't need names but who, maybe by office or directorate, would you expect to be able to

help us with workforce reviews in relation to psychology or psychiatry?

MS. FORREST: I imagine that would sit within the Medical Director's remit.

MR. McEVOY: Okay. Thank you. 10:22

MS. SHAW: Mr. McEvoy, if I may come in? The director is responsible within their directorate for workforce, ultimately. The Executive Director of Nursing, for example, would be responsible for the workforce for nursing, and the medical director would be responsible, 10:23 therefore, for the medical side of the house.

MR. McEVOY: The medical director, presumably, would look after psychiatry for the purposes of proposing or preparing a workforce review?

MS. SHAW: Yes. 10:23

MR. McEVOY: What about psychology?

MS. SHAW: That sits within the medical director's office as well.

MR. McEVOY: Thank you.

10:23

Can we move on then to paragraph 57. Now, the issue that arises here relates to a policy framework which was published or produced in 2012 called Delivering Care. The two of you would be familiar with that then. The Delivering Care policy framework seems to have been 10:24 broken down into a number of phases; is that right?

MS. FORREST: That's correct.

MR. McEVOY: How did the phases work? Was it intended that the faces would follow each other sequentially, in

other words there would be a first, second and third phase of work under Delivering Care? Was that the idea?

MS. FORREST: There are currently eleven phases of Delivering Care and they relate to different areas and specialisms within nursing and midwifery. 10:24

MR. McEVOY: That 2012 framework then still prevails in 2023; is that correct?

MS. FORREST: If it would be helpful, I could provide some clarity in relation to that. 10:25

The first and second phases of Delivering Care, the first phase, which I believe you have a copy of, was related --

MR. McEVOY: That was about acute services; is that right? 10:25

MS. FORREST: Yes, it was. It was related to medical and surgical inpatient areas. Phase 2 was related to emergency care. The first two phases -- those were the first two phases to be implemented as part of the Delivering Care framework. Those are still in use today. However, there have been a number of phases that have been looked at in relation to Delivering Care, Phase 9 for learning disability inpatient and community setting being one of them. 10:25 10:26

There are a number of phases out of the 11 phases that are ongoing and not yet completed and, therefore, have not yet been implemented.

We are, at present, with the Department of Health and the Public Health Agency reviewing Phase 1 and Phase 2 of Delivering Care as they have been in place now for approximately nine years. 10:26

MR. McEVOY: That Delivering Care framework then is something that was commissioned by the Chief Nursing Officer. Maybe if we just look back then to paragraph 52, just for clarity or context. We're told there that the aim was to support the provision of 10:27 high-quality safe and effective care in hospital and community settings. I think this is picking up the point I asked you about a moment or two ago.

"...through the development of a series of phases to 10:27 determine staff ranges for the nursing and midwifery workforce and a range of specialties."

We have been working through them, then, I think that's the position then one after the other; sequentially, 10:27 essentially. We are told then at paragraph 57 in particular, which is where I asked you to go to a moment ago, if you can go back to that, please. There we're told then:

10:27

"Phase 9 of Delivering Care relates to learning disability nursing and inpatient and community settings."

We are told there it is underway but not yet complete.

When did work on Phase 9 commence?
MS. FORREST: I'm sorry but I wouldn't have the exact date of that, of when it commenced. 10:28
MR. McEVOY: Would you know roughly?
MS. FORREST: No. I'm sorry, I couldn't know the exact date of each of the phases but I would be able to provide that information for you.
MR. McEVOY: Okay. 10:28

You're maybe then not able to help us with this one but can you help us with why learning disability was left to Phase 9 when there were clear indications of issues at Muckamore? 10:28
MS. FORREST: The -- sorry. We would not -- the Department of Health and the CNO decided the order in which the phases would be looked at.
MR. McEVOY: So, it is not a matter for the Trust, that's your evidence? 10:29
MS. FORREST: It's not a matter for the trust.
DR. MAXWELL: Can I just ask? There are a range of bodies that advise the CNO. There's CNMAC. Would they have had any input to Delivering Care and determining the time scales? 10:29
MS. FORREST: There was a -- the work that led up to Delivering Care involved a number of stakeholders. All of those people would have been involved in contributing to the principles and methodology in

relation to the assumptions that were included in Delivering Care and the staffing ranges, as would the best evidence associated with the available nursing tools and models of care also fed into that piece of work. 10:30

DR. MAXWELL: Would CNMAC be involved in managing the process?

MS. FORREST: They would not be involved in managing the process. I believe that this work was led and each of the pieces of work is led by the Public Health 10:30 Agency in relation to the phases.

If I could just, for additional clarity, that would be reported back through CNMAC in relation to the... but the expert reference group involves a number of key 10:30 stakeholders from the Trust and service and it's led by the Public Health Agency. However, it would be reported back.

DR. MAXWELL: CNMAC has representatives from all the Trusts on it, does it. 10:31

MS. FORREST: It does, yes.

DR. MAXWELL: So who is the Belfast Trust representative on CNMAC?

MS. FORREST: The executive directors of Nursing from each of the Trusts would sit on CNMAC. 10:31

DR. MAXWELL: Thank you.

MS. SHAW: May I come in as well? I suppose the conversation around Delivering Care began in and around 2012. While there were issues known around workforce

for learning disability care, the issues pertaining to Muckamore weren't known at that point. That may be why their disability sits in Phase 9 rather than in the earlier phases.

MR. McEVOY: Is it possible to deduce or conclude that there is a degree of priorities. I think you said they were 1 to 11, Ms. Forrest, a moment or so ago? 10:31

MS. FORREST: That's correct.

MR. McEVOY: Is it possible to deduce or conclude from the fact that there are 11 phases that there's an inevitable degree of prioritisation in allocating those phases? 10:32

MS. SHAW: I don't know that we would be able to comment on that. I think that that would be something that would have to be commented on by the Public Health Agency. 10:32

MR. McEVOY: Why would the Public Health Agency be able to assist there?

MS. SHAW: Just because, as Ms. Forrest said, they managed, I suppose, the outworkings of the Delivering Care framework. 10:32

MR. McEVOY: Was it the Public Health Agency then who worked out the sequence and what would be examined and looked at when in terms of the phases?

MS. SHAW: I'm not able to answer that, I'm sorry. 10:32

MR. McEVOY: All right.

CHAIRPERSON: Can I just ask? Did the phases follow sequentially? Because if we look at your paragraph 58, the work was commissioned in 2012, you told us, and

then you referred to Delivering Care Phase 2; is that produced in 2017? Then Phase 3 also produced in 2017. So, did it take five years to get to producing Phase 2?

MS. FORREST: The work associated with Delivering Care commenced in 2012. The framework was actually implemented -- the first phase was implemented in 2014, in relation to -- and that was for the acute inpatient areas for medical and surgical. The work has been ongoing for a number of years. 10:33

CHAIRPERSON: Sure. I'm not being critical, as it were, I just want to understand how it works. Are the phases sequential in terms of timing, or might you bring Phase 9, you know, in early? 10:34

MS. FORREST: In general, they have been sequential. However, they could possibly change the sequence of the phases. 10:34

CHAIRPERSON: If it was necessary. Okay.

DR. MAXWELL: Is it the case that some of them were happening simultaneously and some reached conclusion earlier than others because there was more evidence? 10:34

MS. FORREST: That is correct. If it would be helpful, can I just clarify a few issues in relation to the question?

So, whilst there are a number of phases within Delivering Care that are ongoing, that does not indicate that the modelling for the workforce within the Trust is not responsive. We look at the assumptions that have been laid down within Delivering 10:34

Care, and whilst we recognise that that is best practice and that is how we need to look at the nursing workforce in its entirety, we have used the assumptions on which to base the workforce in a number of areas in which Delivering Care has not yet been implemented. There is opportunity for us within the Trust, and that's what we would do in looking at assurance of quality and safety, planned and unplanned absences, skill mix. So, we use some of the evidence that is contained within the first phases -- 10:35

CHAIRPERSON: Because it is transferable.

MS. FORREST: Because it is transferable in relation -- some of the tools are transferable into, and then we use service specific benchmarks or quality performance indicators as part of that. 10:36

CHAIRPERSON: Thank you.

MR. McEVOY: Thank you.

Moving on to paragraph 61 then, please, just across the page, page 27. This section looks at the work of the Nursing and Midwifery Task Group which was set up in 2017 by the minister at the time for health. You tell us then that it was chaired by Sir Richard Barnett. It's aim was to develop a road map that would provide direction in achieving world class nursing and midwifery services over the next 10 to 15-year period. Then you tell us that the work streams broke down into workforce, long-term conditions, and population health. 10:36 10:36

There's then a quote at paragraph 62 from the conclusions or the findings of the Nursing and Midwifery Task Group dealing specifically with the question of workforce planning. You can see it in italics there, I think. 10:37

MS. FORREST: Yes, I can. Thank you.

MR. McEVOY: Turning overleaf, please. One can see just on the second of the italic paragraphs, the group notes that: 10:37

"Agency spend has risen" - hopefully you have it there in front of you. "Agency spend has risen from £9.8 million in 2010/11 to £51 million pounds in 2018/19. Bank costs have also doubled from 30 million in 2010/11 to 61 million in 2018/19". 10:38

Can you tell us what the main drivers behind those increases were?

MS. FORREST: Yes. If you could just give me a minute, I'll refer back. 10:38

MR. McEVOY: Of course.

MS. FORREST: If it would be helpful, if I could just refer to the 2020 Northern Ireland Audit Office Report. That is in paragraph 69. 10:39

There are a number, there's not just one single reason associated with the increase in vacancies and therefore the cost of temporary workforce spend. For many years, in summary the vacancies have arisen really since 2013

to 2019 and have gone up considerably. Whilst the nursing workforce did increase by 8% between that time, we would need to have increased the nursing workforce by 23% to meet the needs of our patients and the rising demand. At a point in time, a decision was taken by the Department of Health to reduce the nurse training budget for preregistration training, and that was noted to have contributed significantly to the workforce shortages. For a period of five years, we had over 700 less training places. 10:39 10:40

In summary, the number of nurses being trained was not sufficient to meet the demands of our service users and the population. You can understand that it takes three years to train a nurse, so therefore the impact of those reduced training places over that period of time had a significant impact for many years to come. 10:40

PROF. MURPHY: Could I just ask a question about that? You were obviously getting nursing from somewhere so presumably it was from agency nursing staff, was it? 10:41

MS. FORREST: At that period of time we had significant vacancies across the Trust in relation to the nurses that were being trained, and they weren't sufficient to meet demand. Yes, we did start to use an ever-increasing temporary workforce to maintain staffing levels within the organisation. 10:41

PROF. MURPHY: My understanding is that makes it much more expensive because agency nursing staff are paid at a higher rate, or you have to pay them a higher rate?

MS. FORREST: That's correct. It is much more expensive is one of the aspects of that. Obviously, the high use of a temporary workforce is also challenging.

10:41

I would just like to make one other comment. In 2014 the introduction of Delivering Care meant that we required additional nurses because we had staffing ranges that were higher than what we had pre Delivering Care. That also contributed to our vacancy position at that time. 10:42

PROF. MURPHY: Given you were employing agency staff, they're obviously out there somewhere. I'm just wondering why they didn't want to be employed by the Belfast Trust. 10:42

MS. FORREST: I can't comment on that particular time but over the last number of years, the feedback in relation to why staff work agency from the staff themselves is it gives additional flexibility in relation to their work life balance. As you have said, it pays more for people, and really that is a benefit that they feel to them in relation to the type of work they choose to do, whether that's in an agency position rather than in substantive role within the Trust. 10:42

CHAIRPERSON: Sorry, I didn't many to interrupt, Professor Murphy. 10:43

One of the answers you gave was "We had staffing ranges that were higher than we had pre Delivering Care".

What do you mean by staffing ranges? Does that mean just numbers?

MS. FORREST: If it would be helpful, I could describe some of the tools that we use in relation to workforce modelling that may help to answer. 10:43

CHAIRPERSON: Right. If that would explain what ranges means, yes, great.

MS. FORREST: Workforce is a very complex science and we look at many tools or components to consider. It's not just about the numbers of staff that we have on a 10:44 ward, it is also about the skill mix of that staff in relation to the registrant staff and the non-registrant staff. We also need to consider planned and unplanned absence. We consider things like annual leave, sickness absence, study leave, educational 10:44 requirements, the environment in which staff are. For example, if there are a lot of single rooms, that may require higher staffing levels. We consider a number of factors. The literature would suggest that many people would like to have a definitive number of nurses 10:44 required to look after a patient, but we respond to patient need and their acuity and dependency associated with the specialism. Therefore, within Delivering Care we have not given an exact nurse-to-patient ratio; however a recommended range of staffing. It could 10:45 range from 1.3 to 1.5 staff in relation to what we call a nurse-to-patient ratio. Then we would have to consider the skill mix also associated with that. The recommendations and those assumptions are what I have

referred to before in relation to the things we need to consider when we're planning workforce for any area.

CHAIRPERSON: So when you refer to staffing ranges that were higher, you're talking about taking a host of those factors into account; a general shifting upwards, as it were, either of numbers or skill? 10:45

MS. FORREST: That's correct. As the tools -- we've had many tools available to us as nurses. For a number of years, one of the ones we've referred to is the Telford. It has been in place since the 1970s and we still use that today. But there's not only one tool that would help us to look at how we decide what numbers of staff that we need. 10:46

CHAIRPERSON: I understand. One has to look at the particular facility as well. Muckamore may be in a very different place, for instance, to an acute hospital. 10:46

MS. FORREST: Absolutely, the environmental factors. Obviously we start with the patients or our service users at the core of all of that in relation to their specific needs. 10:46

CHAIRPERSON: Okay. Thank you.

MR. McEVOY: Can we look across then. I think you touched on paragraph 69, which was the audit office report, I think a moment ago you made reference to it. Specifically, I think you had drawn the Inquiry's attention to the reduction, the decision of the Department to reduce the training budget, which I think appears at the bottom of page 30 just in paragraph 69. 10:47

Are you able to help us with whether or not the effect of those cuts or reductions were even more profound on the training of nurses in learning disability, when contrasted with some other areas, that is to say? 10:47

MS. FORREST: Our undergrad -- if I could just provide some clarity on the allocation of training places. We have three higher education institutions who train nurses for us within Northern Ireland at present: The University of Ulster, Queen's University and the Open 10:48 University. We have a number of branches of nursing and midwifery that make up the training places that are trained every year. The majority of the places are for training adult nurses, and then the other places would be allocated to learning disability, mental health, and 10:48 children's. Then there would be specific training for midwifery associated with that. The numbers are smaller in the learning disability, mental health and children's preregistration training programmes.

10:48

The effect of the reduction in training places was felt across all areas. I'm sorry, I haven't considered whether the learning disability -- reduction in learning disability places at that time had even more of an effect on the service, but I could look at that 10:49 if that would be helpful.

CHAIRPERSON: Yes. Thank you.

MR. McEVOY: Then if you could look across, please. I suppose if you commence at paragraph 70, which is

under the heading of "Workforce Planning Within the Belfast Trust". Here then, the statement deals with workforce planning in respect of learning disability. Before doing so, you touch on what you describe as the science in terms of how workforce planning takes place. 10:49
You make reference to 14 operational directorates within the Belfast Trust. The overall responsibility for workforce planning in respect of a directorate lies with the director of the directorate. Within each directorate, there are staff members with 10:50
responsibility for oversight of workforce issues.

At paragraph 72 then, we are told that from 2007 to 2009, learning disability services fell within the remit of the Mental Health and Learning Disability 10:50
Directorate. Then in September 2009 until August '12, learning disability services fell within the remit of the Social Services and Primary Care Directorate. Then we are told from August 2012 until August 2021, the learning disability services was part of the Adult 10:50
Social and Primary Care, or ASPCC, Directorate. Then in 2021, learning disability services became part of the Mental Health Intellectual Disability and Psychological Services, or MHIDPS, Directorate.
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So, in the period from 2007 to date, there have been four shifts; learning disability services has been shifted around four directorates. What was the reason for that? Perhaps more particularly, what was the

practical effect of that for the delivery of learning disability services by the Trust?

MS. SHAW: I think it is noted that learning disability services did move between these different directorates across that period of time. I suppose the Belfast Trust, as it is, came into being in 2007. As much as I don't know a definite answer, it could be assumed that it was a reprofiling of directorates as the Trust settled into the state it is within now. That is why, then, it moved between Mental Health and Learning Disability to Social Services and Primary Care. Then the longest period was the Adult Social and Primary Care; it was there between 2012 and '21. That would be the only explanation that I might give, is that it was just the bedding-in period of The Trust and just finding the reprofiling of directorates as we settled.

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MR. McEVOY: Yes. What was the practical -- I mean perhaps you don't know, and I gather from the gist of the answer you have just given us that there may be an element of speculating, so I'm not asking you to do so. I guess from a corporate knowledge perspective, can you give us any idea of what the practical effect, then, of that shifting with reprofiling - and it may just help as well within your answer if you can explain what profiling is - what the practical effect was - there maybe there wasn't any - on the delivery of disability learning services?

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MS. SHAW: Okay. In respect of the effect it had on learning disability services, I wouldn't be able to

comment. I don't have the knowledge of that and I haven't considered that for today.

Reprofiling is where, I suppose, directorates would rearrange themselves and move services in and out to get the right fit for that service and make sure that it has the right oversight and processes in place. 10:53

MR. McEVOY: Can you give us, even in broad strokes, an idea of the type of factors and issues that might come into play in reprofiling in and within the delivery of a service, particularly learning disability. What sort of factors may be in play in the decision-making process around that? 10:53

MS. SHAW: Well, you would hope that when you reprofile, it would be pretty straightforward because you're not changing the management structures within that service but it can lead to someone -- just the directorate being unsettled for a period of time. 10:54

MR. McEVOY: Okay. Is there any form of assurance to offset the risk of instability as regards the people to whom it is supposed to deliver the service, i.e. that persons with learning disability wouldn't be negatively affected or impacted by shifts? 10:54

MS. SHAW: I suppose to be clear, Mr. McEvoy, I haven't suggested that there was an impact to learning disability services through the reprofiling, but there are systems and processes in place across the Trust for governance to ensure that things don't get knocked off if reprofiling happens. 10:54

MR. McEVOY: Can you give us, even in general terms, an idea of what those might be and how they would work?
MS. SHAW: That would be our policies and procedures and how we provide assurance up through to the Trust Board and executive team. 10:55
MR. McEVOY: In the next paragraph then, we're told that it is important to acknowledge that workforce planning for a directorate must be carried out within the broader strategic framework within which directors are required to operate. The Belfast Trust developed 10:55
and implemented a strategic reform and modernisation programme entitled Maximising Outcomes, Resources and Efficiencies, or MORE, chaired by the chief executive. Under the MORE programme then, each directorate is allocated various efficiency targets including 10:56
workforce efficiency targets.

I guess are you telling us there that MORE means less in the sense that efficiency is about cuts, ultimately?
MS. FORREST: If I could offer additional clarity. It 10:56
is not about making cuts but it is about being more efficient. In relation to maximising the workforce that we already have, so we would not be making cuts to nursing posts, or the delivery of -- or that would impact the delivery of patient care. However, we may 10:57
consider thing like roster management to maximise the workforce that we have, looking at how we could potentially reduce the huge agency spend that we have in relation to looking at the additional use of our

bank staff within the organisation. Ultimately, it would be looking at recruiting into vacancies to reduce the temporary workforce spend.

So, it wouldn't necessarily just be easily as interpreted as making cuts. There would be a number of factors that we would need to consider in relation to how we could most effectively maximise the use of our existing workforce, and, where we do need temporary workforce to backfill the level of vacancies, that that would be done in an efficient way associated with not using high-cost off-framework agencies. So, those are some of the things that I could give as an example in relation to the MORE programme. 10:57 10:58

DR. MAXWELL: Could I just ask do the Trusts have cost-saving efficiency targets? 10:58

MS. FORREST: There are cost savings efficiency targets that are given to The Trust by the Department of Health. An example of one which I could give you this year is around the reduction in agency spend is one of the targets. 10:58

DR. MAXWELL: What percentage is that?

MS. FORREST: I would not be able to provide you with the exact detail but each Trust would be given a cost savings target associated with that by the Department of Health. 10:59

DR. MAXWELL: The Department of Health, when setting up the annual contract, part of that contract is a target for cost-saving efficiencies. Would it be right to say

that it is up to the individual Trust to decide how to achieve those, so where it is going to make those saving? That's not directed by the Department, it is just an overall target and the Trust Board decides where it is going to seek those savings? 10:59

MS. FORREST: I'm sorry, I haven't considered that in the nature of what I'm responding to at the minute, but I do know this year that a specific target has been set associated with the reduction of agency spend. That has been a specific target for savings that need to be made associated with the reduction of agency staff. 10:59

DR. MAXWELL: I think it would be interesting to clarify whether that's an internal decision by the Board, or whether it's an overall efficiency target from the Department of Health and the Board decides where to make it, or whether the Department of Health has specifically required that be made through temporary staffing. If you could come back to us on that, it would be great. 11:00

MS. FORREST: Yes 11:00

MR. McEVOY: In the next paragraph, 74, you tell us that from 2015 to 2019 as part of the MORE programme, the Trust utilised the public sector transformation fund as a mechanism for reducing staff costs. It was financed from borrowing -- that is the fund was financed from borrowing under the Reinvestment and Reform Initiative, and was designed to support voluntary exit schemes across the sector. 11:00

Bearing in mind that we already heard that there is a mushrooming cost in agency staff and on bank staff at or about this time, as noted by the Barnett Group, can you tell us what the point was of using the PSTF against that backdrop? 11:01

MS. FORREST: I'm sorry, I wouldn't have detail in relation to that. I would have to come back to you with any additional information.

MR. McEVOY: Can I ask you, please, then to turn to paragraph 88, which is on page 36 hopefully. I'm just waiting for it to come up on screen. 11:01

There's discussion in paragraph 88 around the Nursing and Midwifery Workforce Steering Group which was established in 2010/'11 chaired by the Executive Director of Nursing and User Experience. Who is that person relative to you then, Ms. Shaw? 11:02

MS. SHAW: The Executive Director of Nursing and User Experience is my direct line manager.

MR. McEVOY: This includes divisional nurses, trade union representatives. In broad terms, the purpose of the steering group is to provide assurance to the executive director on staffing and governance issues relating to the nursing and midwifery workforce, and the impact of those issues on patient and client care. 11:03

That meets on a bimonthly basis. We're told then that that material is going to be disclosed to the Inquiry. 11:03

Do you attend that group, Ms. Shaw?

MS. SHAW: That group is actually attended by Ms. Forrest.
MS. FORREST: Yes, I attend that group.
MR. McEVOY: Okay, Ms. Forrest, maybe you can help us then with whether or not that group produced or had produced or commissioned specific assurance reports about staffing and staffing issues at Muckamore Abbey? 11:03
MS. FORREST: If it would be helpful, I would just refer to paragraph 90 in relation to how that works. In 2018, the nursing workforce team worked in collaboration -- my team work in collaboration with the divisional nurses within each division to look at their workforce action plans. Obviously, my role is in relation to the overarching workforce direction linked to the strategic direction. So, these plans that would be developed with the support of my team at divisional level would be very operationally focused. Those are the basis on which the divisional nurses would report back at the Nursing and Midwifery Steering Group on a bimonthly basis. 11:04 11:04 11:05
DR. MAXWELL: I can see that there's plans and there's reporting on the progress of those plans, but is there any assurance about the patient care being delivered, what is the risk to patient care by any deficits in staffing? 11:05
MS. FORREST: As part of those plans, if there was identified a significant level of vacancy or high use of temporary workforce, as part of our workforce assurance we need to triangulate information against

patient safety data. There may be specific indicators for an area that would include -- I have some examples of that in relation to pressure sores or risks associated with the quality performance indicators in patient care. Those elements would be fed back at the senior nurse and midwifery team meeting on a monthly basis as part of the overall assurance, and if there was deterioration in relation to some of the patient safety indicators, of course we would look at workforce as part of an element contributing to that. Each area would or could have risk assessment documents in place if there was a high level of vacancy or a high use of temporary workforce to mitigate against some of those risks, and the patient safety indicators would be very clearly written into the workforce plan. It's not just simply about workforce, it's about ensuring that we can triangulate that information with the quality indicators also.

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DR. MAXWELL: So pressure areas, pressure ulcers, would be a significant indicator for adult services but probably not so much for Muckamore. Were there specific indicators such as seclusion, restraint, use of PRN sedation?

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MS. FORREST: Yes, there were. There were service-specific indicators. I have given you an example, just to clarify, of the general things that may be identified in NHS safety thermometer, for example. However, the patient quality indicators would be service-specific, and the quality indicators are

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associated with the patient population that is being cared for.

DR. MAXWELL: So you would be able to track vacancy rates, use of temporary staffing, and very specific LD quality indicators? 11:08

MS. FORREST: Yes.

DR. MAXWELL: And those reports go on a bimonthly basis to corporate nursing?

MS. FORREST: Yes, that's correct.

MS. SHAW: They go on a monthly. Every month the 11:08 divisional nurse will do what we call a variance report. That captures that information, and that's then presented to the Executive Director of Nursing at our senior nurse and midwifery team meeting on a monthly basis. That's where, you know, if there's any 11:08 trends observed, the divisional nurse would be reporting that to our executive director and we would then have a discussion around how that would be managed or what mechanisms might help to be in play. We would then mobilise Paula and our teams to go and assist the 11:09 divisional nurses with any work that needs to be done in those areas.

DR. MAXWELL: So, this is a different route from the reporting within the directorate, so you have this additional route of assurance? 11:09

MS. FORREST: Yes.

DR. MAXWELL: Even if you weren't hearing directly from the directorate, you would pick it up through this route?

MS. SHAW: Yes.
DR. MAXWELL: And any trends would be reported directly to the Executive Director of Nursing?
MS. SHAW: Yes.
CHAIRPERSON: That describes the position now but we're looking at a very long period. I just want to understand how long that system has been in place. 11:09
MS. SHAW: So the Executive Director of Nursing who is currently in post has been in post since 2010, I believe, and she introduced that processes very quickly after she arrived. 11:09
CHAIRPERSON: So, from around 2010 onwards that description applies?
MS. SHAW: Yes. I understand there's a copy of the variance reports in the bundle as well. 11:10
CHAIRPERSON: Thank you.
MR. McEVOY: That system that you have described then has run since 2010/'11 when the current executive director then came into post.
MS. SHAW: Mhm-hm. 11:10
MR. McEVOY: Okay.

Just looking, if we can then, please, at paragraph 93 over the page. Back to the topic of Delivering Care which we looked at earlier on, and the establishment by the Trust of a Delivering Care implementation group which was chaired by the Executive Director of Nursing, to oversee this time-limited project to ensure the Delivery Care funding was allocated, and all posts were 11:10

advertised and reviewed and appointed by year end.

We're told that funding allocation was for 2021/'22. The identification of posts, according to the statement, is of a learning disability -- sorry, of one Band 8B consultant nurse, one Band 8A nurse practitioner, and two Band 7 nurses. The Band 8B consultant nurse post and Band 7 nursing posts have been appointed. The Band 8A remains vacates and interviews then are due to take place, or were at the time of the statement. 11:11 11:11

Now, the clear implication of that information is that the implementation group identified a number of senior nursing posts. Quite a short question, really, are any of those based at Muckamore Abbey? 11:12

MS. FORREST: Yes. I'll answer that.

Just to give some clarity, the identification of what posts were going to be funded through the Nursing and Midwifery Task Group in Phase 1 is associated with that. Whilst we identified there was workforce shortages, the lack of specialist and advance clinical posts was a major concern, particularly on the impact on delivering the ambition outlined in Delivering Together. There were a number of senior posts across each Trust that were identified as part of the Phase 1 funding for the recommendations within the Nursing and Midwifery Task Group. 11:12 11:12

The posts that you have referred to, we have appointed a consultant nurse and we actually have appointed a trainee advanced nurse practitioner. So, I'm pleased to say that the interviews that took place in April were successful and that person is commencing in post on 1st July. We obviously have the two Band 7 posts which have also been appointed. 11:13

The posts are -- yes, and they contribute within Muckamore Abbey. However, it is for the learning disability service and the lifespan of learning disability patients and clients. So, they are roles that are associated with community and acute service provision. 11:13

DR. MAXWELL: We've heard from quite a lot of witnesses that people who are in Muckamore, and certainly people who remained in Muckamore after the initial phases for resettlement, have particularly complex needs and have specialist needs that need specialist skills. Their needs are possibly quite different from people who have never been admitted. Prior to these posts, where was the clinical nursing expertise coming from? 11:14

MS. FORREST: So, there are a number of senior clinical staff within the workforce within Muckamore prior to the implementation of these posts, and they were at ward sister level. They would have been clinical coordinators at senior lead nurses within the area. 11:14

DR. MAXWELL: A lot of those roles often spend a lot of

their time doing operational management. Where was the clinical nursing expertise coming from, because that's the whole point of a nurse consultant, an advance nurse practitioner role, isn't it?

MS. FORREST: Yes. 11:15

MS. SHAW: We had nurse development leads working in Muckamore Hospital and they would have supported the staff with clinical education, training, supervision, things like that at a higher level. These specific posts -- so, for example, the 8B consultant nurse, they 11:15 do specialist clinics with a key focus on dementia, which, as Ms. Forrest said, looks at the lifespan of the patient, and is also doing a project looking at meaningful activities for patients in Muckamore Hospital. 11:16

The Band 8A will be working on the transition from child to adult services, and will very much be across acute and community settings. Then the Band 7s, one is focused on epilepsy services and will link in with the 11:16 neurology team, and the other Band 7 is an in-reach post, so they will support the acute services where we have patients with learning disabilities across our other wards and departments.

DR. MAXWELL: So not the specialist inpatient 11:16 facilities; when they come to more general surgical wards and things like that?

MS. SHAW: Yes. Yes. Yes.

MS. FORREST: Sorry, could I just make one other point?

We successfully appointed a senior nurse who is a clinical academic nurse. We have a joint appointment with Queen's University to look at the links between service and academic and making sure we can support our students, et cetera. We appointed that nurse approximately two years ago. We were looking for additional opportunities outside of the Nursing and Midwifery Task Group recommendations to look at that senior leadership and clinical within Muckamore Abbey in particular. 11:17

MR. McEVOY: At paragraph 94 then, which is the next paragraph down, there is mention then of the implementation in June 2021, which is obviously towards the end of the Inquiry's terms of reference. It makes reference to the implementation of a nursing work for strategy from 2021/'22 to 2025/'26. You've enclosed that, of course. 11:17 11:18

We're told that the strategy was developed to address the unsustainable nursing vacancy rate within the Belfast Trust, and outlines proposals aimed at reducing the nursing vacancy rate. Have there been any green shoots of progress, even at this stage, in relation to that strategy with respect to learning disability? 11:18

MS. FORREST: I just would like to outline and give additional clarity around the sort of three-to-five year plan associated with that. 11:18

I suppose the first priority for us within the Trust

was to look at reducing our vacancies and the stabilisation of our nursing workforce. The Minister did commit to increasing nursing undergraduate places. However, that did not come into fruition until last year where we would have seen the outworkings of the increased number of undergraduates. We sought to look at bespoke international nurse recruitment programme as a way to fill our vacancies. Of course, I looked at the opportunities to place our international nurse recruits within learning disability services, and particularly in Muckamore. However, I haven't been able to do that, to bring international nurse recruits with a learning disability qualification into Muckamore Abbey Hospital. The rationale for that is that international nurses are trained in a more social care model associated with the care of our clients with learning disability. To enable them to register within --

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MR. McEVOY: Sorry, just to pause you there. Do you mean by that that their skill set doesn't lend itself to a hospital setting such as Muckamore readily.

MS. FORREST: I'll provide some clarity for you on that.

MR. McEVOY: Forgive me interrupting. It was just to help out --

11:20

DR. MAXWELL: Are you saying they can't register with the NMC?

MS. FORREST: Yes, that's correct.

DR. MAXWELL: So you can't place them there because

they're not registered in the UK because of the nature of their curriculum in their home country?

MS. FORREST: The training in their home country is not aligned to the preregistration standards that would enable them to register with the Nurse and Midwifery Council as a registered nurse for disability within the UK. 11:21

MR. McEVOY: The end of paragraph 94 just notes that the key strands of the Trust's workforce strategy and plan were to increase the number of international nurses, which you touched on, alongside improvements in recruitment and retention, management of staff absence, and enhanced use of other roles to support registered nurses. 11:21

11:21

You touched on international nurses but alongside the issue there, can you give us any indication of the extent to which you have been able to utilise those strands and implement the plan with regard to Muckamore. I'm thinking of the enhanced use of other roles, for example. 11:21

MS. FORREST: You will see in the workforce strategy, the first two years are associated with really looking at stabilising the workforce and reducing the vacancies. This year our primary focus will be on the retention of our staff and looking at other roles to support registered nurses in relation to that multidisciplinary care model to provide the best care, putting our patient at the centre. At present, this is 11:22

our focus, in relation to my work plan for this year will be focusing on those two key elements that I outlined in the workforce strategy.

MR. McEVOY: Paragraph 95 then notes that:

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"It is important to acknowledge that the issues facing the nursing workforce at a regional level have inevitably impacted the Belfast Trust. The Trust employs approximately 32% of the entire nursing workforce across the entirety of the health and social 11:23
care system in Northern Ireland. Regional nursing shortages, combined with the increased demand for nursing care consequent to the shift from hospital to community care, are examples of the challenges faced by the Belfast Trust in workforce planning." 11:23

You then go on to say:

"Furthermore, the implementation of Delivering Care" - which we have been talking about this morning – "has 11:23
highlighted a significant disparity between actual staffing levels across care settings and those which have been identified for the optimum delivery of safe and effective care."

11:23

You describe a significant disparity but can you tell the Inquiry how bad the disparity is in real terms?

MS. FORREST: I had outlined earlier in relation to the implementation of Delivering Care increased the

ranges -- increased the numbers of staff within a range that we didn't have pre-2014 prior to Delivering Care. I suppose what that refers to is in the wider context of the vacancy position that we found ourselves in associated with not enough nurses being trained, combined with the introduction of Delivering Care in 2014, which meant that our staffing levels for optimum delivery of safe and effective care were higher than what we had pre-2014. That was really what was referred to in that paragraph. 11:24 11:25

Is there anything else that I could --

DR. MAXWELL: You're saying that the vacancy rates are based on establishments that have been drawn from Delivering Care normative staffing ranges? 11:25

MS. FORREST: Yes, that's correct.

DR. MAXWELL: What is the current vacancy rate?

MS. FORREST: The current rate within Belfast Trust overall for nursing and midwifery is 15% vacancy, and we have a 5% vacancy within our Band 5 workforce. 11:25

DR. MAXWELL: Five percent in Band 5; so you a have higher vacancy rate at higher bands?

MS. FORREST: Yes, that's correct.

DR. MAXWELL: Much higher.

MS. FORREST: Yes. 11:25

DR. MAXWELL: What's the vacancy rate at Muckamore, do you know?

MS. FORREST: So, our vacancy rate at Muckamore Abbey is 75%.

DR. MAXWELL: Is that across all bands or do you see the same difference, that it's the senior nurses you're most short of?
MS. FORREST: No, it's predominantly in relation to Band 5 staff in Muckamore Abbey. There have been additional senior staff employed over the last number of years to provide that senior clinical leadership at Band 6 and Band 7. In our profile, we see a higher vacancy level at Band 6 and a higher vacancy level in our non-registrant workforce. However, in Muckamore Abbey we have only 15% of -- or, sorry, we have a 75% vacancy rate within that, across... 11:26 11:26
DR. MAXWELL: Can I just ask, the senior nurses who have been brought into Muckamore Abbey, are they learning disability RNs? 11:27
MS. FORREST: Yes, they are.
DR. MAXWELL: All of the senior nurses have an RNLD qualification?
MS. FORREST: Yes.
DR. MAXWELL: Thank you. 11:27
MR. McEVOY: Chair, I'm consent to pause there. I realise we have been going for an hour and a quarter and we have probably another hour perhaps or three quarters of an hour, but an hour anyway.
CHAIRPERSON: Yes. That 75% deficiency, as it were, is that being made up effectively by agency? 11:27
MS. FORREST: It is.
DR. MAXWELL: 100% or are there still...
MS. FORREST: About 90%.

DR. MAXWELL: So you have a 90% short rate.
MS. FORREST: Yes, we do. Yes.
CHAIRPERSON: We better take a break, I think, you've both been for about an hour and a half now. We'll take a break for 15 minutes. Thank you very much. 11:27

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

MR. McEVOY: Thank you, Chair, thank you, Panel. I would like to look at the question specifically of 11:49
Muckamore Abbey workforce planning. It is a section which starts at paragraph 105, please, on page 41.

In your introduction to this specific aspect then of the statement, you tell us: 11:49

"As is the position with the workforce planning in respect of the ASPC Directorate, there is no one person within the Belfast Trust who can speak to the issue of workforce planning at MAH from 2007" - which is when 11:49
the Trust, I presume, then amalgamated or was created - "to present. The workforce planning requirements in respect of MAH were overseen by senior staff members who are no longer employed by the Trust and the information is limited to that which it was possible to 11:49
address within the timeframe."

So, no one person but I suppose we have the two of you so we will try to do our best, if we can. Specifically

then looking at 107 and 108 just over the page. We're told in 107 that:

"A Muckamore Abbey workforce strategy steering group was established to manage the employed issues related to the Muckamore Abbey resettlement project. The Muckamore Abbey resettlement project was part of the regional community integration programme established to improve the lives of those with learning disabilities by providing a range of services that support personal choice". 11:50 11:50

108. "The Muckamore Abbey resettlement project affected all staff groupings at Muckamore Abbey Hospital. A workforce planning subgroup of the Muckamore Abbey workforce strategy steering group was established to identify the workforce resources." 11:50

How was the workforce at Muckamore affected by the resettlement plan? The reason that question is asked is because there is a curiosity, if I can put it that way, on the part of the Inquiry, an important one, to try to understand how changes to the workforce which may have been affected by the resettlement plan had an effect on persons with learning disabilities. Those in the hospitals, in other words, those patients in the hospital. 11:51 11:51

MS. SHAW: I haven't prepared for that question. That's something I could come back to you on. I wouldn't have the knowledge of how the resettlement

plan affected workforce.

DR. MAXWELL: Can I ask some specific questions about that? We know as patients were resettled, the ward closures and ward mergers, so there were teams from different wards who came together to work on a new ward. Sometimes they were working with a different case mix of patients, patients with different needs to those that they were used to. What sort of education programme or organisational development programme was put in place to, one, establish a new team, because we know merging teams can be difficult and, secondly, to make sure that staff had the skills for this new group of patients that they were working with? 11:52

MS. SHAW: I am not clear of what upskilling staff had whenever they were moved on to a different environment to work. I would have to come back with that information. 11:52

DR. MAXWELL: It would really be interesting to know if there was a skills audit and a recognition that, actually, they were dealing with patients with different needs quite often. Also that other point, the organisational development, maybe your colleague from HR would be able to answer this, but we know bringing two teams together can be difficult. What was done to ensure a new team emerged? Thank you. 11:53

MR. McEVOY: The two of you may not have the personal knowledge to be able to answer this particular point but I suppose what I was driving at previously was to what extent did the workforce planning around the issue 11:53

of resettlement take into account the fact that a reduction or potential reduction in workforce numbers may have an effect on patients? In other words, might learning disability patients - clients, if that word is appropriate or necessary - have been made even more acute, and might their demands have increased if there was a reduction in workforce? Where did that figure -- and do either of you have the personal knowledge to be able to answer that, I guess. 11:54

MS. FORREST: I'm sorry, I wouldn't have that personal knowledge in relation to the plans that were developed in 2015 associated with that. 11:54

MR. McEVOY: Is that because, as you've indicated at the outset or as has been indicated at the outset of this portion of the statement, people who may have the answers to that have since left or have retired? 11:54

MS. FORREST: That's correct.

MR. McEVOY: Then at paragraphs 110 and 111, please, towards the bottom of this particular page and over to the next one, you indicated then that the workforce at Muckamore - I'm just going to summarise - was significantly impacted following the emergence of the allegations of abuse of patients in Muckamore in 2017. Then you indicate the particular impact of that around what that has meant for specific members of staff. 11:54 11:55

At paragraph 111 you say that workforce planning was a core feature of the response to increase suspension and the increased use of agency staff as the stabilisation

of the Muckamore workforce was a key priority in ensuring patient safety. There was, therefore, I think in simple terms, an increased use of agency staff to mitigate the effect of suspensions and so on.

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Has the Trust conducted any research around the question of whether or not the increased use of agency staff might increase the risk of harm or the possibility, on the patient safety implications, more broadly for learning disability patients?

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MS. SHAW: Where we would use agency or temporary staff, there's always a risk to a reduction in quality or safety. We would have been very, very aware of that as our agency use in Muckamore, I suppose, increased due to the impact of the CCTV investigation in Muckamore. So, there was a number of mitigations put in place to avoid that risk or to reduce a risk to patient harm. They included risk assessments, which Ms. Forrest has already touched upon, where you are using any sort of agency or temporary staff. We also then -- you know, the focus was on maintaining services but there was governance arrangements put into place as well. They included safety meetings across the Trust, daily safety huddles on each ward. MDAG was formed; that was the Department and Trust stakeholder meeting that provided assurance to the Department and the CNO. There is the nursing workforce meeting which we discussed earlier, and then the Muckamore governance meetings. There's a Muckamore assurance meeting held

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every three weeks with the Executive Director of Nursing where we discussed any nursing professional issues. So, there was a range of different processes built in to ensure that patient safety was kept at the forefront of our thinking throughout that period. 11:57

MR. McEVOY: Can we conclude from that therefore that there must have been an appreciation or an acknowledgment that the use of agency staff at least posed a risk that had to be managed?

MS. SHAW: Yes. The use of any temporary workforce can increase the risk. 11:58

CHAIRPERSON: Can I ask a very basic question? When you are dealing with an agency and you're going to ask them to supply staff to a place at Muckamore, are you able to specify to the agency we need LD registered nurses? 11:58

MS. FORREST: If I could provide some additional clarity. The use of temporary workforce in any setting increases the risk in relation to that. However, one of the things that we did recognise is that there needs to be a level of continuity and consistency of care for the residents or patients within Muckamore Abbey. As part of the plan, within my remit I managed the nurse bank which links up with the agencies. We worked very closely with a couple of agencies only to secure staff that would provide the temporary workforce cover needed within Muckamore Abbey Hospital. The rationale for that was we wanted to ensure that we had staff who were block-booked, as we refer to it, which means that they 11:58 11:59

would not come and go on a daily basis, so there wouldn't be that turnover of staff associated with that. That would be one of the mitigations that we put in place.

11:59

So, we worked very closely with one agency in particular, and still now we only work with three or four agencies. We work very closely with them, and we have a separate service level agreement with those particular agencies associated with providing staff for 12:00
Muckamore Abbey Hospital.

At that time we were able to secure 50 registered nurses to come and work with -- from that agency, an English agency that came to work in Muckamore Abbey 12:00
Hospital. There is not a huge supply of registered nurses with a learning disability qualification, so therefore the majority of those staff were registered nurses with mental health qualification.

CHAIRPERSON: So mental health, not LD? 12:01

MS. FORREST: Yes, that's correct.

As part of that then, we were able to put in place a local induction and training in respect of the agency workers who were coming from that agency. That was 12:01
overseen by the nursing development leads within the area at that time specific to the skill set that was required that wouldn't be their specialism as such. At present, we meet regularly with that agency and the

management team at Muckamore Abbey Hospital, with my service improvement lead within the nurse bank and with the nurse manager associated with that agency, and we discuss a number of issues in relation to that. Some of those staff have been there for over a year and for prolonged periods of time. At present, we have 78 registered nurses who are block-booked through that particular agency or a couple of agencies, three of which do have a registered nurse learning disability qualification. 12:01 12:02

CHAIRPERSON: Three.

MS. FORREST: Three out of that.

CHAIRPERSON: Is it just nurses or are you also dealing with allied health professionals and other forms of care worker who are not nurses through that agency, or does that agency mainly supply nurses? 12:02

MS. FORREST: No, it just provides nursing staff for us. We have a separate -- as I said, a separate service level agreement with two or three agencies who provide us with staff particularly for Muckamore Abbey. That's outside the regional nursing agency framework for provision of temporary workforce. That agreement has been in place for a couple of years now and is in place until October 2023, at which point we will revisit and relook at. We have a very close working relationship with the nurse manager in relation to sort of key stakeholders involved. 12:02 12:03

CHAIRPERSON: The nurse manager at the agency?

MS. FORREST: At the agency, yes.

DR. MAXWELL: Can I ask, is it just registered nurses or do you use agency healthcare assistants?
MS. FORREST: We do use agency healthcare assistants as well. There wouldn't be a requirement for this particular agency. They would be provided within the agency framework arrangement. However, the same principle would apply, that we would be looking for staff to be block-booked into an area to ensure that there is continuity of care and that the staff who are working there get to know the patients. 12:03
DR. MAXWELL: So, you are having difficulty recruiting healthcare assistants as well?
MS. FORREST: We are indeed, yes.
DR. MAXWELL: When you were talking about the normative staffing arrangements, you were saying there were a number of factors that determined how many you needed. One of those is the way you organise staff or deploy staff or the nursing model. Can you tell us whether care is managed through team nursing, where the sum of the nurses on the ward look after some of the patients, or named nursing, where every patient has a key worker nurse or task allocation. That's my first question. 12:04

My second one is have you had to change the model because you have so many temporary staff? 12:04
MS. FORREST: It would be fair to say that that level of temporary staff is indeed challenging. The first thing that I would say in relation to the model of care that we provide is that the key priority is that the

patient is at the centre of that model. On occasion and depending on some workforce challenges - and I'm talking in general terms, not specifically in relation to Muckamore - we may have to look at allocating appropriate tasks that move away from our philosophy of developing care and a model of care around individuals. I think it has been responsive to the needs of the patients, responsive to the number of staff that we have available. Then, looking at the risk assessments, if those would not be an ideal situation, what mitigation we may need to put in place to assure appropriate levels of person-centred care are provided. 12:05 12:05

DR. MAXWELL: Just a final question from me on this: You said that only three of the 75 agency block-booked staff are learning disability nurses. Does that mean that on some shifts there isn't an RNLD supervising the care of patients? 12:06

MS. FORREST: That's correct. However, that is one of our safety quality indicators that we look at. So, there are a number of learning disability registered substantive nursing staff, and from the agency. That's one of the factors we look at. I would be able to tell you that we have, on 50% of the shifts worked, a registered nurse with a learning disability qualification. 12:06 12:06

DR. MAXWELL: So 50%; that obviously means 50% don't?

MS. FORREST: Yes, that's correct.

DR. MAXWELL: What support do the nurses on the ward have? Do they have access by telephone to

somebody with learning disability expertise?
MS. FORREST: Yes. If I just -- sorry, if you just give me...

As I'd said earlier, that is correct, they do have access. There will be senior staff on site with a learning disability qualification at both -- sorry, if I could just... 12:07
DR. MAXWELL: You can answer it later if you need to have more time to think about that. 12:07

You say you monitor this, this percentage. How far back does that monitoring go? Is that just since 2017, or would you be able to tell us even further back how often there was a shift without an RNLD nurse? 12:08
MS. FORREST: I'm sorry but I can't give you an exact timeframe. Actually, we look at that data as part of our assurance meeting with the Chief Nursing Officer. I could provide the information as to how far that goes back exactly for you. 12:08
DR. MAXWELL: That would be interesting. I understand you can't have everything there.
MR. McEVOY: Ms. Forrest, maybe just before we leave this topic then and picking up on what you just told us about block bookings, can we just have a little bit more detail around that. How long, for example, is the typical block booking, if such a thing exists? 12:08
MS. FORREST: We would be working with the agency to make sure that we would be securing staff for a number

of months and not just a number of weeks. As I have said, we've have some agency staff who have been working in Muckamore Abbey Hospital for a year, 18 months.

MR. McEVOY: That is true of registered nurses and also healthcare assistants; is that correct? 12:09

MS. FORREST: Yes. That would be what our aim would be in relation to not -- in general terms, we could use agency staff who should be used to fill short-term gaps or short-term absence or gaps in rotas. However, the challenges that we have with workforce, we need to have a different approach in relation to providing that continuity of care across all posts within the nursing family, which would be registered nurses and/or nursing assistants. 12:09

MR. McEVOY: Can I ask you then just to move forward in the statement to page 190. It's paragraph 487. We are still on the theme of vacancies and vacancy rates here. This part of the statement discusses the workforce strategy which we talked about before the break this morning, and its purpose. There is then a bit of detail which you touched on, just before we rose for a break, around vacancy rates; Band 5 rates being at around 24 percent as against an average across the Trust of 18. This is reflecting a gradual growth in the vacancy rate of Band 5 which stood at 12% in 2016. Then you indicate that the nursing vacancy rate for RNLDs as at January 2021 was 72%. Before the break I think you had indicated that the vacancy rate at 12:10 12:11

Muckamore itself was 75%.

MS. FORREST: That's correct.

MR. McEVOY: Is that across all posts then, just to confirm?

MS. FORREST: Yes, that is correct. That is the end of March '23 position. 12:11

MR. McEVOY: That vacancy rate in terms of learning disability nurses then would also be felt, presumably, in the community as well?

MS. FORREST: That's correct. 12:11

MR. McEVOY: In terms of the shortfall, then, we have discussed this I think but it's fair to say that that shortfall is being made up with a combination of agency and bank staff?

MS. FORREST: That's correct. 12:12

MR. McEVOY: Turning then to what is said in terms of the reasonable vacancy rate. There's reference at paragraph 489 again to the audit office report. There's discussion around -- just looking at page 191, in the italics. Page 2. 12:12

"The demand placed on the local health care system has been increasing due to a growing population which has been developing more long-term conditions. Although the HSC registered nursing workforce has increased by 8.8% between 2012 and 2019, this has been insufficient to meet the rising demand." 12:12

There has been an increase, according to the audit

office report, of 8.8% in terms of the nursing workforce and yet we have been discussing a shortfall. Can you explain to the Inquiry, just perhaps in fairly simple terms if you can, why that should be so? Looking at that, one sees an increase, whereas we have been discussing vacancy rates everywhere.

MS. FORREST: Some of the things that I've referred to previously in relation to the reduction in undergraduate places, the implementation of Delivering Care and the increase in the nursing workforce has not matched the demand for our services in relation to the population health of our service users within Northern Ireland. So, to meet the needs and demands of our population to deliver this sort of package of healthcare needs, we would need to have increased the nursing workforce levels by not 8.8 percent but rather by 23% to meet the demands of our population.

MR. McEVOY: Thank you.

Then the next issue that is dealt with in your statement is against this backdrop, I guess, that of safe staffing. That starts at paragraph 493 at page 193. The statement at the outset indicates clearly then:

"The issue of turnover and vacancy rates on wards is closely linked to the issue of safe staffing levels. The Belfast Trust recognises safe staffing levels to be critical for patient safety and quality of care."

There are then a number of items that you develop getting that message across to the Inquiry. If I can you to turn, in particular, to paragraph 502, which is at the bottom of 197. One of the items that the 12:15
Inquiry would like to know a bit more about is the use of the SafeCare Live tool within the health roster system. I appreciate this is sort of quite a specialised area perhaps for those following along in the public, but it might be helpful if you explain just 12:15
the background to what SafeCare-Live is and how it works before we develop the discussion a bit further.
MS. FORREST: Okay.
MR. McEVOY: It is 502 on 197, if you have it.
MS. FORREST: As I have indicated before, it is quite a 12:16
complex operation and there are things that can assist us with looking at workforce modelling. I believe that you have been provided with information around the Safer Nursing tool. That looked at patient dependency and acuity a number of metrics and multipliers. That 12:17
was developed by the Telford Group and out of that came SafeCare-Live. That takes into displaced staff and information. It is not just associated with the number of staff, there are a number of indicators within that tool that look at the acuity and dependency of 12:17
patients. That enables us within the organisation to look at the dependency and acuity of patients based on the number -- and then compare that in the triangulation of data to the number of staff that we

have on duty, the skill mix of the staff, and whether we have enough staff on duty with the appropriate skills and expertise to ensure that we are meeting the acuity and dependency needs of the patient in a certain area. 12:18

SafeCare-Live, there are a number of dependency scores and tools associated with this dependency tool that we use as part of the electronic rostering system. When we purchased the tool within Belfast as part of 12:18 the e-rostering system, a pilot was undertaken in four adult inpatient wards within the acute setting associated with medical and surgical areas. It is quite a significant undertaking to roll out this tool, and there is a level of education and development 12:19 required for staff in relation to gathering the information associated with this tool. As I've said, we use this in combination with the Telford, which is what I referred to before as the professional judgment tool associated with the numbers of staff. This, then, 12:19 enables us to look at whether our professional judgment is accurate, and it gives us additional info on acuity and dependency of our patients.

I think it's important for me to give you some level of 12:19 context in relation to this. There are four dependency and acuity tools that are available within this portfolio of SafeCare Live. The acuity of all patients is different, depending on the specialty. Again, this

is where I say about the complexity of workforce planning. There is one SafeCare Live tool that is associated with adult acute inpatient areas and specific dependency and acuity of that. There's another SafeCare Live tool which focuses on acuity and 12:20
dependency of children and young people. There is another acuity and dependency tool, part of SafeCare Live, which focuses on emergency departments. The final one within that portfolio at present is
associated with acuity and dependency of mental health 12:20
inpatient areas.

DR. MAXWELL: But not learning disability?

MS. FORREST: No. I will then go on to provide some information in relation to. There is not an acuity and
dependency tool associated with learning disability 12:21
inpatient settings. The rationale for that is that most care is provided within a community setting. So, the acuity and dependency tool that is referred to in relation to this was... If I take you to - because
I have actually a point of clarity that I'd like to 12:21
make associated with this - as part of the work that was undertaken by the roster team at the time - they conducted a Telford exercise - there are a number of factors that have to be in place to facilitate the
roll-out of this tool. That is, we have to have our 12:22
Telford in place, we need to have good roster management in the initial stages, because this is linked to the health roster.

The roster team did work with the subgroup at this time within Muckamore Abbey and looked at the Telford exercises - that's the professional judgment tool - and reviewed a selection of the rosters in preparation for the implementation of SafeCare Live, which was a wider organisational piece. The purpose of this was to look to see if the acuity and dependency tool for mental health could be adapted and modified to try and meet the needs of looking at acuity and dependency within the learning disability inpatient area because we didn't have a suitable tool to do that. 12:22 12:22

The roster team then carried out a series of workshops. This is the point of clarity I would like to make. They were carried out through March 2018, prior to the implementation of SafeCare Live at Muckamore. However, based on the work that was undertaken, it was felt that they weren't at a point of readiness to roll that out in relation to effective roster management because of the high use of temporary workforce, the roster perform indicators that needed to be worked on. So, there was a significant amount of work that needed to be undertaken associated with good roster management. 12:23 12:23

Equally, as we've said, there's not a SafeCare Live patient dependency and acuity tool that is associated with a learning disability inpatient setting, and so it was felt that it wasn't the appropriate time or we didn't have the appropriate tools to roll out an 12:23

acuity and dependency tool at that point in time.
MR. McEVOY: I suppose long story short, to summarise, it's not in use at Muckamore?
MS. FORREST: No. The SafeCare Live tool is not in use in Muckamore. 12:24
DR. MAXWELL: Can I just ask a question? I understand that Muckamore is the regional hospital for Northern Ireland, and you haven't Northern Ireland comparators, but there are inpatient facilities in the rest of the UK and the Republic of Ireland. Has the Belfast Trust 12:24 ever done any comparison work with inpatient LD settings across the rest of the UK and the Republic of Ireland?
MS. FORREST: I'm sorry, I wouldn't have the information as to whether that was done at that time. 12:25 However, in my role currently, I look at availability of other workforce models and comparators, and I have not been able to, within the literature at present, find a tool that measures patient acuity and dependency in an inpatient setting. That's not to say that that 12:25 might not be available, I have to add, but I suppose for the nature of the patients within Muckamore who are awaiting resettlement, et cetera, I haven't been able to find anything that would be suitable in relation to that. 12:25

However, there are other quality metrics that I referred to before in relation to things that we can measure around the quality of care. There are some

elements of the SafeCare Live mental health tool that could potentially be adapted.

CHAIRPERSON: Could I just ask on a very general note, who do you pick up the phone to when you are looking for that kind of toolkit and you don't want to invent the wheel yourself? Who's there at the NHS that you pick up the phone to and say have you got one of these ready to go? 12:26

MS. FORREST: We have a number of connections throughout the UK that enable us to benchmark. Internally within Northern Ireland, I have -- well, as nurses we have various senior nursing forums that we can look at asking for information if we have a particular query. We can do that and look at that through the chief nursing officers of the four countries, and look at things about how we can benchmark a practice or what is available in different areas. 12:26

CHAIRPERSON: Is there a reasonably good communication system, as it were, if you need to find? 12:27

MS. FORREST: I would say that there was a reasonably good communication system. Many of us in senior positions have worked outside of Northern Ireland and would still have established connections with people in other parts of the UK and wider, if needed. 12:27

CHAIRPERSON: Thank you.

MR. McEVOY: Okay. Thank you.

Perhaps we could look forward then, just on that score,

to 545, if you could look there, which would be on page 213. I guess it is just a question on that theme of trying to make sure that -- going back to that point that has been made very clearly in the statement about ensuring within workforce planning and against all of the other challenges that you face, patient safety and all of those considerations are observed. Then at 545 you give some examples. You say you give some samples that have been taken to stabilise workforce at Muckamore from 2017 forwards. 12:28

You discuss at 546 the use of SITREPS, situation reports or safety reports. These contain information on a number of key care metrics designed to measure and monitor safety. I suppose the general question there is if there's no SafeCare Live or general toolkit at Muckamore, are the SITREPS centrally recorded and tracked? 12:28

MS. SHAW: I'm not sure if they are recorded, no.

MR. McEVOY: I know something, Ms. Shaw, you picked up this morning or mentioned this morning, which is that the safety huddle or safety call is used daily at Muckamore, and that's something that has been in place since October 2019. The safety call is something that takes place at eight o'clock each morning. 12:29

CHAIRPERSON: We're at 547.

MR. McEVOY: 547, I beg your pardon. Thank you. The next paragraph.

"The purpose of the safety call is to provide a forum for the daily staffing in each ward at Muckamore to be reviewed and to allow for issues with staffing to be addressed at the earliest stage."

12:29

Again, is that something that has had to be implemented obviously in light of all of the other challenges, but it is another measure that has had to be implemented because of the absence of a SafeCare Live or similarly adapted tool for the care of patients with learning disabilities?

12:30

MS. FORREST: Can I just make a comment?

MR. McEVOY: Yes, of course.

MS. FORREST: SafeCare Live is only one element of a workforce sort of triangulation in relation to patient dependency and acuity. SafeCare Live would not be the only thing that would be --

12:30

MR. McEVOY: It's not a fix-all or a cure-all in that sense.

MS. FORREST: As we don't have SafeCare Live in all areas implemented within the Belfast Trust with a plan in place to do that, it wouldn't be a comparator, the only comparator in relation to patient safety. It is one element of the workforce modelling that we can use to assist with reviewing the acuity and dependency of our patients.

12:30

12:31

MR. McEVOY: I guess what I'm asking then is if you don't have a SafeCare Live or similar tool at Muckamore, how else then do you ensure the same

standard of triangulation for patients with learning disabilities at Muckamore as you do in any other ward or any other hospital or establishment within the Trust?

MS. SHAW: Your safety huddle would be collating the information present on the ward at that time. They would be looking at, as Paula has spoken about before, the acuity of the patients. The patients in Muckamore, many of them are long-term patients, but they would be, you know, considering maybe any emotional or physical distress that the patient might be in; they might be thinking about the environment on that day; they certainly would be looking at their staffing on that day as well and understanding is there anything that they need to flex or look at differently to support the environment and the patients for that shift, or for the coming shifts over the next couple of days. 12:31 12:31 12:32

They would be, I suppose, triangulating all the quality indicators that they have. They would be looking at things like what meds have been given, is there are any PRN medications have been given, things like that. Just the quality indicators that would be representative of how the ward is managing and functioning on that day and how the patients are. 12:32 12:32

MR. McEVOY: How is that daily data then tracked or recorded in the absence of a toolkit, as it were?

MS. SHAW: All of the quality indicators, anything that presents as a risk on the ward is Datix-ed, and that's

the inbuilt system. Then we would be able to track performance around Datix.

MR. McEVOY: That's the key tool then. That's very helpful. Thank you.

12:33

If I can move on then to paragraph 557, please. If I might, I'd just like to pick up on some reports that you mention or discuss in the statement around nursing assurance. In fairness to you then, I'll give you the context at 557. This is that on 31st May 2019, the 12:33
Chief Nursing Officer wrote to the Belfast Trust's Executive Director of Nursing, Ms. Creaney, and sought assurances regarding patient care and treatment and professional nursing at Muckamore. Then Ms. Creaney duly responded. The letter, indeed, is in the 12:33
exhibits.

Later in 2029, the Belfast Trust commissioned Mr Francis Rice, who is a former Executive Director of Nursing and an interim Chief Executive for the Southern 12:34
Trust as professional nursing adviser for Muckamore. His primary role was to assist in stabilising the nursing workforce at Muckamore. Mr. Rice is a predecessor of Ms. Creaney; is that correct or am I missing something? 12:34

MS. SHAW: He was an Executive Director of Nursing in another Trust.

MR. McEVOY: In another Trust, so a counterpart.

MS. SHAW: Yes.

MR. McEVOY: All right. Thank you.

He commenced his work in September 2019 and then in January '20 produced a report Professional Nursing Assurance At Muckamore. That has become known then in your statement as the 2020 Professional Nursing Assurance Report. There are then, at paragraph 558, a lengthy set of terms of reference. 12:34

If I could just take you to 559 then, you helpfully summarised his conclusions as follows: 12:35

"Mr. Rice found that staff, carers and advocates at Muckamore to be receptive to his work at Muckamore. Mr Rice also ascertained a significant level of commitment to ensure the complex needs of patients were met and that patients received the best care possible in what Mr. Rice considered to be very difficult circumstances". 12:35

He identified a range of issues relating to the workforce, governance and safety leadership and then he drew up an action plan. He identified a range of future challenges. I'm just summarising. But those challenges, you say at paragraph 561, page 220, that the challenges are systemic and regional, and the action plan was implemented and maintained. 12:35

In summary - I haven't opened it in a great deal of

detail - but in summary is there any means or method by which Mr Rice's action plan has been reviewed and considered just to make sure that the recommendations have within followed up?

MS. SHAW: Yes. So, I followed up before coming today with the divisional nurse in Muckamore, and was assured that the action plan had been followed up and completed. 12:36

MR. McEVOY: At the same time then, or around about the same time as Mr. Rice commenced his work in September 2019 - I am at paragraph 562 now - in 2019, Ms. Creaney directed a review of the nursing workforce at Muckamore to enable the development of a nursing staff model for inpatient learning disabilities within the Trust relating to those both at Muckamore and Iveagh. The purpose of the nursing staffing model was to ensure there was safe and effective nursing staffing levels with the appropriate skill and grade mix. That then was a review which was carried out by Ms. Esther Rafferty, divisional nurse and former service manager at Muckamore. 12:36 12:37 12:37

Before I go any further, was there overlap between, let's call it the Rice review and the Rafferty review?

MS. SHAW: Mr. Rice's work was looking at professional assurances. He was looking at the overall, I suppose, picture within Muckamore and how the nursing function was operating within Muckamore, whereas Mrs. Rafferty's piece was looking at the workforce. So, there were two 12:38

different strands. Mr. Rice's work will have touched on the issues around workforce that had come about through the investigation and subsequent suspensions.

MR. McEVOY: Okay. Moving on then to paragraph 567, which is at page 222. A further review of the nursing workforce, which was specific again only to Muckamore, was carried out in 2021/'22 by Ms. Patricia McKinney. Who is Ms. McKinney? 12:38

MS. SHAW: Ms. McKinney had been an interim divisional nurse in Muckamore for about two years, between '21 and '22. 12:39

MR. McEVOY: Since 2019 then, there have been three reviews broadly on the question of nursing at Muckamore. Your evidence has been that the status on Mr. Rice's review is that it has been implemented. In terms of Ms. Rafferty's and then Mrs. McKinney's, what is the position there? 12:39

MS. SHAW: In terms of Ms. Rafferty's, I can't comment.

MR. McEVOY: Is there a reason why you can't comment?

MS. SHAW: I don't know. I don't have the knowledge of what happened with that review. I'm speculating that that was done in the face of the very fast-changing situation in Muckamore Abbey, so it was looking at safe staffing in that area. 12:40

12:40

Ms. McKinney's work then was looking at a proposed model, nursing model, for Muckamore. I know that that was leaning towards a more social care model whereas we operate under a hospital care model. A social care

model would have a different nurse-to-patient ratio. However, that paper remained in draft and was not progressed.

MR. McEVOY: Then just above that, the preceding paragraph, 556, I think you say that: 12:40

"Draft staffing model is not agreed or implemented as the strategic direction of learning disability services has changed to full resettlement model. Staffing model has reduced in line with resettlements and as the 12:41 hospital reduces in bed numbers."

I suppose if that is so, and it does seem to be so, how is the Trust assuring itself and therefore its patients, their loved ones and the public in general, 12:41 that those patients in Muckamore are receiving safe and effective care?

MS. SHAW: That will be through the datasets that we spoke about a short time ago, where we are measuring the quality indicators of care within the Muckamore 12:41 setting. That would be looking at our incident reporting on Datix and doing the triangulation work. Then there has been the introduction of a patient feedback tool as well in Muckamore, where patients are encouraged to provide the feedback to facilitators to 12:42 gather data about how life is for them.

MR. McEVOY: Of course, something the Inquiry has already heard something about and certainly is interested to know about, self-evidently patients at

Muckamore may not be in the best position to be able to get the best value of an interaction with a facilitator given the nature of their particular needs. How do you mitigate that and make adjustments and allowances for that? 12:42

MS. SHAW: The staff who are working in Muckamore, many of them have been there - even the agency staff we're using for a long period of time through the block booking - and many of them have got to know the patients very well. Where patients aren't able to 12:42 participate in that kind of piece of work, either their families would be encouraged to assist with that or the staff who work with them in that kind of therapeutic way. So, you know, they are asked. We use makaton, we use communication boards at Muckamore as well. 12:43 Where a patient uses a different way of communicating, that's facilitated to try to involve them. It is about that patient-centred care approach, putting patients at the centre.

MR. McEVOY: In your answer you haven't mentioned or 12:43 made reference to patient advocates or advocacy service; is there any reason why?

MS. SHAW: I don't have any knowledge of those, sorry.

MS. FORREST: Excuse me, could I make a comment? 12:43

Just in reference to the nursing workforce staffing models. I think that as an organisation, for me the changing staffing models need to reflect the changing nature of the progression of the resettlement of

patients. In relation to the 2019 model, the piece of work that was carried out by Ms. Rafferty, the staffing model was not agreed or implemented because of the change in the strategic direction to a full resettlement plan. 12:44

I think that all of the nursing workforce modelling needs to be reflective of the changing needs and places where our patients within Muckamore are going to be cared for. I suppose it needs to be constantly kept under review, which it is. It needs to be reviewed and updated on a regular basis in line with the changing resettlement associated with the care needs of our patients and service users within Muckamore. 12:44 12:45

Thank you.

MR. McEVOY: Chair, those are the areas I was proposing to cover with Ms. Shaw in conjunction with Ms. Forrest.

CHAIRPERSON: What we could do, because you have quite a way to go with the remaining two witnesses, is take our lunch break there and come back in an hour and start at 1.45. Can I thank you very much. It may be you will be returning in any event but can I thank you very much in the meantime. 12:45 12:45

Ms. Shaw, we'll see you back at 1.45.

THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIRPERSON: What are we moving on to?
MR. McEVOY: Chair, Panel members, you see now that Ms. Shaw has been joined by Carol Chambers. We are now moving on to look at topics 4B, C and H, which are respectively training and recruitment of learning disability nurses, the leadership and education of managers and senior nurses, key performance indicators. Then, the programme at Muckamore for clinical audits, university placement audits, and NIMDTA placement audits. 13:50

Ms. Shaw, Ms. Chambers, hopefully you'll have been able to follow along with proceedings this morning so by now you are, hopefully, a little familiar with how we're proceedings. If you wouldn't mind now when you are answering, just indicate that it is, in fact, you speaking, and of course yourself, Ms. Shaw, just to keep matters in order for our stenographer. 13:50

Ms. Chambers, if I could turn to you first, it might be helpful just if you could indicate for the Inquiry what your current role is. 13:50
MS. CHAMBERS: Okay. I am Carol Chambers. I am the Lead Nurse Practice Education Coordinator for Belfast Trust, which entails that I am the manager of practice education facilitators, whose main responsibility is to maintain and uphold the NMC standards for education. 13:51
MR. McEVOY: Thank you.
DR. MAXWELL: Can I just clarify, is that

preregistration students?
MS. CHAMBERS: Preregistration and post-registration.
DR. MAXWELL: Does that include the education of people who aren't on a formal NMC-recognised course as well?
MS. CHAMBERS: My expertise is on the regulated, the NMC regulated. 13:51
DR. MAXWELL: So it's for any course regulated by the NMC, not any in-house training?
MS. CHAMBERS: No, I'm not the expert in that.
MR. McEVOY: Is there another Trust official or member of management who would have responsibility for the areas that Dr. Maxwell has described to you? 13:51
MS. CHAMBERS: Yes. My colleague, Anne-Marie Ward would be the lead nurse for education, regulation and informatics. 13:52
MR. McEVOY: Okay. Within that role then, what specifically would she have regard for that you don't?
MS. CHAMBERS: Anne-Marie would have oversight into statutory mandatory training; the service level agreement with the clinical education centre as well. That included -- it includes non-registrants as well as our registrants for their mandatory statutory training. 13:52
MR. McEVOY: All right. It's possible then that as we proceed through these questions, the questions may touch on areas that are not strictly within your ambit but within your colleague's. We'll just take it as we can. All right. 13:52

The first matter that I was hoping to discuss with you,

Ms. Chambers and Ms. Shaw, can be found and begins at page 45 of the statement. It is paragraph 114, please. Essentially I just want to summarise, if that's okay, what's discussed here but basically you are setting the scene for some information about training for learning disability nurses in the context of undergraduate programmes. There is really, on this particular matter, just one query which relates to what is stated at paragraph 118 over the page at page 46. 13:53

In the context then of a discussion about available undergraduate nursing places, you tell us that of a total number of such places commissioned annually, there are a set number of places which are available for the RNLD programme in 2019, with a number of undergraduate places for RNLDs available in Queen's University, Belfast, increased from approximately 30 to 50 places. The increase in places on the programme, the RNLD programme, was part of the increase in all commissioned nurse training places at that time. 13:53 13:54

The Inquiry would like to know, Ms. Chambers, or indeed Ms. Shaw, be that as it may in that there was an increase across the board in training places, did the revelations at Muckamore and the subsequent suspensions bear at all on the increase in the number from 30 to 50 places? 13:54

MS. CHAMBERS: I wouldn't be able to answer that as the numbers are dictated by the Department of Health.

MR. McEVOY: Okay.
DR. MAXWELL: Can I just ask, do you know if they were able to fill those places?
MS. CHAMBERS: In 2019, yes, they were. They were able to fill all their places. 13:55
DR. MAXWELL: They took on all 50?
MS. CHAMBERS: Yes, they did.
CHAIRPERSON: Did you not have any discussion with the Department of Health about how many places were needed?
MS. CHAMBERS: I personally don't have those discussions but I understand, again through consultation, that there are increases. As Ms. Forrest had already previously said, the outweighing of the workforce issue needed to be met, and one part with that with the training places as well. 13:55
CHAIRPERSON: Yes, sure. I understand that.
MS. CHAMBERS: That's what the increase was for.
CHAIRPERSON: Thank you.
DR. MAXWELL: Actually, the workforce might be discussed at CNMAC? The Trust's concern about workforce might go through CNMAC to the Chief Nursing Officer? 13:55
MS. SHAW: I haven't attended CNMAC but I would imagine that would be one of their discussion points.
MR. McEVOY: You don't attend that discussion group, Ms. Shaw, as your role. 13:56
MS. SHAW: No, that would be the Director of Nursing.
MR. McEVOY: Your line manager, might she be able to speak to that particular issue?

MS. SHAW: Yes.
MR. McEVOY: Can we then just go forward, please, to page 56 to paragraph 141, please.

The subtopic here is that of post registration training for RNLDs. The statement tells us that education and training for nurses, including RNLDs, does not cease at the point of their successful entry onto the NMC register at initial registration, rather there's a career long continuum of learning for registered nurses. The continuum of post registration learning commences with the period of preceptorship undertaken within the first six months of their employment as a registered nurse. Then it is noted that: 13:56 13:57 13:57

"It takes effect through NMC processes such as supervision and revalidation."

Given the complexity and the mental health acuity of patients remaining at Muckamore, and indeed perhaps the increasing complexity given that there is a reducing number of staff available, permanent staff available to deal with the patients, has the Trust requested any second registration education in mental health to ensure adequate mental health training in your learning disability skill practitioners? 13:57 13:57
MS. CHAMBERS: I'm not aware of that.
MS. SHAW: I understand that the core elements of the RNLDs and RNMH education programme are very similar.

Then the mental health trained registrants who work in Muckamore have additional training are then upskilled and have additional training given to them around autism and other elements of learning disability that might apply. 13:58

MR. McEVOY: Moving then to paragraph 144 at the foot of the page. Ms. Chambers, this is in relation to mandatory and statutory training so, based on what you told us, this may not be within your immediate area of responsibility but if you can at least try to help us with this as far as you can. The Trust's core statutory and mandatory training policy addresses the minimum core mandatory training requirements for all Belfast Trust staff and volunteers. I suppose we can take it from that that everybody, and certainly people at a management level, would be expected to have some familiarity? 13:58 13:59

MS. CHAMBERS: Yes, that's correct.

MR. McEVOY: "Policy applies to all staff" - it should probably read - "except staff engaged through an agency or contractor. It is a framework for the completion and associated provision management monitoring and reporting of provisions relating to the completion of the mandatory training requirements". 13:59 13:59

At 145, ten particular courses are set out. Specifically, in relation to that of adverse incident reporting, is this a course that is a one-off or is it something that is repeated during the lifetime of an

employment or engagement with the Trust?
MS. CHAMBERS: As far as I'm aware, that is a course that should be updated and all members of our staff need to be aware of the most up-to-date methods, tools and resources that should be used. It's something that we need to maintain. 14:00
MR. McEVOY: Do you know how often then adverse incident reporting training is updated?
MS. CHAMBERS: I'm sorry, I'm not sure.
MR. McEVOY: All right. Do you know how long the training is? Again, it's understood that this is not specifically your area of responsibility but if you can help. 14:00
MS. CHAMBERS: I think possibly it is just one day. It's seven and a half hours of training. 14:00
MR. McEVOY: You may have answered already but just to be clear, what levels of staff then have to undertake the adverse incident reporting training?
MS. CHAMBERS: All staff need to be aware of the escalation of concerns. That includes student -- you know, the student nurses that come in to any area. The training will be set at the level in which the roles and responsibilities of that member of staff would be expected to take. 14:01
CHAIRPERSON: Can I just ask, because the paragraph starts referring to the employees of Belfast Trust. Does this include - probably what Mr. McEvoy was just about to ask - does this include agency staff? Do agency staff undertake the same training or not? 14:01

MS. CHAMBERS: It would be my expectation that on entry into any of the clinical areas, the agency staff would be made aware of the mechanisms in place to raise any concerns --

CHAIRPERSON: That's different. Do they have to take the training or not? 14:01

MS. CHAMBERS: I'm sorry, I'm not aware.

CHAIRPERSON: Ms. Shaw, it looks like you're saying no, they don't, or do you not know?

MS. SHAW: No, I don't know. 14:02

MR. McEVOY: Then at 149, at the conclusion of that section, just to close that particular discussion point off. It's on page 59, the top of page 59. Within each service area of the Trust, there is at least one clinical educator or nurse development lead. A 14:02 clinical educator is a registered nurse who is responsible for supporting the training and induction processes for registered nurses and ensuring that the registered nurses within their service area are compliant with the statutory and mandatory training 14:02 requirements.

It is plain that it applies to registered nurses but what about other staff? One thinks particularly of HCAs and so on who may be in the clinical areas and 14:03 environments on a daily irregular basis.

MS. SHAW: The ward manager, the ward sister or charge nurse, would be responsible for overseeing the training matrix for the unregistered staff.

DR. MAXWELL: Can I just ask, the clinical educators, do they spend a lot of time in their assigned clinical area?

MS. CHAMBERS: Yes, they do. The clinical educators would be linked -- or would actually basically reside in that clinical area. 14:03

DR. MAXWELL: Would they work in the clinical area clinically as well?

MS. CHAMBERS: Yes, they would. Yes.

DR. MAXWELL: So they have a good understanding of the culture and the way things are done in that area? 14:03

MS. CHAMBERS: Yes, they do.

MR. McEVOY: Look across then to page 64, and it's paragraph 163. This is where you deal with the issue of revalidation, or the statement deals with the issue of revalidation. 163 tells us: 14:04

"All registered nurses and midwives must go through a process of revalidation to maintain their registration with the NMC." 14:04

Presumably the Trust will have its processes, and that's your responsibility to ensure the Trust that those registered nurses who are employees of the Trust are properly revalidated? 14:04

MS. CHAMBERS: That's correct. That's actually my colleague's responsibility as well within revalidation. But as a registrant, I'm responsible for my own revalidation.

MR. McEVOY: Yes, of course, of course. Agency nurses also have to revalidate?
MS. CHAMBERS: That's correct, yes.
MR. McEVOY: Who then in the Trust checks that they have? 14:05
MS. SHAW: The agency are the employer of the agency staff member, albeit that we subcontract them. So the agency is responsible for, I suppose, ensuring that their staff are maintained on the live register. But it is always the registrant's responsibility to 14:05 maintain their registration.
MR. McEVOY: Yes. So, you are essentially taking it on trust then from the agency that the nursing staff that they are providing to you, the registered nursing staff that they are providing to you, their 14:05 revalidation is up to date?
MS. SHAW: There will be checks and balances in place with the agencies involved. Ms. Forrest talked earlier about the contract, the agency contract. Within that there will be an established way of overseeing that. 14:06 I can't describe that for you but it wouldn't be taken on trust. There would be assurance given that staff are live on the register.
MR. McEVOY: Reference was made this morning to an SLA or a service level agreement? 14:06
MS. SHAW: Yes.
MR. McEVOY: If one looked at that, might one find an answer? Might provision be made in the service level agreement that the agency would be giving an assurance?

MS. SHAW: I haven't had sight of the SLA so I don't know.

DR. MAXWELL: Can I just double-check? You said they're employed by the agency. It is my understanding that they're not employees, that they're self-employed. 14:06

MS. SHAW: The agency manages them so they --

DR. MAXWELL: But not as employees?

MS. SHAW: But not as employees, yes.

MR. McEVOY: Looking across to the topic of supervision, page 67 at paragraph 169. Just by way of 14:07 introduction then on this topic so that everyone is clear about what it is we're talking about:

"Supervision is an important mechanism to support and improve the practice of registered nurses. It is 14:07 described by NIPEC as 'a participative process of supported reflection that enables nurses and midwives to develop personally and professionally to improve the quality, safety and person-centredness of their practice'." 14:07

It is indicated then that supervision formed part of the continuum of what was described earlier of live-long learning and professional development for nurses. 14:07

Could I ask you to turn overleaf then just to page 68 and to paragraph 172 in particular. Then there is a little bit of discussion here about a document that was

published in 2007 by the Chief Nursing Officer entitled Standards for Supervision for Nursing, two regional standards which were set out for the supervision of registered nurses which were subsequently revised. The revised standards are, we can see there, standard 1: 14:08

"Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection." 14:08

Standard 2 then:

"An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care." 14:08

Now, the Inquiry would like to know, if you can help us, about how those standards in practice cover the question of how often supervision should take place. In other words, in practice when these standards are being implemented, how often is supervision undertaken? I appreciate there may not be one straightforward answer to that but if you can help us as best you can, please, that would be appreciated. 14:09

MS. CHAMBERS: That standard, that organisational framework suggests that a minimum of two occasions per 14:09

year of supervision. We, as registrants, had that standard to uphold. We then feed back on the supervision of our teams and of ourselves for that. As you say, that's the straight answer. The rest, you know -- but that's not to say if an occurrence happened, positive or negative, that we would encourage our staff and we encourage each other to talk, to discuss, to provide support for each other at any stage. Then it can be recorded and documented as supervision. So, you could go for two -- have two sessions per year or you could have one session or month, depending on the situation and the environment in which are you working. 14:10 14:10

MR. McEVOY: If it was put to you - and I'm not putting it to you - but if it was put to you that short-staffing might create a pressure around the delivery of supervision and the observance of it, what might you say? 14:10

MS. CHAMBERS: I would say whilst acknowledging, yes, the short-staffing, but it is a requirement and it is a standard in which we in the Belfast Trust would uphold and do, as I say, ask for those records. Again, it is reminding if people are challenged, if ward managers are challenged to give time, it is finding out the different mechanisms and resources that are in place. If a group can't sit down for a period of time, then can one person sit down with another person for a period of time and be recognised as supervision and a valuable conversation had? Because ultimately, again, 14:11 14:11

we're going back to this is about our patient safety, to ensure that our staff are able to express what is happening, to be able to express how they feel, and in order to be able to move forward and be supported. That's the element of supervision, to feel supported and guided by another peer. 14:12

MR. McEVOY: Is there any way of tracking at a central level, at a management level such as your own, where supervision has not taken place; instances maybe where it has fallen down? In other words, where maybe there are establishments where you are not seeing the observance of it that you might expect to see? 14:12

MS. SHAW: We are required to complete our supervision outcomes quarterly and that captures then how many of our supervisees or registrants who work within our teams have received either their first or their second supervision. That is collated centrally. There's an annual report that goes for assurance to the Executive Director of Nursing. Where it is seen that performance around supervision has dropped, the Executive Director of Nursing would be seeking understanding as to why that was the case, and would be expected to have a very clear action plan provided as to how the directorate is taking that forward to improve those standards. 14:12 14:13

I suppose it would be expected that, you know, a very clear rationale would be given where performance had dropped. 14:13

DR. MAXWELL: Is it possible to track the compliance

that you refer to in paragraph 174 by Muckamore Abbey? If the Inquiry was interested, would you be able to provide the compliance on a monthly basis for Muckamore Abbey rather than the aggregated performance of the whole Trust in the annual report? 14:14

MS. SHAW: Yes. Each divisional nurse or manager who is responsible for teams beneath them has to provide the number of supervisions that they have carried out with their staff, so that would be available for Muckamore as well. 14:14

DR. MAXWELL: You could break it down to, Muckamore because the divisional nurse would have other areas?

MS. SHAW: Yes.

DR. MAXWELL: If we were interested, we could get that data? 14:14

MS. SHAW: Yes.

DR. MAXWELL: When did that monitoring start, do you know?

MS. SHAW: I'm not sure when it started. The annual report goes in April to the Executive Director of Nursing. I don't know how far back it goes. 14:14

MR. McEVOY: Certainly we have within the exhibits an annual report for '16/'17. We needn't open it but there's reference to the provision of that material in the context of the annual report. Presumably it goes back at least as far as '16/'17. 14:15

DR. MAXWELL: I'm wondering if it goes back to 2007 because that's when the standards were created by the Chief Nursing Officer.

MR. McEVOY: In specific reference to what Dr. Maxwell has raised with you there, you note in your final bullet point, point 174, that monthly supervision compliance data is presented and discussed during the monthly senior nursing and midwifery team meetings. So, that is available then. 14:15

Turning then to page 71 and paragraph 180. Just by way of introduction then, what we're moving on to look at here are specific additional training issues which the Inquiry has raised with you and drawn your attention to. You have listed then the specific matters that the Inquiry asked you to set out in the statement. 14:15

Specifically, the Inquiry would like to look at, for present purposes, restraint, which is discussed on page 73 at paragraph 186. If you can turn overleaf to that, please. 186. 14:16

The topic of restraint training was one of those matters the Inquiry asked you to tell us about. In the statement you tell us that you have interpreted this, in other words the term "restraint", as a reference to safety intervention training or SI training, previously known as management of actual and potential aggression, or MAPA training. 14:16 14:16

"SI training is focused on the prevention of crisis situations and teaches staff de-escalation skills, as

well as best practice and nonrestrictive interventions."

There's some details about the specifics of the course. The Inquiry would like to know when MAPA was replaced by SI, and if you are able to help us then, the extent to which it differs. 14:17

MS. SHAW: MAPA, the terminology MAPA was replaced by safety intervention training in the last 18 months. I'm not clear really what date, but in the last 18 months. The difference between them is the safety intervention training has a much more focus on positive behaviour and deescalation rather than MAPA, which was about, I suppose, different holds and things like that and would have been understood more about that. Safety intervention and positive behaviour training is much more focused on deescalation, seeking to find alternative ways to work with the individual, to maybe get them to interact with something else to take their focus away, and help them to manage their distress behaviour. 14:17 14:18 14:18

MR. McEVOY: It is more than just a change, I think you said of terminology. It is not just a rebilling, it is substantially different?

MS. SHAW: Yes. 14:18

MR. McEVOY: At 187 then, we're told that it is mandatory for any individual providing direct care at Muckamore, including registered nurses, doctors, nursing assistants, social workers and allied health

professionals. It's also mandatory for mental health and learning disability nurses employed by the Trust more widely.

What is the position around agency staff and the provision of that training for agency? 14:19

MS. SHAW: Agency staff working in Muckamore Abbey Hospital receive this training whenever they come to us. They will receive some of their training through the agency, but the upskilling around the positive behaviour training and safety intervention and all of that work will be done with the agency staff before they would start working on the wards. 14:19

MR. McEVOY: So the Inquiry can be clear then agency staff are given SI training before they are admitted onto a clinical area? 14:19

MS. SHAW: Absolutely. Yes.

DR. MAXWELL: What happened before the change? I understand you now have these block contracts for the agencies, but presumably in the past there has been spot use of agency staff because of an unexpected absence. How would you direct the management of distressed behaviours? 14:20

MS. SHAW: Traditionally in Muckamore, the staff tended to cover a lot of the gaps in the rotas themselves. It was a very tight team, if you like, that came from the same area, and they would have covered a lot of those shifts themselves, so they would have already had the training. 14:20

In respect of agency staff who were booked ad hoc, I don't know the answer to what happened with them.

MR. McEVOY: There's mention then at 188 of seclusion training, which is the next paragraph. The use of seclusion is an emergency intervention and it is only used as a last resort when all other strategies to manage risk to self and/or others have been unsuccessful. 14:20

What's the current position around the use of seclusion at Muckamore, or do you know? 14:21

MS. SHAW: Any episode of seclusion would be recordable on Datix. The last episode of seclusion that happened was April '22, and there hasn't by any seclusion happened since that. Seclusion would be considered as an emergency intervention and only where the risk of using a prolonged restrictive hold outweighs the patient safety. But, as I say, it is a practice that hasn't been applied since April '22. 14:21

MR. McEVOY: There are still patients with substantial needs and also exhibiting challenging behaviours, and they have those needs and exhibit those behaviours as much today as they might have done prior to the decision to no longer use seclusion. What is happening where circumstances may require resort to some sort of approach to achieve an outcome which preserves the safety of the patient and staff alike? 14:22

MS. SHAW: We're possibly seeing the outworkings of the

positive behaviour strategy with patients where staff are now seeking to find a distraction for the patient, seeking to deescalate the behaviour, remove them from the situation, rather than moving straight into maybe a restraint or a seclusion. You know, there's been work done with the staff as well around their own resilience and training, and possibly that, you know, it's the outworkings of all of those things that we are seeing.

MR. McEVOY: All right. 14:23

Turning then to medication, which is the next paragraph overleaf on 74, medication training. In respect of use of medication and side effects of medication, nurses, including RNLDs, receive training on this area during their undergraduate training programmes. All registered nurses are required to complete training on the administration of medications during their professional nursing induction. 14:23

What is the guidance that is given to registered nurses in relation to, for example, the use of what the Inquiry terms or has heard termed PRN sedation, including rapid tranquilisation, and so on? 14:23

MS. SHAW: The patients who reside in Muckamore, who are in Muckamore currently, a lot of their medications would be the same, they haven't changed. But the PRN medication would be used, as you've said there, for rapid tranquilisation, if required. I don't know what the status of that is, when that was last used. That 14:24

would be one of our quality indicators now, that is something that we measure. It is always recorded on Datix, and that would be one of our data sets that we use to triangulate quality of care in Muckamore.

DR. MAXWELL: Would that include PRN oral Diazepam? Say if somebody had PRN oral Diazepam, you'd expect them to complete a Datix form? 14:24

MS. SHAW: Yes. If it is outside of their normal meds, then a PRN would be recorded.

DR. MAXWELL: So any PRN would be a Datix? That doesn't apply to PRN drugs in the rest of the Trust, I presume? 14:25

MS. SHAW: No. No.

DR. MAXWELL: So this is a special measure post particular concerns that Muckamore... 14:25

Was there any guidance before these emergency measures for registered nurses about when to use PRN and what to consider?

MS. SHAW: Not that I am aware of. 14:25

MR. McEVOY: Then if you can look at training and communication strategies for persons with learning disabilities.

At 191 then, training for RNLDs on communication tragedies for persons with learning disability is provided at an undergraduate level. Communications with individuals with an intellectual disability is a core part of the SI training package. SI training 14:25

includes modules on verbal, paraverbal and nonverbal communication.

I suppose, without being critical, one could read that and say there's not an awful lot of detail there. May I give you an opportunity, if you want to, just to add a bit to it because reference to what is provided in terminates of the SI package seems to be it. Is there anything over and above that package, that SI package, which is of substance in terms of communication strategies for persons with learning disabilities? 14:26 14:26

In ease of your position, Ms. Shaw, this morning I think you made reference to the use of makaton and talking mats at Muckamore, how those rolled out and the use of such techniques and so on. How is that rolled out in terms of training at Muckamore? 14:27

MS. SHAW: I don't have that information, I'm sorry.

MR. McEVOY: Could we look at, perhaps, paragraph 196, which is on page 76. The topic here under "Discussion" is training in positive behavioural support in respect of learning disability, autism, and challenging behaviour. That's developing, I suppose, Ms. Shaw, what you said about a refocusing on the positive approach in terms of dealing with patients with learning disabilities and their needs. 14:27 14:28

The statement tells us that from 2015 in particular, there was an increased focus on raising the profile of

positive behaviour support including training in this area. Then you go on to detail specific training in a number of forms in quite some detail. These are set out at A through to G. The Inquiry would like to know about what is said at E on page 78, and in particular the provision by psychological services of a one-day positive behaviour support training course at Muckamore. 14:28

The statement tells us that the training was delivered on two occasions. Attendance was poor due to staffing constraints. In May or June of 2021 the one-day training was repackaged as a half-day training course and offered to staff across the site at Muckamore. However, the same staffing constraints resulted in poor attendance. 14:29 14:29

I suppose on any rational analysis, a course provided on positive behaviour support by psychological services is going to be something of importance for everybody working in the clinical areas at Muckamore. We can see there that there is recognition there was poor attendances. I mean, the premise of what I would like to ask you is poor attendance at training as a result of staff constraints can be a vicious circle. Staff less trained may lead to less positive outcomes, both for patients and of course then for staff, and that leads then to staff not wanting to come to work. Do you know whether the Trust put strategies in place to 14:29 14:30

deal with those sorts of poor attendance?
CHAIRPERSON: I think, first of all, do you accept that premise?
MR. McEVOY: Well, do you accept the premise? I mean, I saw a nod which is why I... I saw a nod. There was no violent disagreement anyway but there was a nod. 14:30
MS. SHAW: There is an acknowledgment that staff pressures across wards can make it very difficult for staff to be released to attend training. The Trust have worked very hard to find innovative ways to provide training to staff and, you know, getting the upskilling happening, because it is so important that our staff are trained and are skilled and are using evidence-based practice. 14:31
MR. McEVOY: Yes. 14:31
MS. SHAW: A lot of our modules have been put on to e-learning and different things like that we can do. I see then in paragraph F, the positive behaviour support training has been included as part of mandatory SI training, so that has allowed there to be a culture of positive behaviour training within Muckamore. That will grow as staff come in and undergo the mandatory safety intervention. 14:31

With regard to the one-day positive support training, I can't comment on how staff -- it wouldn't have been that it was seen as unimportant. It will have been to do with the capacity issue on that day. 14:32
MR. McEVOY: I suppose the concern could be that there

is an expectation and a mandatory requirement that everybody does their SI training, and you don't, effectively, to put not a too fine point on it, cross the door unless you have done it. But psychological services and what they may be able to add in terms of positive behaviour support may be another dimension or another layer of understanding which could be provided to staff. 14:32

You presumably would want to maybe comment on whether or not everything that flows from the introduction of a positive behaviour support approach flows from SI training. Is there not more to it than that? Without minimising, do you just leave it all to the SI training to get the positive behaviour support message across? "Philosophy" perhaps is a better word than "message". 14:32 14:33

MS. SHAW: I don't know what other ways Muckamore have tried to achieve that positive support other than it being part of the mandated safety intervention training. 14:33

MR. McEVOY: Thank you.

Can we then turn to just the question of recruitment of learning disability nurses, which you take up at paragraph 198 and 199 in particular. You tell us something of the mechanics in terms of recruitment. Recruitment by the Trust is managed by the regional recruitment and selection shared service centre, which was established as a unit within the Business Services 14:33

Organisation. The RSSC manages the recruitment process from the initial advertisement stage through to the final offer made to a successful applicant.

The Inquiry has heard some comment about that recruitment process and it being slow and adding to delays in recruitment. What has been your experience? 14:34

MS. SHAW: Personally my experience, on a personal opinion I find the service quite slow.

MR. McEVOY: What does that mean for the tasks that you have to deliver within your roles and responsibilities? 14:34

MS. SHAW: Well, it can mean there's a delay to recruitment. When you are trying to fill vacancies, the timeline around it can be quite long and that can have an attrition rate. So, when you go to fill, that person maybe has gone to another post. 14:35

CHAIRPERSON: When you say "quite long", are we talking weeks, months?

MS. SHAW: Six months. Months. 14:35

MR. McEVOY: How many months, sorry?

MS. SHAW: Up to six months.

MR. McEVOY: Have you noticed any variability with regard to whether or not that can be towards the six-month end if it's a learning disability nurse, for example? 14:35

MS. SHAW: No.

MR. McEVOY: It that sort of the experience across the board then of that kind of delay?

MS. SHAW: Yes.
MR. McEVOY: Turning then to page 81, which is still on the question of recruitment. After paragraph 202 then, reference is made to a longstanding shortage of RNLDs at Muckamore. 14:36

"Shortage of RNLDs nurses could perhaps in part be attributed to the fact that RNLDs are attracted to posts offering both similar and higher hands to work in other areas (such as Accident & Emergency Departments 14:36 that could conceivably be considered less challenging than Muckamore)."

Just pausing there - one sees it in your statement - is that a perception among the nursing profession broadly 14:36 within te Belfast Trust, that A&E is a preferable option to Muckamore?
MS. SHAW: Since the Inquiry into Muckamore began, I suppose there has been a reluctance to take up posts in Muckamore just given some of the challenges. For our 14:37 younger nursing workforce, A&E can be seen as being more attractive because it can be seen as being more exciting and things like that. A&E does tend to attract newly qualified registrants as well, and they're getting a range of experiences when they work 14:37 in A&E, so it could be one of the reasons why they opt to go there as well.
CHAIRPERSON: When you refer to the inquiry, are you referring to this inquiry or the PSNI inquiry?

MS. SHAW: The investigation. The investigation, the CCTV investigation.
MR. McEVOY: So you are getting that difficulty to the revelations, as it were, coming out?
MS. SHAW: Yes. 14:37
DR. MAXWELL: The longstanding shortage occurred before the revelations?
MS. SHAW: Yeah. There has been challenges around the workforce at Muckamore for a long time. They have been acknowledged in a number of reports. In 1995 there had 14:38 been an announcement that Muckamore would close, and that didn't help either. That didn't give people who might have gone to work in Muckamore a sense of stability, so they may have opted to go to other places of work. 14:38
DR. MAXWELL: We have heard from some of the families who gave evidence that there were some changes around and up to 2012, particularly when the new blocks opened that were perceived as more clinical. Did Belfast Trust notice any particular point in time when these 14:38 vacancies became more pronounced?
MS. SHAW: I don't know that. I haven't reflected on that for today so I don't have a response to that.
DR. MAXWELL: The vacancy rates by year would be available? 14:39
MS. SHAW: Yes.
DR. MAXWELL: So they could be plotted to see if there was a trend and when it started?
MS. SHAW: Yes.

MR. McEVOY: I suppose, just picking up on that sort of historical, in other words post revelations, if I can put it that way, situation, turning to page 82 overleaf, just 207. In 2014 and 2015, in response to a shortage of RNLDs in Muckamore, the Belfast Trust 14:39
invited applications for temporary nursing posts. I appreciate it may be sort of another corporate memory question which you may or may not be able to help us with, but do you know why those posts were advertised as temporary in 2014/'15? The reason why I'm asking 14:40
you about that is some of the patient experience evidence that the Inquiry heard suggested that that was viewed negatively by staff.
MS. SHAW: I can't comment on that. I'm just wondering, that was around the same time as the 14:40
workforce review for ASPC, and that review was being modeled on the resettlement proposals. They may have been temporary because of the plans to resettle. But that's surmising.
MR. McEVOY: Thank you. 14:40

At the bottom of the page then - sorry, I'm at 209 - in 2019, the Department of Health authorised a pay uplift of 15% for registered nurses working at Muckamore as a measure to assist the stabilisation of the workforce at 14:41
Muckamore. The uplift remained in place until 2020. It was reintroduced in July 2022 due to the critical nursing levels at Muckamore and is due to remain in place until March of this year.

I suspect maybe we have our answer to this but how effective was the pay uplift in increasing recruitment for nurses, and was a similar uplift applied to HCAs?

MS. SHAW: With regard to the HCAs, I don't know the answer to that. The pay lift that was provided in 2019 was provided to attract registrants to come and work in Muckamore given the ongoing Turnstone Investigation. We were working with our other Trusts across the region to try to attract from their services. It was a sweetener, I suppose, to try to get people to come to work in Muckamore. In 2019 it wasn't successful; we didn't see that it helped at all to do that. 14:41 14:42

When it was offered again in the last run, we can evidence that we did see an improvement in our workforce numbers. In fact, there are some staff who have been asked to return to their substantive posts in other Trusts who are reluctant to go because of the 15% that they are currently availing of. So, we know that that has had -- has helped with our workforce. 14:42 14:43

DR. MAXWELL: If this was removed in March this year, does that mean those nurses then got a pay cut?

MS. SHAW: Effectively, yes. I understand that it is currently being reviewed with the Department about the continuance of it. 14:43

MR. McEVOY: Does a 15% uplift provide any competition with the kinds of rate that an agency might offer?

MS. SHAW: I don't know the answer to that. Sorry.

MR. McEVOY: At 210 then, just closing this particular topic, you say:

"Notwithstanding the various initiatives, including those overseen by the Department of Health, the Belfast Trust continues to encounter difficulty in recruiting RNLDs."

I suppose, reading that sentence in isolation, one might be forgiven for sensing a certain weariness on the part of the Belfast Trust. That might be unfair, you may disagree, please say so if you do. Are there any other strategies under consideration or in train to address the recruitment difficulty around RNLDs? 14:44

MS. SHAW: I don't believe that there is a weariness in the Belfast Trust around the importance of recruiting RNLDs to our learning disability services. There have been a number of recruitment fairs and at those fairs we do have representation from learning disability as we future plan for the services. The posts we would be looking at would be ones that would straddle both Muckamore and then a move, a transition into community-provided care. So, those are all things that we are considering all the time. 14:44 14:45

DR. MAXWELL: There are various schemes in other branches of nursing where people are offered a formal career pathway, so if you can work with us, we'll rotate you around certain wards, we'll guarantee that we'll pay for you to do a Masters course and then you 14:45

will be upgraded to a Band 6 when you've completed that. Has Belfast Trust considered any those sort of schemes for learning disability?

MS. SHAW: I'm going to open that to my colleague who will tell you about our Open University. 14:46

MS. CHAMBERS: Yes, I just wanted to include in that I think it's an important point to offer that we have never closed Muckamore to learning disability student nurses. We have been able to provide placement for them across all the years, thus being able to share our 14:46 learning experiences within Muckamore. That is one strategy, you know, to try to recruit.

But also then we have the Open University. We work very closely with the Open University in their 14:46 programme which provides preregistration nursing programme for our substantive staff who are healthcare assistants. It is over in the last two years they have introduced a pathway for learning disability. Currently we have learning disability students from our 14:47 own staff.

DR. MAXWELL: But my question was about a post registration career pathway and access to Masters programmes and higher endings. It has worked very effectively in children's nursing, for example, which 14:47 for a long time had shortages.

MS. CHAMBERS: Absolutely. We had the specialist practice learning disability programme in Ulster University. There are Masters programmes available

both in Ulster and Queen's University. That's not guaranteed --

DR. MAXWELL: That was my point.

MS. CHAMBERS: They are not guaranteed places.

DR. MAXWELL: There are ways of encouraging people more than just giving them more money today. 14:47

MS. CHAMBERS: Yes.

DR. MAXWELL: But you haven't thought of a pathway that guarantees them a career pathway.

MS. CHAMBERS: That would be something that we would be certainly working on. A very definite pathway is that of the advanced nurse practitioner. 14:48

DR. MAXWELL: But it hasn't been in place at Muckamore to date?

MS. SHAW: No. We just recruited into the 8A for the trainee advanced nurse practitioner. 14:48

CHAIRPERSON: Because across the Trust, you've actually got a very broad spectrum of experience that you can offer, of which Muckamore could be part. That's not at the moment been part of the programme, as it were? 14:48

MS. SHAW: Not that I'm aware of, no.

CHAIRPERSON: No. Thank you.

MR. McEVOY: I want to move on now and look at topic C, which is just, in fact, the next line down, which is leadership education for managers of wards and senior nurses/key performance indicators. 14:48

Picking up just at 212 then. You point out that the Inquiry has asked to be addressed on leadership

education for managers of wards and senior nurses. The manager of a ward is known as a ward sister or charge nurse. There are several roles which are considered as senior nursing roles, such as nurse development lead or divisional nurse. 14:49

"It would not be possible for me to address each role which could be considered as a senior nursing role within this statement, and therefore I have focused my present evidence on the leadership education for a ward 14:49 sister or charge nurse."

Is that to say that there's no accepted definition of what a senior nursing role or senior nurse is, or is that just that there are so many that you have focused 14:49 on two particular types?

MS. SHAW: I suppose there's different types of senior nurse, yeah.

MR. McEVOY: Okay.

14:50

In terms of leadership development programmes, those are something that would be made available to nurses in senior nursing roles, and certainly the two you have identified, would that be fair to say? So, to ward nurses charge nurses? 14:50

MS. CHAMBERS: Yes, we certainly would -- we present learning opportunities to all our staff, but for leadership we would look from the Band 6, Band 7 level for that focus on leadership and management.

MR. McEVOY: Would records show us how many Band 6s and 7s at Muckamore attended or availed of leadership development programmes in the period of the terms of reference and certainly since the Belfast Trust was created? 14:51

MS. CHAMBERS: Yes. We would have the records from once they started. I took over the programme, so the records were certainly evident.

MR. McEVOY: From your own experience, and I guess this is perhaps asking you off the top of your head to an extent, but do you know whether there would be a culture of Band 6s and 7s at Muckamore availing of such opportunities? 14:51

MS. CHAMBERS: Yes, they were certainly made available to all of those. I am almost sure that we have had attendance from our Muckamore colleagues. 14:51

MR. McEVOY: Looking down then to paragraph 214, which is page 84. The role of a ward sister or a charge nurse is set out in a document published by NIPEC in 2011 as part of the regional ward manager project, that being a projected commissioned by the Chief Nursing Officer to support and strengthen the role of ward sisters and charge nurses in Northern Ireland, and you have exhibited that to the statement. In broad terms, the main duties and responsibilities of a ward sister, you tell us, involve leading on a hospital ward in the following key areas: Ensuring safe and effective practice, enhancing the patient client experience, providing effective leadership and management, and 14:52 14:52

contributing to the delivery of the organisation's objectives.

Would there have been a ward sister or charge nurse in every ward at all times in Muckamore? 14:53

MS. SHAW: In Muckamore, there is the ward sister and then they would have junior ward sisters underneath to maybe Band 7 and then Band 6. They would always be from Band 6 up in charge of the ward. So, across night duty and things like that, you would have a junior ward 14:53 sister in charge.

DR. MAXWELL: Is that in charge of every ward or just one for the site?

MS. SHAW: No, in charge of the ward.

DR. MAXWELL: So there's always a Band 6 on every ward? 14:53

MS. SHAW: Yes.

MR. McEVOY: Can I ask you then just to look forward, it should be page 88 and paragraph 224. In this paragraph then, you discuss the introduction of a framework known as the -- is it the SIAF framework, 14:54 which is Support Improvement Accountability Framework for ward sisters, charge nurses and community nurses. It came into the picture in 2011 and its purpose was to clearly set out the range of activities to be undertaken by the ward sister, charge nurse and 14:54 community nurse, and link effective nursing leadership at ward/community level and Trust objectives. It evidences the contribution that these nursing leaders make to patient and staff experience and outcomes of

care through a self-assessment process across a range of indicators. That framework was implemented until approximately 2016.

Is there a reason why it was dis-implemented and is not implemented now, if that is the case? 14:55

MS. SHAW: This was almost like an accreditation system that ran. I don't know why it was to stood down in 2016; that was prior to me joining the Belfast Trust. I don't know how effective it was. Self-assessment processes aren't independent, so maybe that was the reason. 14:55

MR. McEVOY: You don't know for sure?

MS. SHAW: Don't know for sure.

DR. MAXWELL: Was it replaced by another ward accreditation scheme? 14:55

MS. SHAW: No.

DR. MAXWELL: So there's no ward accreditation scheme in the Trust?

MS. SHAW: No. We have our quality indicators so they would be how we would measure performance. 14:55

DR. MAXWELL: But not an accreditation scheme?

MS. SHAW: No.

MR. McEVOY: You then went on to deal with key performance indicators, which you describe as - paragraph 225 now: 14:55

"A quantifiable measure that can be used to evaluate the success of an organisation, team or employee in

meeting objectives for performance over time. The Belfast Trust is committed to using meaningful data to inform and measure improvement."

Are there any specific KPIs for learning disability and for learning disability nurses in particular? 14:56

MS. SHAW: So in preparation for coming today, I had conversations with the last divisional nurse for Muckamore. The KPIs that we follow in the acute services would be for falls, tissue viability, venous thrombosis, omitted meds, early warning scores and MUST, which is the Malnutrition Universal Screening Tool. In Muckamore, they don't report against all of those indicators. They would look at falls and they would look at omitted meds, and then seclusion and PRN medication. They would be locally set quality indicators that they have that they work to. That would be because the others wouldn't necessarily be applicable to their service. 14:56 14:57

DR. MAXWELL: Are you saying they didn't do the MUST score? Because we know that malnutrition can be a significant problem for people with learning disabilities, yet they are not using the malnutrition Universal Screening Tool? 14:57

MS. SHAW: The MUST wasn't one that was mentioned to me but I would have to check that for you and make sure that that was the case. 14:57

MR. McEVOY: Would you be surprised to note that it may not be being used, if that was the case? Would you

expect it to be being used at Muckamore?
MS. SHAW: Yes. It would be a tool that would be useful in learning disability.
MR. McEVOY: Can we go forward then to page 160. Here you're taking up, as asked by the Inquiry, the question of a programme at Muckamore for clinical audits, which you have defined as a quality improvement - this is at 399: 14:58

"A quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit standards. Relevant Belfast Trust policies relating to clinical audits, together with relevant healthcare quality improvement partnership guidance documents, were addressed as part of the Belfast Trust's response to Module 3." 14:58 14:59

At 400 you tell us you're not personally aware of any fixed programme of clinical audits at Muckamore. They're not routine; that seems clear. Where they are undertaken, what's the mechanism for them being initiated? Who initiates them? 14:59
MS. SHAW: Who carries them out?
MR. McEVOY: Yes.
MS. SHAW: They would be carried out by staff in Muckamore. 14:59
MR. McEVOY: Okay. Who would trigger it? Who would say this has to be carried out? Who would give that instruction or direction?

MS. SHAW: It would depend on what it was they were looking at but it would be the collective leadership team who would, through maybe governance meetings and things, where they might identify. There might be a theme and they want to drill down a little bit more and seek some more understanding. That's then where an audit might be asked for. 15:00

MR. McEVOY: At 400 then we can see that you have had some conversations with Ms. Hughes, who is currently in a senior position at Muckamore, as I understand it. She has been in that position since March 2022 and her knowledge is limited therefore to clinical audits carried out from March 2022. What about for the period the Inquiry is examining under its terms of reference? Is there any way that the Inquiry could be provided with information on any audits prior to Ms. Hughes coming into role? 15:00 15:01

MS. SHAW: I would have to check that and come back to you on that. I do know that there was an seclusion audit carried out, and that was done monthly and a monthly report then sent in. So, that was the only one that I am aware of. 15:01

MR. McEVOY: Okay. We might be able to look at that actually because it's in the exhibits. There's an example, I think. This is quiet far down, 10351 in the exhibits. 10351, please. Take a moment or two. Here is a seclusion audit for September 2019. As far as the Inquiry can see, it's the only example that has been provided in the statement or in the bundle of exhibits 15:01

with the statement.

Maybe zoom out a little bit so we can see a bit more of the page anyway. Would you expect there to be one of these for every month then? 15:02

MS. SHAW: Yes. I understood it was monthly.

MR. McEVOY: Okay.

Moving over to just a couple of pages down, in fact, at 10355. We have there as a lone page within the 15:02 exhibits; there doesn't seem to be anything behind it. Do you know what that might be? It is a report? It is obviously described as a seclusion report but is that something that might have been provided as an audit?

MS. SHAW: I understood there was a monthly audit and 15:03 report provided for seclusion.

CHAIRPERSON: I think the question is where's the report.

MR. McEVOY: Yes.

MS. SHAW: I'll have to come back to you on that. 15:03 I wouldn't be able to tell you that.

MR. McEVOY: Okay.

If I can just go back to page 160, please. If you just go down to 400. We've discussed in my previous 15:03 questions a few moments ago the question whether or not there may be previously conducted audits such as that example we have just looked at. Is there a Trust policy on retaining audit data on reports?

MS. SHAW: I don't know that there is.
MR. McEVOY: Now, can we just look down then to paragraph 403 on 161. This is a discussion around a thing that we have already talked about this afternoon, which is that of seclusion, but here you are seeking to 15:04
explain the seclusion database at Muckamore. This is described as a live spreadsheet setting out the details of each use of seclusion within Muckamore, including the name of the patient placed in seclusion, the duration of the period of seclusion, the start and 15:05
finish time, the reason for the use of seclusion, and the place of seclusion. The information on the Muckamore seclusion database is derived from daily ward reports. I suppose could we start maybe by dealing with the question of a daily ward report. What is a 15:05
daily ward report?
MS. SHAW: A ward report would be the number of patients that you have. I haven't worked in learning disabilities but in the ward reports that I have in my practice used, it's the number of admissions you have, 15:05
the number of discharges you have, the movement within the ward at the time. So that would be where you would then capture, presumably, when a seclusion took place.
MR. McEVOY: Then you mention in the following sentence that the ward reports are monitored by a medical 15:06
records librarian at Muckamore who inputs the relevant information into the seclusion database. Presumably - and that's in the present tense - that information could be pulled down and provided to the Inquiry on

request?
MS. SHAW: Presumably.
DR. MAXWELL: Can I ask about these daily ward reports? You and I probably remember the days when we handwrote them at the end of a late shift, but presumably now all that data is on the electronic patient registration system. Is the librarian pulling it from, perhaps, the patient administration system, or is somebody on the ward writing a report and giving it to the librarian? 15:06
MS. SHAW: I don't know what the process is in Muckamore for doing that and whether or not it is something that still occurs today. 15:06
DR. MAXWELL: So we're not entirely clear what the ward report is, daily ward report is?
MS. SHAW: We can find out if it was digital or handwritten. 15:07
DR. MAXWELL: I suppose secondly, if it is digital, how does it extract seclusion? Because presumably seclusion was recorded in the patient record, or are we reliant on somebody to put it in manually, which could lead to errors? 15:07
MS. SHAW: Yes.
MR. McEVOY: Turning over the page then to 404, 162. The findings of a seclusion audit are set out in the seclusion report. This is what we had looked at then in the exhibits. You go on in the paragraph then to say: 15:07

"It is important to acknowledge that seclusion audits

are only carried out for the months during which a period of seclusion is recorded".

You then say that seclusion has not been used at Muckamore since August 2022, I think, earlier you said April. 15:08

MS. SHAW: Can I make a correction to the note there, please. Yeah.

MR. McEVOY: Therefore, the most recent seclusion audit at Muckamore was that for the month of 2022. 15:08

Now, we have looked at a definition of seclusion and all of the various ways in which it is managed, looked at, and indeed recorded. Maybe you can't help us with this, but is there any other practice? I asked you the question about what other approaches are being used and your answer, in fairness to you, was that perhaps the roll-out of positive behavioural support strategies maybe had a reducing effected on a need to resort to seclusion. Again just picking up on that theme, can it be said - I'm not asking you to speculate - that the effect of that could actually have reduced the need for seclusions to nil as and from last August? Are you able to say that? 15:08 15:08

MS. SHAW: I could possibly say it possibly contributed to it but I wouldn't be able to say that that was the overall reason that it stopped. 15:09

MR. McEVOY: I know we have looked at this previously but the issue raises its head again here. If a patient

is going through a particularly bad time and is exhibiting particularly challenging behaviours and is in considerable distress, do you know whether the staff at Muckamore are using any other approach other than seclusion, any other specialist approach? 15:09

MS. SHAW: Yes, they use distraction. I can give you an example of a case. So, there is a patient in Muckamore who the staff saw them displaying distressed behaviours. Using the data that we've talked about earlier today, they were able to establish that his 15:10 behaviours appear to always happen on a Monday, and that was the day after he returned from his weekend visit. So, they understood then he was distressed on the Monday because his visit was over and he had to wait for the following week to happen before -- so, on 15:10 the Monday they were able to build a schedule with him to doing things that he enjoyed to do or that he wanted to participate in and things like that. Then they saw, you know, a drop in his distressed behaviours on that day. 15:10

It would be those type of interventions with the patient at the centre that staff would be trying to use to make it a much more meaningful intervention for the patient. 15:10

DR. MAXWELL: Can I ask if there was a similar drop in the rates of restraint, and is that zero now?

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

CHAIRPERSON: I'm just thinking about timing because the two witnesses have now been at the witness table for an hour and 20 minutes, which is a reasonably long time, especially when you are being asked questions by at least three different people. How much more do you think you have on this section? 15:11

MR. McEVOY: I have one further matter to ask Ms. Chambers in combination with Ms. Shaw, and that will conclude Ms. Chambers' contribution.

CHAIRPERSON: Ms. Chambers, are you all right to keep going? 15:11

MS. CHAMBERS: Yes. Thank you.

MR. McEVOY: There is one further matter and then there will be a natural break, as it were.

15:11

That actually appears at paragraph 407 then, Ms. Chambers and Ms. Shaw, which is where the statement discusses the establishment in September 2009 of the Mental Health and Learning Disability Audit Lead Committee, being a committee chaired by the senior manager for service improvement, modernisation and governance, involving various staff members from the MHLD service group, an audit manager, and a carer or user representative. It met approximately six times a year until 2017. Then you describe its functions: Reviewing audit priorities; approving audits for the service group; to facilitate staff undertaking audit and assist with the application process; to ensure staff undertaking audits are working within the 15:12 15:12

application process, and to encourage multidisciplinary audit within the service group.

It seems to have been in place between September '09 and approximately 2017. Can we take it that it is no longer meeting or is no longer in existence? 15:13

MS. SHAW: I don't know about that committee, I'm sorry.

MR. McEVOY: Okay. It is mentioned, obviously, in your statement, hence my question. Do you know then what has replaced it? Is there anything in its stead? 15:13

MS. SHAW: I don't believe that that committee meets any more.

DR. MAXWELL: Just one question. You said earlier, when I asked you that the clinical educators know the areas they are assigned to very well, they know the culture. If they had concerns about an area, who would they report them to? 15:13

MS. CHAMBERS: They would report them to their divisional nurse through their line management. 15:13

DR. MAXWELL: And if they weren't satisfied with the response?

MS. CHAMBERS: Then there is a process of raising them. Central nursing are very available and visible to all our colleagues. If they felt that they were -- they can come to any of the... 15:14

DR. MAXWELL: Is that an informal process?

MS. CHAMBERS: If they wished to make it formal, then we would go through that process. They can certainly

come and talk to us for us to provide support and guidance.

DR. MAXWELL: Did any of the clinical indicators ever raise any concerns about Muckamore?

MS. CHAMBERS: Not to me, certainly, during this time. 15:14

DR. MAXWELL: Thank you.

CHAIRPERSON: All right. We'll take a break. Thank you very much, Ms. Chambers.

Ms. Shaw, how are you feeling? It is a long day for you. What I would like to do if we can is about another hour, but we'll stop at 4.30. But if in the break you have any concern about that or don't feel you can do yourself justice, will you just let counsel know? 15:14 15:15

MS. SHAW: I will.

CHAIRPERSON: Because we have tomorrow morning.

MR. McEVOY: Yes.

CHAIRPERSON: Thank you. Preliminary, I'll say quarter past. 15:15

THE INQUIRY WAS THEN ADJOURNED TO 10:00 A.M. ON THURSDAY, 1ST JUNE 2023