MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 29TH MAY 2024 - DAY 85

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THE INQUIRY RESUMED ON WEDNESDAY, 29TH MAY 2024 AS FOLLOWS:

CHAIRPERSON: Thank you. Right. So our first witness is Professor Adair. 09:54

MS. BRIGGS: Yes, Chair.

CHAIRPERSON: Just before she is called, can I just say a couple of words about the second statement of Andrea Sutcliffe.

CHAIRPERSON: CPs and others who are interested will know that that second statement was posted on the Inquiry website and provided to all CPs, I think it was last Friday, 17th May. Yesterday, it was removed at about I think 10:30, shortly after the Inquiry was alerted to an issue in relation to the exhibit which was the transcript of a court hearing. 09:54

Just so that everybody is aware, the statement itself has now been republished for anybody who wants to look at it, but the exhibit itself has been removed and we're exploring whether that can be republished or not and, if it is, whether it's subject to redaction. But it seemed to me that the rest of the statement was, as it were, inoffensive, it's quite useful, and so that is now available again. So I just thought people should be alerted to that, because it's only happened this morning. 09:54 09:55

All right. Shall we get the witness in?

MS. BRIGGS: Yes, Chair. It's Professor Pauline Adair. She has provided two statements, Panel, references 232 and 239.

PROFESSOR PAULINE ADAIR, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS: 09:55

CHAIRPERSON: Professor Adair, can I just welcome you to the Inquiry.

A. Thank you. 09:56

CHAIRPERSON: Thank you very much for your statement and thank you for coming along to assist us. I'll hand you over to Ms. Briggs.

A. You're welcome.

1 Q. MS. BRIGGS: Thank you, Chair. Professor Adair you have made two statements for the Inquiry, they're dated 17th April 2024 and 25th April 2024. We can bring the first of those up on the screen, and you have copies of both of them in front of you, Professor Adair. I want to firstly ask are you content to adopt the contents of those two statements as your evidence to the Inquiry today? 09:56 09:56

A. Yes, I am.

2 Q. In terms of your role then, your position within Queen's is that you're the Interim Head of the School of Psychology, isn't that right? 09:57

A. Yes, that's right.

3 Q. Okay. And you've been involved in, you say in your statement, education in the field of psychology in

Scotland and Northern Ireland, isn't that right?

A. Yes. Yes.

4 Q. Okay. And your background yourself is in psychology?

A. Yes. Yes. That's correct.

5 Q. The Inquiry has already heard evidence about the courses in psychology that are offered by Queen's. Okay. Mr. Alistair Finlay has already told the Inquiry about that. And isn't it right to say that Queen's provide a postgraduate course and that's a Doctorate in Clinical Psychology? 09:57

A. Yes, that's correct.

6 Q. And that's a three year course, isn't that right?

A. Three year. Three year doctorate, yes.

7 Q. And it's that course that your evidence is focused upon? 09:57

A. Yes. Yes.

8 Q. Okay. For your first statement then, Professor Adair, you were asked about the number of clinical psychology trainees graduating from the doctorate course, and you gave numbers from the 2002, and I think we can show up on the screen? It's at paragraph 9, page 5 of that statement. Oh, I'm sorry, it's page -- sorry, at page 2 through to page 3, that's my mistake. So at the bottom of page 2, then paragraph 6, we can see the first number of graduates from the doctorate in clinical psychology is 8, and over the page we can see the numbers then from 2003 right through. Okay. And you reference then, if we go on -- we show those numbers on the screen. If we go on to paragraph 9 then 09:58 09:58

at page 5, you comment at paragraph 9 that there are fewer clinical psychologists trained each year in Northern Ireland compared to the rest of the UK?

A. Yeah.

9 Q. Okay. Have there been any conversations that you're aware of about increasing the number of clinical psychologists within Northern Ireland? 09:59

A. Yes. So since 2019 we've seen a gradual increase in the training numbers going from -- so prior to 2019 it was about 11, and then it went to 15, 19 in 2020, and we are currently at 21 since 2021, and are continuing with 21 at the moment. So that, that was really reflective of a national increase in training numbers in clinical psychology across the UK, and Northern Ireland followed suit. 09:59

10 Q. Okay. So there's been an increase across the UK in the number of graduates?

A. Yeah.

11 Q. But is it right to say that the number in Northern Ireland is still comparatively low? 10:00

A. Yes, it's low. Per hundred thousand of population we are the lowest in the UK.

12 Q. Okay. Can you say why that might be?

A. Mm-hmm, yeah, it's an interesting one. I mean clearly a lot of training is to do with funding, so funding constraints may be an issue. There certainly has been a strong argument, given the waiting lists in Northern Ireland for psychological help as well as vacancies that we have across the Trusts for clinical 10:00

psychologists, and those arguments have been put forward. But, yeah, I suspect it's funding constraints and priorities.

13 Q. Okay. And have there been any conversations about trying to bring Northern Ireland comparatively back on a level with the other jurisdictions in the United Kingdom? 10:01

A. Yeah, this is something we talk about frequently. So we meet with the Department of Health twice a year for a consultation meeting, and that's Department of Health, Business Services Organisation, who are our HR business partner, the heads of psychology services, and representatives from the School of Psychology and the training programme, and we do discuss this, but I think at the end of the day it comes down to availability of funds. There is certainly a willingness to increase the numbers and a recognition that the training numbers should be increased but, yep -- and the numbers have doubled in the last sort of four or five years. 10:01 10:01

14 Q. Okay. The Inquiry has heard some evidence from Donna Fitzsimons yesterday, and she provided a statement where she talked about the Education Commissioning Group, do they take a role with trainee psychologists or is that just in relation to nursing? 10:01

A. Certainly not with our trainees. We would have our own, we would have our own governance processes within the School of Psychology around the education of clinical psychologists, and also because of accreditation. So we are regulated by the Health and 10:02

Care Professions Council and by the British Psychological Society, so we would have regular cycles of accreditation meetings.

15 Q. Thank you very much, Professor Adair. We'll go on through your statement. If we go back to where we were, that was the bottom of the table on page 3. So at question 2 then, you were asked about how many of those graduates from the doctorate in clinical psychology go on to work in learning disability posts, and you give the answer to that at the bottom there of that page for 2002, and then over the page again you give figures from 2003 onwards, and the numbers we can see there are really noughts, ones, and twos. 10:02 10:02

A. Yes.

16 Q. So fairly low in comparison to the numbers that are graduating from the course. 10:03

A. Yeah.

17 Q. Can you explain why that might be?

A. Okay. So our training programme is, it's a very generic curriculum. So we train our trainees to work across different specialties, and they are adult mental health, neuropsychology, learning disability, child and family, Looked After Children Services, and other specialist areas such as clinical health Psychology, Occupational Health Psychology. So jobs tend to get advertised across these wide range of areas. And also because of the number of vacancies, trainees have quite a lot of choice about what posts they go for. So that's perhaps one explanation. 10:03 10:03

I came to the programme in 2017, and at that point, although it's not reflected in the numbers I have to say, but at that point very few of our trainees undertook learning disability placements, but we have now changed that, based on advice from one of our heads of psychology services, and now all of our trainees undertake a placement in Learning Disability Services. Although, as I say, it's not reflected necessarily in the numbers of trainees taking up posts. 10:04

18 Q. Okay. And other than providing a placement within learning disability setting, are there any other incentives for trainees to go into learning disability posts or to learn about what that might involve, for example? 10:04

A. Not that I am aware of. I mean there are some incentives that have been developed really just in the last year or two for some posts for trainees, and they're called preceptorships. So they go in at a certain level and then after two years they're able to move to the next level. 10:05

19 Q. Okay.

A. And that's agreed at the beginning. They don't have to compete for, you know, another post at a higher level.

20 Q. Okay. 10:05

A. But I'm not aware of that being offered in learning disability. It may be, but I don't know for sure.

21 Q. Okay. And is there any type of workforce forecasting to inform how many clinical psychologists we might need

within Northern Ireland?

A. I am not involved in this, but I am aware that there is workforce planning in mental health ongoing at the Department of Health at the moment, but I'm not involved in it, so I don't have the details around that. 10:05

22 Q. Okay. Thank you, Professor Adair. And you're asked later on in your statement about trainees going then to work in Muckamore?

A. Yes. 10:06

23 Q. And you say that you're not able to provide that type of information. Did Muckamore or the Belfast Trust have any conversations with you or anyone within Queen's about the need for more psychologists there in Muckamore? 10:06

A. No, not that I can recall. There certainly hasn't been a conversation. There has been general conversations around our trainees going into Learning Disability Services generally, and that includes both community and inpatient, which is why we then increased the trainee experience, because it was felt that if trainees don't get that experience in learning disability then they're less likely to apply for posts in that area, that was the rationale. But not specifically to do with Muckamore. 10:06 10:06

24 Q. Okay. Okay. You answer questions in your first statement then, the statement that we have on the screen, about whether you became aware of any concerns at Muckamore. All right.

A. Mhm-mhm.

25 Q. And your answer is at paragraph 10, page 5.

A. Yes.

26 Q. You say there:

10:07

"One of our trainees who was on placement in Muckamore raised a concern in November 2017 through an e-mail to the programme (I can provide the e-mail exchanges if necessary) as the trainee felt that due to staff suspensions at the time that staff morale was low, and they perceived the wards to be understaffed. The trainee was requesting a move to another placement." 10:07

And you go on to say how that was resolved.

Firstly, you've provided those e-mail exchanges and they're exhibited to your second statement, okay, and I don't propose that we show those on the screen because everyone has those, all right, and they're on the Inquiry's website. But we can see there from paragraph 10 in particular that the trainee felt that due to the staff suspensions that staff morale was low and they felt that wards were understaffed, was that particular trainee concerned that staff suspensions were impeding the availability to provide good care within Muckamore? 10:07

A. I don't have any evidence to support that. I mean I had a look at the placement forms that the trainee had completed for that placement and there isn't anything there that would raise concerns. Some of the concerns were around the severity of the conditions that the 10:08

trainee was dealing with, and their confidence to do, you know, to do that, although they were working under supervision of an experienced clinical psychologist, but there was nothing specific around anything they saw that was inappropriate or of concern. 10:08

27 Q. Okay. And you've referenced there, looking back at the notes from the placement, would you be able to provide those to the Inquiry if the Inquiry requested those?

A. Yes, absolutely. Absolutely.

28 Q. Okay. All right. Did any other trainee psychologist raise any concern about Muckamore to the best of your knowledge? 10:09

A. No.

29 Q. All right. What about in terms of the opportunities that were involved at Muckamore for learning, was there anything raised about that at all at any point? 10:09

A. No, the detail in the placement form demonstrated that the trainee had good opportunity to learn. I think there was a slow start to the placement for that particular trainee because of illness, but as the placement continued, and after the concern raised by the trainee we did ask the supervisor for some community experience for the trainee to give them a broader perspective of the field, and that was provided. 10:09 10:09

30 Q. All right. That's all the questions that I have for you, Professor Adair. The Panel may have some questions arising. All right?

CHAIRPERSON: No. That was a short appearance. So can

I thank you very much for coming along to assist the Panel. Thank you.

A. You're very welcome. Thank you.

MS. BRIGGS: Panel, that concludes Module 2 of the organisational modules. Next is Module 3, which Mr. McEvoy is dealing with. 10:10

CHAIRPERSON: Okay. Well we'll take a very short break. The witness is here?

MS. BRIGGS: I'm told that the next witness is here, Chair. 10:10

CHAIRPERSON: Right. Well, we'll take a short break to allow Mr. McEvoy to get himself ready and then we'll continue. Thank you.

SHORT ADJOURNMENT 10:10

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Right. That was a bit longer than I intended, but are we now ready? 10:37

MR. McEVOY: We are.

CHAIRPERSON: We are. Okay. And everybody has been alerted as to why we're dealing with two different witnesses instead of Andrea Sutcliffe. 10:37

INTRODUCTION TO ORGANISATIONAL MODULE 3

MR. McEVOY: Chair, members of the Panel, today in this session we are commencing Organisational Module 3 dealing with professional regulations, and just to set some context it may be helpful if I explain the purpose of this module.

CHAIRPERSON: Yes, please.

MR. McEVOY: Which is to examine the role and effectiveness of bodies and organisations with responsibility for regulating the two principal healthcare professions operating within Muckamore Hospital, namely; the Nursing and Midwifery Council and General Medical Council. 10:37 10:38

This module is of particular relevance to paragraphs 10 to 12 of the Inquiry's Terms of Reference which require the Inquiry, so far as is relevant for this module, to firstly examine the adequacy of methods available to communicate concerns, including allegations of abuse by staff, patients, relatives and others about the treatment of patients at Muckamore. Secondly, to examine the response to such concerns by those with responsibility for professional oversight. And, thirdly then, to examine the operation of all supervisory and regulatory agencies to determine whether and, if so, why there were failures in the early identification, investigation and resolution of issues raised about the treatment of patients. 10:38 10:38 10:38

In setting this module up, the Panel requested statements from three individuals for the purpose of this module. Those were initially from Una Lane on behalf of the General Medical Council, and then both Lesley Maslen and Sam Foster on behalf of the Nursing and Midwifery Council. The format of each of those requests was to seek responses in witness statement form to a series of specific questions set by the Inquiry. 10:39

Now, firstly, as regards the General Medical Council, it was agreed that Mr. Charles Massey would be best placed to address the statement request, and the Inquiry was content to permit that course. Mr. Massey has produced a statement to the Inquiry dated 8th March 2024, and it is available on the Inquiry website at reference 210. It totals 24 pages. 10:39

The Panel has confirmed it does not wish to call Mr. Massey at this stage to give oral evidence, but it has directed that he be asked to deal with a number of supplementary matters by way of follow up, and the Inquiry team is in the process of engaging with Mr. Massey and the General Medical Council about those matters. 10:40

In those circumstances, rather than deal with his evidence piecemeal, it's proposed to return to

Mr. Massey's evidence and thus the evidential contribution on behalf of the General Medical Council to this module when that picture is complete.

CHAIRPERSON: And I think in relation to that, we'll have to see who is the best person placed to deal with the additional questions, because it may be, of course, it is not Mr. Massey. 10:40

MR. McEVOY: That's correct, sir. Turning to the Nursing and Midwifery Council, or NMC, I have indicated that the Inquiry initially requested statements from two witnesses, namely Sam Foster, who is the Executive Director for Professional Practice within that organisation, and Lesley Maslen, who is the Executive Director of Professional Regulation. 10:41

It was agreed subsequently that the Chief Executive of that organisation, who is Andrea Sutcliffe, would be in a position to address all issues on behalf of the NMC in a statement and in oral evidence, and Ms. Sutcliffe then provided a statement dated 20th March of this year and a supplementary statement dated the 9th of May to the Inquiry. Chair, you dealt with the latter of those statements earlier this morning. 10:41

Ms. Sutcliffe is, however, unable to attend to give evidence due to unforeseen circumstances and, therefore, we have reverted to the original position where Ms. Maslen and Ms. Foster have helpfully attended the Inquiry today to address matters arising from the 10:41

two statements provided by Ms. Sutcliffe in oral evidence.

The plan is that this morning Ms. Maslen will cover the sections relevant to regulation, which are paragraphs 5 to 12 and 101 to 160 of the first Sutcliffe statement, and then if necessary the supplementary statement, and then this afternoon Ms. Foster will cover the sections on standards and education, those other remaining paragraphs, in other words 13 to 100. 10:42

CHAIRPERSON: Right. Thank you very much.

MR. McEVOY: In those circumstances I propose to call Ms. Maslen then.

CHAIRPERSON: Yes. Thank you. 10:43

MS. LESLEY MASLEN, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

CHAIRPERSON: Ms. Maslen, can I just welcome you to the Inquiry, and normally I thank people for making a statement, but we have it in the name of Sutcliffe. I see also you've got a lot of files with you. I hope you don't need to refer to them because the relevant documents will be put up and exhibited on the screen. 10:43 10:44

A. Yes.

CHAIRPERSON: But if they give you comfort to have them there, or if you feel you need to refer to them then obviously please do.

A. Lovely.

CHAIRPERSON: Mr. McEvoy.

MR. McEVOY: Thank you, Chair. Ms. Maslen, thank you for attending. In front of you, hopefully, are the two statements produced to the Inquiry by Ms. Sutcliffe. The first of those is dated 20th March 2024, and the second is 9th May 2024. Hopefully before you came in you will have heard me explain to the Inquiry that an indication has been given by the NMC that you're able to speak to paragraphs 1 to 12 and 101 onwards of the first statement, and the whole of the second statement, if necessary? 10:44 10:44

A. That's correct.

31 Q. You're content then to follow that course?

A. Yes, I am. Yes. 10:44

32 Q. Well, I suppose, before we get into the substance of this statement, it might help, it might assist everyone if I could invite you just to give a brief outline of your current position within NMC and any relevant previous roles and qualifications to that post? 10:45

A. Okay. So, I am employed at the NMC currently as Exec Director of Professional Regulation. That means that I look after our fitness to practise operations and our maintenance of the Nursing Midwifery Register.

33 Q. Okay. 10:45

A. Previous to my employment here, my most relevant employment was the job that I had before I joined the NMC, and I was the lead Ombudsman Director of Casework at the Financial Ombudsman Service.

34 Q. All right. Okay. So you have a regulatory background then rather than a nursing one, would that be a fair way of putting it?

A. That's correct, yes.

35 Q. Okay. Turning then to the substance of your statement. If I can take you just to the first section, which begins at paragraph 2 -- page 2 and it's paragraph 5. Sorry. This is just dealing with the, in general terms, the role of the NMC, and you describe the NMC as the regulatory body for nursing and midwifery professionals in the UK, and you set out then a statutory basis for the organisation under the Nursing and Midwifery Order 2001, and that you hold a register of some 808,000 more nurses and midwives in the UK, and nursing associates in England, and then you set out what your statutory obligations and powers are within that order. 10:45 10:46 10:46

You say that the order sets out that your principal functions are to establish standards of education, training, conduct and performance for nurses, and midwives and nursing associates, and to ensure the maintenance of those standards, and that rules made under the order regulate the performance of those functions. 10:46 10:46

In general terms can you help us to understand how the NMC protects the public and assures them that the standards of education have been translated into

competence and skills and practice?

A. Could you just repeat the question?

36 Q. Yep. How does the NMC protect the public and how does it assure them that standards of education have been translated into competence and skills and practice? 10:47

CHAIRPERSON: Can I just say this, if at any stage you think a question is more suited to be answered by the witness who is going to follow you, you just let us know.

A. Yeah. Yeah, I will do. I will do. So the standards of education, they're translated into the kind of working practices of the professionals on our Register through the use of the Code. So the Code sets out the expectations, the professional expectations, and the standards, behaviours and competence that we expect of Registrants that are on our Register. 10:47 10:48

In terms of, you know, how do we kind of manage the conduct? The first question that you asked is around we can take, we can take anybody that is said to be not performing against the Code, they can be referred to into our fitness to practise operation. 10:48

37 Q. Okay. And you've indicated, indeed, at the start of paragraph 8 that your overarching objective is the protection of the public, and in the footnote that anchors that in Article 3 of the order. How is that conveyed to the public, would you say, from your role as a regulator? How do you assure the public that protection, that their protection is being guaranteed, 10:48

as it were?

A. So, we obviously have a -- we maintain a register of professionals, they're required to revalidate every three years, and Sam will touch on more of that this afternoon. 10:49

38 Q. Yes.

A. If we get, if we get reports, then there are all sorts of ways that people can access our organisation. There the particular professional isn't observing the Code, we can undertake to review them under our fitness to practise legislation. 10:49

39 Q. Okay. And we can turn to that then, and if you go then to page 19, and it's paragraph 101, which really commences the part of the statement that is within your remit. You describe the fitness to practise process in the following way by way of introduction really: 10:49

"When a concern is raised about the conduct, health or competence of a professional on our Register, we investigate through our fitness to practise process. We take regulatory action, where needed, to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained." 10:49

10:50

As you know, or as hopefully you know, this Inquiry has at its focus patients with learning disabilities. In a hospital such as Muckamore Abbey, how would you inform patients with learning disabilities and their families

and loved ones of how to raise concerns about nurses through the fitness to practise process?

A. So the key mechanism would be information on our website.

40 Q. Yes. 10:50

A. It's also within the Code and the Standards of Education. So there are three places. I appreciate that's very difficult for people with learning difficulties.

41 Q. Yes. Yes. I think you've possibly anticipated where I might have been going. In terms of availability of information on the website, that's the key gateway for concern raising? 10:50

A. It is.

42 Q. Are there any others? 10:51

A. There are. We have regulation advisers. So we have a regulation adviser for Northern Ireland that works with the Trust.

43 Q. Yep.

A. So she has networks into senior professionals within the Trust. So concerns can be raised to a regulation adviser. We also have a phone number for members of the public, they can call us if they wish to express concerns, raise referral, aren't sure whether it was a referral or not. So it can also be done that way. 10:51 10:51

44 Q. Do you, in terms of the use of the website as the main gateway, would the organisation ever sort of regularly equality screen for accessibility and those types of issues, the use of a website could potentially, you

might disagree with this, and please say if you do, but the use of or reliance on the use of a website could present an impediment for persons with learning disabilities, older people potentially who aren't maybe typically as au fait with the website and technology generally, and persons maybe who are at a social and economic disadvantage, digital poverty and the like.

A. Yes.

45 Q. Are those considerations ever weighed in the balance? 10:52

A. I think they are, because we do have a phone line where people can phone. We don't force them down an on-line route at all, and we will transcribe the concerns ourselves and document them in that way.

46 Q. And am I correct in understanding that a concern must be eventually reduced to writing? 10:52

A. It must be in writing, but it can be in writing by our teams.

47 Q. So that will close that circle then?

A. Yeah.

48 Q. All right. That's helpful. 10:53

DR. MAXWELL: Can I just ask do you have an easy read part of the website, so that people with learning disabilities, often organisations would produce an easy read version?

A. I don't know the answer to that question. 10:53

DR. MAXWELL: Okay.

A. I'm sorry.

49 Q. MR. McEVOY: One to think about perhaps?

A. Yes, definitely!

50 Q. And moving on then to the screening stage, which you've helpfully set out, and when I say "you", I mean the corporate you of course. The screening stage is described at paragraph 104 and following, and this is described as the first stage in the fitness to practise process, and:

"If we receive a concern about a nurse, or midwife, or nursing associate's conduct..." 10:53

- and to be clear, nursing associate is just in England, is that right?

A. Yes, that's right.

51 Q. So for present purposes in Northern Ireland it would be a nurse or midwife: 10:54

"...about their conduct or practice, our screening team completes an initial assessment of their referral, including an assessment of risk based on the information referred." 10:54

And then there's consideration and assessment about whether it may be necessary to seek an interim order. Does that screening process consider previous concerns about a Registrant or just the current concern? 10:54

A. It will look at previous concerns.

52 Q. Okay. And does it consider the number of concerns arising from that particular location? In other words, if there is, for the want of a better term, if there's

a hotspot of concerns arising, is that something that the screening process would identify or flag in some way?

A. So that, that would be identified through our regulatory intelligence unit, which sits in our strategy and insight team. So where we do identify trends like that, there are two different committees within the organisation that will look at where we see a pattern. Quite often it's really difficult with our data to see any patterns, and typically where there is a regulatory issue we see a lag factor, so the referrals come later down the process as opposed to earlier. I think our ability to provide early warning signals is somewhat limited. 10:54 10:55

DR. MAXWELL: Can I just ask about, you said that any previous concerns about a Registrant would be considered with the current referral, but some of the referrals get screened out and don't go forward to the fitness to practise process. So are you saying that if I was a Registrant and a referral had been made and it had been screened out as not having substance, that would still be on my record and would come up if I was referred in the future? 10:55 10:55

A. Yeah, we would still see that.

CHAIRPERSON: So the screeners get a sort of full history, do they? 10:56

A. Yeah.

CHAIRPERSON: But then once it gets to a Panel they don't? Or do they?

A. It would probably be incorporated in some of the investigation if it was relevant.

DR. MAXWELL: Who would make the decision about whether it was relevant?

A. It would be, I think -- do you know what, I'm really not sure. 10:56

CHAIRPERSON: If you're not sure we'd much rather you came back to us and answered questions, you know, in writing.

A. Yeah. Yeah. Okay, yeah. Yeah. 10:56

CHAIRPERSON: So please...

A. Okay.

CHAIRPERSON: The other thing I was going -- sorry, Dr. Maxwell. The only other thing I was going to say is this; I know that you now have introduced a new interim orders guidance or procedure, could you just let us know, when you answer any questions, if there's a distinction, as far as you know, between the old procedure and the new? 10:56

A. Yep. 10:57

CHAIRPERSON: Sorry, Dr. Maxwell.

DR. MAXWELL: And you talked about the Intelligence Unit looking at hotspots. Would the screeners have that information? So if the Intelligence Committee had identified there had been an increase in referrals from Northern Ireland, would the screeners know that? 10:57

A. Probably not.

DR. MAXWELL: Thank you.

53 Q. MR. McEVOY: You might be able to clarify paragraph 105

for us, which talks about the three questions then at the screening stage. Step 1, where you have a written concern about a nurse on the Register. Step 2, where there's evidence of a serious concern that could need us to take regulatory action to protect the public. And then Step 3, where there's clear evidence to show that the nurse, midwife, or nursing associate is currently fit to practise. Is that -- is there a typo perhaps there? Should that say perhaps "unfit to practice" or is that correct? 10:57 10:58

A. No, it actually is correct. It is fit to practise, yes.

54 Q. It is correct. The reason why I raise that is because over at 115, when you're talking about Panel hearings, it says that: 10:58

"The Panel must decide on the balance of probabilities whether it finds facts proved and whether those facts prove the charges in relation to the professional's misconduct or competence." 10:58

Can you help us to understand then if the screening team decide that the nurse is fit to practise, is that the end of the process? Is it screened out, despite there being a written concern and evidence of a serious one, or what happens? 10:58

A. It's a combination of all three questions at screening. So if we decided that the concern was not serious and didn't require regulatory action, and we could see that

the nurse, midwife, nursing associate was still fit to practise, then it would be screened out.

55 Q. Okay.

A. It's kind of a double negative I think.

56 Q. Yes. Yes. I think that's a good way of looking at it. That's helpful. 10:59

DR. MAXWELL: Can you help us with how the screeners would determine whether somebody was currently fit to practise before an investigation?

A. I think it would relate specifically to the seriousness of the allegation and the action that had been taken since that had happened. 10:59

DR. MAXWELL: But screening is pre-investigation. So are you saying you're relying on the employer's evidence at this point? 10:59

A. No, I mean in screening we will also talk to the individual that has been referred.

DR. MAXWELL: So the individual that has been referred would be notified that there's been a referral and can supply evidence to say they're fit to practise? 11:00

A. They can provide, they can provide their perspective on the issue, yes.

DR. MAXWELL: And, so, the decision about whether that meets the threshold that they are still fit to practise, is there any guidance around that, or is that the discretion of the screeners? 11:00

A. So it'll be looked at by two different people. So it would be looked at by a screening case officer and then a screening decision-maker that will be looking at the

overall threshold.

DR. MAXWELL: What are the qualifications of the screeners?

A. So the screeners, it's kind of mostly an entry level job. They are given quite a lot of training, they're supported sometimes by the screening decision-makers. 11:00

DR. MAXWELL: But they're not Registrants themselves.

A. Some are Registrants, some are not.

DR. MAXWELL: So it's an entry level job, they're not necessarily Registrants, and they're making a decision about whether somebody is fit to practise? 11:01

A. Yep. But they do have access to our clinical advisers. So we have a team of clinical advisers. So not all of the referrals relate to something clinical, but if it does relate to something clinical then they can call, and will call, on a clinical adviser to review the referral. 11:01

DR. MAXWELL: Thank you.

CHAIRPERSON: Sorry to get stuck on this, but I need to understand this process as well. If we just -- can we go back to paragraph 105? Right. So, "We consider", you say: 11:01

"...three questions at this stage.
Step 1, whether we have a written concern..." 11:01

So in other words, has something come in, in writing to raise an issue?

A. Yep.

CHAIRPERSON: Step 2:

"Whether there is evidence of a serious concern that could need us to take..."

11:02

- could need us:

"...to take regulatory action to protect the public."

Now if there is a "no" to that, there is no evidence of 11:02
a serious concern, is that the end of the process?

A. Yes.

CHAIRPERSON: Right. If, however, there is evidence of a serious concern, you still then go on to Step 3:

11:02

"Whether there is clear evidence to show that the nurse is currently fit to practise."

So I just need help as to how those two square. There's evidence of a serious concern, but then there's 11:02
clear evidence to show that the nurse is fit to practise. Does that then get screened out?

A. If there was a serious concern it wouldn't get screened out. It would be --

CHAIRPERSON: So you don't get to Step C? 11:02

A. No.

CHAIRPERSON: No. That's what I asked.

A. Yes. Sorry. Yep.

CHAIRPERSON: Right. Okay. So if there's no evidence

of a serious concern, you still then consider Step 3, which is:

"Is there clear evidence to show that a nurse is currently fit to practise?" 11:03

A. Yep.

CHAIRPERSON: So the mere putting in of a complaint, as it were, is sufficient for a nurse to -- for a Panel to consider, an Interim Orders Panel -- sorry, a Screening Panel, to consider whether that nurse is fit to 11:03 practise or not?

A. So this hasn't gone to a Panel at all at this stage.

CHAIRPERSON: No, it's the screeners.

A. Yes.

CHAIRPERSON: My fault. But that is the position? 11:03

A. Yep.

CHAIRPERSON: I see. Okay. Sorry, Mr. McEvoy. Thank you.

57 Q. MR. McEVOY: In terms of the role of the screening team, what it does, 106A, we're told that it makes 11:03 enquiries to enable them to make a decision. You helpfully indicated a moment or two ago that enquiries are made of the Registrant in question. Is there -- who else would enquiries be made of?

A. They could be made of the employer. 11:04

58 Q. Mhm-mhm.

A. They could be made of other people that were potentially witnesses.

59 Q. Yep.

A. That would mainly be it. Of course if it was the referrer, and we needed more information from the referrer, we'd be going back them and asking for more information too.

60 Q. In terms then of investigation, which is the following paragraph over at the top of page 21: 11:04

"Following a decision at the screening stage to refer a matter for investigation, the investigation team..."

11:04

- this is a separate team from the screening team?

A. It is a separate team.

61 Q.

"...investigates the concerns, including gathering key information, documentation, and witness statements." 11:05

At both the screening and investigation stages then you ask the professional to respond to the concerns made against them:

11:05

"...and this provides them with an opportunity to reflect on the concerns raised and provide context."

So I suppose so the Inquiry is clear then, the person who is the subject of the concern is effectively always 11:05 aware of the concern. Is that right?

A. They are. Once we've got sufficient information.

62 Q. Yes.

A. Yes.

63 Q. And the reason why I ask that is that the Inquiry has had some evidence from staff witnesses to say that they don't know, they haven't known what it is that they've been accused of sometimes for years, but your evidence, the NMC's evidence would tend to suggest that that wouldn't be something that your process would permit if you were aware of a concern? 11:05

A. So the difference would be if there's an ongoing police investigation, as there is in this case.

64 Q. Yep. 11:06

A. So we're looking at information. So that's why we currently have a number of cases in screening that are kind of stuck, because we don't have the evidence that we can share with the Registrant in order to make the decision about where to go with the case next. 11:06

65 Q. So effectively it can't go forward without the input of the subject?

A. Yes. Yes.

66 Q. Okay. We're then told something about the role of case examiners and the role that they carry out, essentially at 110, to decide whether there's a case to answer on the facts, and then whether or not the nurse's fitness to practise is currently impaired. 11:06

You point out at paragraph 111 at the bottom of the page that: 11:07

"Case examiners do not decide whether the case against the nurse is proved or whether the incidents happened

or whether their fitness to practise is actually impaired."

But over the page then at 22, it's effectively a binary decision between whether or not there is a case to answer or not, and then it goes to the Investigating Committee? 11:07

CHAIRPERSON: Dr. Maxwell.

DR. MAXWELL: Just before we get there. Can I ask what the qualifications of the case examiners are? 11:07

A. So case examiners are partnered up. Quite often they're somebody from a regulatory background, but there is a Registrant involved in every case examiner decision. If the partners can't agree whether it is a case to answer or no case to answer, then we do have the process where the decision goes to the Investigating Committee. It's very rarely that happens, but it has happened. 11:08

67 Q. MR. McEVOY: You then describe the role of the Investigating Committee, pointing out that historically prior to March 2015 those decisions, in other words case to answer decisions, were made by that committee, which still exists to consider the making and reviewing of interim orders, cases relating to fraudulent or incorrect entry, or cases where in fact there has been disagreement among the case examiners on that case to answer decision. 11:08 11:08

On point C there, where there is disagreement, is that

a frequent occurrence?

A. No, it's not a frequent occurrence. So I think there's been -- I mean I've been at the NMC for about 20 months, and I think it's happened once in that time.

68 Q. And then we have the Fitness to Practise Committee then, which is the final stage of the fitness to practise process. And if a case is referred to the Fitness to Practise Committee, it's considered at a meeting or hearing, and: 11:09

"The Panel is independent and must make its own decision about a nurse, midwife or associates fitness to practise. In both meetings and hearings there will be an independent legal assessor to give legal advice." 11:09

Now, at paragraph 114 then, you give us a description of the two types of way forward.

"At the meeting the Panel makes its decision in private based only on documents. There is no attendance from the nurse or any witnesses, but written statements are considered. Whereas hearings are held in public and live evidence is presented." 11:10

Can you tell us something about the decision-making process about whether it should be a meeting or a hearing and what the criteria would be for that decision? And whose decision it is? 11:10

A. So I'm not entirely sure, so I think I would come back

to you on that. What I think happens is that the case examiners make the decision, and it's based on the level of seriousness. So if it was really serious it would still go through to a hearing. But I need to confirm that. 11:10

DR. MAXWELL: Can the Registrant appeal that and ask for a hearing or do they just have to accept the decision?

A. The Registrant can always have a hearing.

DR. MAXWELL: They can always? 11:10

A. Yes, yes, they can.

69 Q. MR. McEVOY: Are there circumstances in which a hearing may not be in public?

A. There are situations.

70 Q. Can you give us examples? 11:11

A. I think it's just where it is a really serious type issue they can be held in private.

71 Q. Okay.

CHAIRPERSON: I'm sorry, I don't understand that actually. If it is a really serious issue isn't there every reason for it to be public? I mean I can understand there could be circumstances where, for good reason, you can't have a public hearing. 11:11

A. Yeah.

CHAIRPERSON: But the level of seriousness, I'm just a bit surprised that that delineates whether it's public or private. 11:11

A. Yeah, I'm not sure what the rules are on that. I'm sorry.

CHAIRPERSON: No. Okay.

72 Q. MR. McEVOY: You may not be able to answer this one. Are there any Registrant-centred or professional-centred reasons why a hearing may not be in public? 11:12

A. Mm-hmm, I think if there are certain mental health conditions or issues with the Registrant.

73 Q. Okay. In terms then of the response provided in the statement to question 5, which is at the bottom of page 26, the question posed by the Inquiry was: 11:12

"How many referrals did the NMC receive in respect of Registrants working at Muckamore Abbey Hospital across the time period covered by the Inquiry's Terms of Reference?" 11:12

In other words, between the 2nd December '99 and the 14th June 2021. There is an explanation at paragraph 132 that you conducted a search using relevant search terms including employer coding, and that you were able 11:13 to identify 51 referrals relating to 51 nurses received in that time period. And you say then that:

"As our data recording has changed over time there may be other cases received between 2nd December 1999 and 11:13 2014 which you have not been able to identify."

Was there a change in the recording process then in or around 2014?

A. Yes, there was...

74 Q. I appreciate that was maybe before your time?

A. It was. As I understand it there was a different system that they were using.

75 Q. Can you help us understand -- and there's a number there 51, and you may not know this off the top of your head, but do you know how many referrals from Muckamore Abbey there were before 2017? 11:13

A. No, I don't. I'll be able to get you that information, but I don't know that. 11:14

76 Q. Okay. And in terms of those 51 Registrants, can you help us understand who would have raised the concerns about them? In other words, was it other professionals, was it someone within, or persons within the Trust, or some other person? For example, the patient in question or family? 11:14

A. As I understand it the vast majority were raised by the Trust themselves.

77 Q. And in terms of where the Muckamore Abbey scenario sits in the sort of UK-wide scale of things, is this the largest number of nurses from any hospital in the UK to have been referred, do you know? 11:14

A. I don't know that answer.

78 Q. And then moving to the next question then, the Inquiry asked: 11:15

"Regarding the number of outcomes of NMC investigations in relation to those referrals, how many led to an interim suspension?."

And the statistics are broken down in the following way: so for these 51 referrals, 21 have had an interim suspension order applied to their registration, 5 have had an interim suspension order applied that was then changed to interim conditions of practice order at a subsequent review hearing, and then 8 had interim conditions of practice orders, and that meant then that the total number of interim suspension orders applied is 26? 11:15 11:16

DR. MAXWELL: Could you just explain what the criteria for deciding between interim suspension and interim conditions of practice might be?

A. Yes. So an interim suspension order would be where the risk to the member of the public was so significant for that individual continuing to practise was such that we felt they needed to be suspended. Conditions of practice would be where we felt the allegations were of a less serious nature, and that actually with perhaps a degree of supervision, or working in a slightly different field. So a lot of the time it's kind of an extra level of supervision that they can continue to practise. 11:16 11:16

DR. MAXWELL: So is that -- is there a formal tool to guide the Panel as to how to distinguish between the two, or is it at their discretion? 11:16

A. No, there is documented guidance.

DR. MAXWELL: And that's something, if we wanted to see, we might be able to have a copy of?

A. Yes. Yes.

DR. MAXWELL: Thank you.

CHAIRPERSON: Can I just ask while we've paused. You were asked about where most of these complaints came from and you said the Trust. Let's move away from the Belfast Trust for the moment, but any Trust, if any Trust has received a complaint about a nurse, presumably they can institute their own disciplinary investigation, but is any Trust duty bound to report that nurse to the NMC? 11:17

A. No, they're not.

CHAIRPERSON: So the Trust has to, the Trust concerned has to decide whether to take this purely through their own investigative procedure or whether, in addition, to report to the NMC? 11:17

A. Yeah. But often it will be a Senior Registrant is looking at it that is also bound by the Code, and that might inform their decision-making about making that referral.

CHAIRPERSON: Yes. Yes. Thank you. 11:18

79 Q. MR. McEVOY: So picking up just where I left at 133 and 134. Hopefully my maths are correct, but we have 26 suspension orders and 8 conditions of practice orders, which is 34, and 11, I think, still at a screening stage, according to the statement. Can you tell us 11:18 then about the remainder, there would be approximately maybe 6 others, would that be right? What's happened with those referrals?

A. So they could have progressed through the process and

not require an interim suspension order, or they could still be sat in screening. We know 11 are still sat in screening.

80 Q. Yes. On those 11, you may have given us the reason for that, but why are those cases taking so long to get past screening? 11:19

A. So in order to put an interim order on these cases we need some evidence, and we need some evidence from the PSNI. So the PSNI are able to give us probably CCTV footage or evidential statements, but at this stage they're not happy for us to share that information with those Registrants, pending conclusion of the criminal investigation and their interviews of those Registrants. 11:19

81 Q. Okay. 11:20

DR. MAXWELL: Can I ask a little bit about the decisions that have been made, which you refer to in paragraphs 139 to 140? Is it common for things to get closed by the case examiners and the Investigation Committee after they have been screened in without going to a hearing? 11:20

A. Yes, it is.

DR. MAXWELL: It is quite common?

A. Yes.

DR. MAXWELL: So this wouldn't be unusual? 11:20

A. No, not at all.

82 Q. MR. McEVOY: Okay. So over on page 29 then, question 7 posed was:

"Does the NMC monitor fitness to practise trends within practice units, for example, at Muckamore or within parts of the Register? For example, registered nurses for learning disability."

11:21

And this expands upon something that you mentioned a little bit earlier, which was about internal oversight groups where colleagues come together to share and consider issues of concerns, those groups focusing on patient safety related concerns identified from a variety of sources, including regulatory intelligence, education assurance and concerns identified through external inquiries and media reports and so on.

11:21

You say:

11:21

"We don't routinely monitor trends either by employer practice units or for specific parts of the register as the dataset is small, but these groups can commission thematic, such as employer or field specific analysis across our fitness to practise referrals to identify trends."

11:21

You then go on to say at 144:

11:22

"Where we have conducted analysis in the past, we have seen that professionals do not necessarily work in their specific nursing fields."

Pausing there. Is that something that would pose a concern for the NMC?

A. I don't think so. I mean we've got Registrants that are dual Registrants, for example, a nurse and a midwife, and they chose to work in the different fields. But we just see that people kind of, you know, move into a different area of preference. We don't have any insight as to why.

83 Q. Yes. What if they're not dual registered? Would that pose a concern? In other words, if you were registered to another part of the Register but you were working in learning disability? 11:22

A. I don't know. That would be a question for Sam I think.

84 Q. I think Dr. Maxwell is going to take up on that point. 11:22

DR. MAXWELL: I was going to ask the same question.

A. Yes. Yes.

DR. MAXWELL: Presumably the reason you have four parts of the Register is because the skill set is different -- 11:23

A. Yes.

DR. MAXWELL: -- in different parts of the Register.

A. Yes.

DR. MAXWELL: How can the NMC be protecting the public if it has no position on people working in a field when they're not on the Register for that field? It seems to defy the whole purpose of public protection. And going back to the Code, which says you should not undertake work that you're not competent to do, that's 11:23

one of the central tenets of the Code.

A. Yep.

DR. MAXWELL: How can you work in a field that you haven't been prepared for that you're not on that part of the Register for as a registered nurse and be compliant with the Code? 11:23

A. Yeah. So I think that would be a question that Sam would be able to help with this afternoon.

DR. MAXWELL: That's not a question that the Fitness to Practise team would consider then? 11:24

A. I think -- I can't answer that.

DR. MAXWELL: But you are responsible for the fitness to practise exercise?

A. I am, yes.

DR. MAXWELL: Sam is responsible for standards, but you're responsible for fitness to practise? 11:24

A. Yes. So I am not from a nursing background, so I wouldn't know what was actually needed in that specific situation, so what would be needed at Muckamore Abbey in terms of the skill sets of the different registrants. 11:24

DR. MAXWELL: But if you could work anywhere why not just have one Register? Why have four parts of the Register, if being on any part of it allows you to work anywhere? 11:24

A. Yeah. Yeah, I can't answer that.

DR. MAXWELL: Okay.

CHAIRPERSON: Could I ask this, which you may be able to answer, is the question of which part of the

Register a nurse is listed on part of a consideration for a Panel or a screening? In other words, when a complaint comes in does anybody say 'Oh, which part of the Register is this nurse on?', or does it not have any relevance to that?

A. I think they will consider the part of the Register they're in.

CHAIRPERSON: Right. So if that's right, do you know what relevance it has?

A. Yeah. I think that that's where we would use our clinical advisers because they have different skill sets to kind of advise on where we take a case next.

CHAIRPERSON: Okay. Okay.

85 Q. MR. McEVOY: The next question I wanted to probe with you, it doesn't really arise from what is said in the statement per se, but as the Inquiry understands it, there would be an obligation on Registrants to report, there'd be a Code obligation on Registrants to report instances of sub-optimal practice if they raised concerns on other Registrants and colleagues potentially, would that be right?

A. Yes, that's correct.

86 Q. If a Registrant did not do that, in other words saw something that raised a concern and failed to report it, can you give us a broad outline of what the consequences might be for that Registrant of failing to do so?

A. So if that was the case, their fitness to practise potentially is impaired and they would go through the

fitness to practise process. I think the Code is really clear on that.

87 Q. That would be deemed a serious concern?

A. Yes.

DR. MAXWELL: Could that potentially lead to an interim suspension order? 11:26

A. I think it would depend on the circumstances.

MR. McEVOY: Okay. Now, prior to 2017, which is when the allegations that the Inquiry -- give rise to the Inquiry first came to prominence, and I appreciate this is before your time personally with the organisation, but can you give us an idea of how the NMC work with other regulators in Northern Ireland to protect the public? 11:27

A. Yes. So we have recently signed a new information sharing protocol, which was earlier on this month. We do work with other regulators, and if you look at our whistle-blowing report, for example, you can see there that a number of whistle-blowing cases are signposted to a whole range of other regulators. 11:27

88 Q. And is that something then that -- I know that's a recent agreement that you mention, but is that something, or would a similar sort of situation have obtained in Northern Ireland prior to 2017? Would you have had close working relationships with other regulators then? 11:27

A. I think there's always been close working relationships with other regulators, yes.

DR. MAXWELL: Can I ask then, when it became apparent

that there was a significant number of referrals from Muckamore, did you have conversations with the GMC, for example?

A. So I don't know that answer.

MR. McEVOY: I don't have any further questions for Ms. Maslen at this time, maybe the Panel will? 11:28

CHAIRPERSON: I need a moment or two. Do you have any?

DR. MAXWELL: I have a couple.

CHAIRPERSON: Yes.

11:28

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

DR. MAXWELL: There's a large number of Registrants on the Register, in fact I think it's the largest regulator in the world. 11:28

A. Yep.

89 Q. DR. MAXWELL: So it's challenging. Quite apart from cases that are subject to police procedures, what's the backlog in terms of time for screening referrals at the moment? 11:28

A. So at the minute we've got screener referrals unallocated that sits around 900 cases. We take action to reduce that at the moment, so we've just increased the headcount in our screening teams. So early signs are that the backlog is starting to reduce and kind of quite well. 11:29

90 Q. DR. MAXWELL: But at the time this was coming in how many months might a referral take to be screened?

A. So at the time of Muckamore?

91 Q. DR. MAXWELL: Yes.
A. I don't know what the backlog was at that time. I could get that information for you.
92 Q. DR. MAXWELL: And what is it currently, in terms of months, to get through the screening process? 11:29
A. It's probably around 12 to 18 months. But it does go through, it does have initial risk assessments, so they're not just sat not looked at. We do an initial assessment of them to see whether an interim order is needed, and if an interim order is needed because of 11:29 the level of risk, that is prioritised, and we'll go to get the interim order and move it over to investigation. So the casework that's sat at screening at the moment is our lower risk casework.
93 Q. DR. MAXWELL: So when it comes in, somebody makes a 11:30 risk assessment and you can either call into a fast track arrangement or a slow stream --
A. Yes.
94 Q. DR. MAXWELL: -- which is currently somewhere between 12 and 18 months. 11:30
A. Yes.
95 Q. DR. MAXWELL: How long between referral and action, if it has been fast tracked as high risk?
A. So we try and get interim orders within 28 days, but that's subject to getting all the information that we 11:30 need in order to do that.
96 Q. DR. MAXWELL: And how -- so that's your goal. I understand.
A. Yes.

97 Q. DR. MAXWELL: How -- what are you doing against that --
A. So I think at the moment we achieve that in around 67% of times. The main reason that we don't go ahead with the interim order at that stage is because we get to a Panel and the Panel feels the Registrant needs more time to prepare. 11:30
98 Q. DR. MAXWELL: Okay. Thank you. So you talked about the way referrals could be made, and in general terms, not about Muckamore, what roughly is your impression about the split between the number of referrals that are made by professionals or employers and referrals that are made by members of the public? Have you got a percentage split? 11:31
A. We get more referrals from members of the public. The work that we've done with our employer link service has helped us reduce the referrals that we get from employers, inappropriate referrals that we get from employers. So I couldn't tell you exactly the split, but it's probably in the region of 60% members of the public. 11:31
99 Q. DR. MAXWELL: Okay. And then the final question from me. You've talked about your Intelligence Unit, is the focus on individual Registrants or on teams? So I understand Registrants are obviously registered as individuals, and you've talked about the challenges that you don't necessarily know where they're working, but is there any work in the intelligence team about saying there's a team or a service that seems a bit hot at the moment? 11:32

A. Our data at this stage doesn't enable us to interrogate in that way. So it really is if somebody actually notices something within a team and highlights it.

100 Q. DR. MAXWELL: And in terms of the new agreement that you've signed, which I think is fairly hot off the press here in Northern Ireland, the intelligence network, will that be looking at services or at individuals? 11:32

A. From our perspective it would be at an individual level or thematic analysis. 11:33

DR. MAXWELL: Okay. Thank you.

101 Q. CHAIRPERSON: In the second statement that we haven't really touched much upon, there's reference to a number of nurses who had interim suspension orders imposed by the NMC and then they appealed. And I don't need to know much more about that, but I think part of the basis of the appeal was that the interim orders Panel didn't have a sufficient basis for their determination. Can I just ask you this, and perhaps you could answer this "yes" or "no": after this did the NMC or were the NMC given access to CCTV? 11:33 11:33

A. No, I don't believe so.

102 Q. CHAIRPERSON: Right. Because you mentioned earlier that you did have access to CCTV?

A. We've had access to some CCTV in some cases. 11:34

103 Q. CHAIRPERSON: Right.

A. But it has been fairly locked down and fairly restricted.

104 Q. CHAIRPERSON: Okay. Final question -- sorry --

A. So on those when we -- sorry. On those cases when we went back to revisit the interim orders, we based -- the evidence was evidential statements rather than CCTV.

105 Q. CHAIRPERSON: Right. That's very helpful. That explains that. 11:34

A. So it was somebody that had viewed CCTV.

106 Q. CHAIRPERSON: Secondly, are you the right person to deal with revalidation?

A. That would be Sam. 11:34

107 Q. CHAIRPERSON: You say with relief!

A. Yes!

CHAIRPERSON: All right. No, that completes all of the questions from the Panel. Can I thank you very much for coming along to assist and for replacing 11:34 Ms. Sutcliffe. Thank you.

A. Thank you.

CHAIRPERSON: Mr. McEvoy are you dealing with the next witness?

MR. McEVOY: Yes. Ms. Foster is next. Although I 11:35 understand she's not available until...

CHAIRPERSON: 2:00 o'clock

MR. McEVOY: It'll be 2:00 o'clock most likely, but 1:00 o'clock at the very earliest.

CHAIRPERSON: Okay. Well... 11:35

INQUIRY SECRETARY: Chair, the witness actually potentially isn't arriving until 1:00 o'clock, so I would just hold the 2:00 o'clock to be on the safe side.

CHAIRPERSON: All right. All right. Well we could sit at 1:45. We'll try and sit at 1:45 and have an earlier afternoon. So 1:45.

MR. McEVOY: Very well. Thank you.

11:35

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Yes, Mr. McEvoy.
MR. McEVOY: Yes, Chair and Panel. The next witness for the NMC is Sam Foster. 13:42
CHAIRPERSON: So part 2 as it were?
MR. McEVOY: That's right.

MS. SAM FOSTER, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS: 13:42

CHAIRPERSON: Good afternoon, Ms. Foster. Thank you for coming to assist the Inquiry. Before you start, I just want to declare, as it were, that you and I, I think, sat on a Panel last year on patient safety.. 13:43
A. We did.
CHAIRPERSON: But other than that we've not met and we don't know each other.
A. No. 13:43
CHAIRPERSON: And you do know Dr. Maxwell, obviously not in a social capacity and not through the NMC.
A. No.
CHAIRPERSON: In a work context.
A. No. 13:43
CHAIRPERSON: All right. Thank you very much. Yes.
MR. McEVOY: Good afternoon, Ms. Foster, and thank you for attending the Inquiry this afternoon.
A. Good afternoon.

108 Q. In front of you is a statement which was produced to the Inquiry on behalf of NMC by Andrea Sutcliffe, who is the organisation's Chief Executive, and it is dated 20th March past. This morning, I explained to the Inquiry that an indication was given by NMC that you would be able to speak to the content of paragraphs 13 to 100 of that statement, which is essentially a set of responses to a set of questions posed by the Inquiry. Can I check and confirm you're content then with that course? 13:43 13:44

A. I am.

109 Q. All right. Well before I embark on that, could I ask you or invite you to give a brief overview of your current role within NMC and any qualifications, past experience, which is relevant to that role? 13:44

A. Sure. Thank you. So I am the Executive Nurse Director for Professional Practice at the NMC. I've been employed by the NMC since April 2023. I'm a registered nurse by background, Intensive Care speciality. I've been qualified for 30 years, operated at Chief Nurse level in the NHS for nine of those years. My portfolio includes education, quality assurance of education and standards, and the employer link service. 13:44

110 Q. Okay. Thank you very much. As I indicated, the relevant part of your statement deals with what is hoped is within your field of competence and forms responses to some questions, and the first of those can be found at the bottom of page 3, and the first question which is asked is: 13:45

"Please provide an explanation of the competencies which are expected of registered learning disability nurses."

13:45

Arising from that then, the response begins at 13 and 14:

"We set the standards of proficiency necessary to join the Register for each of the professions we regulate. These standards represent the skills, knowledge, and attributes all registered Nursing and Midwifery professionals must demonstrate."

13:45

It continues:

"We set the standards of education and training necessary to achieve the standards of proficiency, and together these are used by the Approved Education Institutions (AEIs) and their practice learning partners to shape the content and design of both the theory and practice programme curricula delivered by AEIs."

13:46

From that, the Inquiry would be assisted if you could help us to understand how the NMC assures itself that changes in practice and in patient needs are reflected in the education standards of those AEIs?

13:46

A. So, the process is that the standards are set by the

NMC. There are 95 AEIs across the four countries. They apply for programme approval. They are given indefinite approval to run their undergraduate and postgraduate programmes, but they must complete annual self reporting and exception reporting. Where there is changes of practice and guidance that needs to be woven in, that will be done by the NMC, and new programme monitoring or continuous monitoring will take place. 13:47

111 Q. Thank you.

DR. MAXWELL: Could you give us an example of something in learning disabilities where the NMC has given direction about changing practice? 13:47

A. I can't give you a specific for learning disabilities, but I can get that information for you.

DR. MAXWELL: Can you, just to explain what you mean, can you give us an example from any other field of nursing? 13:47

A. I guess maybe the most pertinent example might be a change in safeguarding practice, that we'd need to ensure that that was included within curricular for academic institutions. 13:47

112 Q. MR. McEVOY: Over on page 5 at paragraph 19 then, reference is made to the standards framework for nursing and midwifery education, which has helpfully been exhibited, and this states, and we don't need to open it, but it states that: 13:48

"AEIs, together with practice learning partners, must have robust, effective, fair, impartial and lawful

fitness to practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection."

Can you help us understand how the NMC quality assures those practice learning partners? 13:48

A. So the NMC quality assure the programme, and within that quality assurance framework there are elements of relationships with practice learning partners. So the NMC doesn't quality assure the learning partner, it assures the programme. But within there, there are specifics relating to supervision standards for students, educational audits, and a range of other elements that would give that assurance into the annual self report. 13:48

DR. MAXWELL: So the NMC relies on the processes within the AEI?

A. Yes.

DR. MAXWELL: To choose and monitor their practice partners. 13:49

A. Yes.

DR. MAXWELL: And so the NMC wouldn't know who those practice partners are?

A. For the programme approval, my understanding is those practice learning partners are named, but over time the opportunity to grow those practice learning partners is there, and that wouldn't require a modification of programme. 13:49

DR. MAXWELL: It would or wouldn't?

A. Wouldn't require.

DR. MAXWELL: It wouldn't.

A. It wouldn't be seen as a modification.

MR. McEVOY: On the next paragraph then we're told that: 13:49

"The NMC standards for pre-registration nursing programmes state that AEIs, together with the practice learning partners, must ensure students' health and character are sufficient to enable safe and effective 13:49 practice both on entering and throughout the programme."

And then you tell us:

13:50

"The same applies when submitting the supporting declaration of health and character in line with NMC's health and character decision-making guidance. This declaration includes satisfactory occupational health assessment and criminal record checks." 13:50

Can you help us understand what the standard of practice is required of a pre-reg, pre-registration student when working independently as a health care assistant? 13:50

A. Can you just clarify what you mean by that, sorry?

113 Q. What is the standard of practice which is required of a pre-reg student, and I suppose I'm better repeat it, when working independently as a health care assistant?

So perhaps doing something that is not nursing work but is health care assistant work prior to completing a --

DR. MAXWELL: So we know some pre-registration students work as health care assistants during their training.

A. Yes. 13:50

DR. MAXWELL: Does the NMC have a view or any oversight of their practice?

A. So the NMC doesn't regulate students or health care assistants, only registered professionals.

DR. MAXWELL: So the NMC wouldn't have a view if a 13:51 student was involved in an incident as a health care assistant, that wouldn't in any way affect their ability to complete their pre-registration training and qualify?

A. So if an individual practising as a health care 13:51 assistant was involved in a safety incident or a conduct incident that was subsequently investigated by their employer, I would expect that individual to inform their university and the university to take action as appropriate. Whether there is a systematic 13:51 process for that connection, I think that would be varied.

DR. MAXWELL: So that's the responsibility of the university who has been approved?

A. Yes. 13:52

DR. MAXWELL: To meet your standards.

A. Yes. Unless in some cases there are several routes into programme, and the Open University and the apprenticeship route into nursing, the individuals are

still employed by their Trust, and that's certainly the case for some undergraduates at the Belfast Trust.

CHAIRPERSON: But because they're pre-registration they don't fall into the fitness to practise regime?

A. Well they fall into both, because they have a contract of employment as a health care assistant, and then part of the week they are undergraduate students, so they are both students at the university and employees of their respective Trust. 13:52

CHAIRPERSON: Yes, but as undergraduate students they do not form part of your fitness to practise regime? 13:52

A. Not the NMC fitness to practise, no.

CHAIRPERSON: That's right.

DR. MAXWELL: However, had they been involved in an incident -- let's say it's a safeguarding incident and there had been some disciplinary action, that could potentially prevent them joining the Register? 13:52

A. Yes.

DR. MAXWELL: Even if they had met the academic parts of the course? 13:53

A. Yes.

DR. MAXWELL: You rely on them informing the university that they have been involved in that?

A. Yes.

CHAIRPERSON: And, sorry, just to finish this topic off, but also, and this isn't strictly part of your remit I suppose, so if you can't answer, don't, but even if a registered nurse is suspended, they could conceivably continue to work as a health care 13:53

assistant?

A. Yes.

CHAIRPERSON: As long as they're not using their nurse's registration to get the job.

A. Suspended from the NMC or suspended by the employer? 13:53

CHAIRPERSON: Suspended by the NMC.

A. Suspended by the NMC. Suspended by the NMC would have conditions of practice attached to their suspension.

CHAIRPERSON: As a nurse.

A. As a nurse. 13:53

CHAIRPERSON: Yeah.

A. And dependent on the case, that may determine that they can't -- it depends case by case.

DR. MAXWELL: But a Registrant who is still on the Register, whether suspended or not, may choose to work 13:54 as a health care assistant, and that wouldn't be covered by the NMC.

A. Yes. Yes.

CHAIRPERSON: Yes. Thank you. Thank you.

114 Q. MR. McEVOY: Turning to the topic of fields in nursing 13:54 education, on page 6, looking at the very bottom of the page at paragraph 29, we're told that:

"In accordance with the order of 2004 dealing with part entries on the Register, entries on the Register are to 13:54 include a Registrant's field of practice, UK students qualify in a specific field of practice as Level 1 nurse may apply to enter the NMC Register as a nurse in one or more of the four fields of nursing practice, in

other words, adult, children, learning disabilities (LD) and mental health."

And then we're told:

"AEIs and their practice learning partners develop and deliver, manage pre-registration nursing programme curricula. However, AEIs must include routes specific to the relevant fields of nursing practice with any programme leading to registration for which they seek NMC approval." 13:55

And then:

"On successful completion of a programme, students are registered by the NMC as qualifying in one or more fields of nursing practice." 13:55

How many fields can a nurse be registered in?

A. Four. 13:55

115 Q. Okay. And then below that then:

"Education and training requirements for registered learning disability nurses."

We're helpfully directed to two sets of standards of proficiency; one in 2004, and then an updated version in 2010, which was when graduate only entry to nursing was introduced, and then we're told:

"These documents combine both the proficiencies, in other words the knowledge and skills directed at individuals with the education standards, the programme content that education providers should be doing. There has been some repetition of content and inconsistencies, so in 2016 we embarked on a significant educational change programme."

Can you help the Inquiry understand whether the current standards of proficiency contain field specific activities that a student must be competent in prior to registration? 13:56

A. The future nurse proficiencies are generic in description but must be applied to field in the programme, so either in theory or in practice placement. They're split into seven sections. If an individual is returning to nursing, or is educated overseas, the test of competence for learning disabilities nurses is specific. 13:56 13:57

INQUIRY SECRETARY: There's a crackle on the microphone.

CHAIRPERSON: Oh, is there a problem? Okay. The speaker doesn't matter so much if it's broadcasting. Right. Okay. Keep going and then we'll see. 13:57

DR. MAXWELL: Can you just clarify? So if we go back a long time to the GNC, which you and I both -- well, I'm not sure if you do, but I certainly had a GNC book -- there were specific clinical skills that we had to

demonstrate and be signed off by three different people to show they were competent. That doesn't currently exist?

A. No.

DR. MAXWELL: So there are a set of principles, you know prioritising people and the others, how can we be sure that that has translated into practical skills? And, secondly, how can we be sure that two providers are equipping students with the same skills, so that we can say a learning disability nurse from any provider is competent to manage the same conditions? 13:58 13:58

A. So the programme approval is field specific. So whilst the proficiencies are -- I'm reluctant to use the word "generic", but they're not field specific.

DR. MAXWELL: The principles. 13:59

A. The principles. The programme approval for the AEI is field specific. So in order to be approved to deliver learning disabilities undergraduate programme, the university has to apply for that approval. If alongside they want to also deliver undergraduate sick children's nursing, they have to have a separate approval for that. 13:59

DR. MAXWELL: So one of the issues in this Inquiry is Muckamore Abbey Hospital, I think, could probably be described as a specialist environment. There are people with learning disabilities there who have particular needs that are probably in the minority, they have often mental health disorders, epilepsy, a number of other conditions. Would the NMC ensure that 13:59

all pre-registration students had sufficient skills to deal with that type of patient, and how could we be sure that the new graduates are actually competent to manage those patients?

A. So in order for programme approval, the NMC subcontract that independent role currently with a company called Mott McDonald. They would send a visiting team with lay and Registrant members to undertake approval visits whereby the curriculum, both in theory and practice, would be reviewed and tested, which would take that team right from the Year 1 right through to how the AEI would be in a position to make that declaration that individuals had completed the practice and theory elements of the proficiencies required, along with health and good character for uploading on to the Register. 14:00 14:00 14:00

DR. MAXWELL: So potentially, if the Inquiry wished, we could have sight of their assessment and see the extent to which their assessment considered the sort of patients and conditions managed at Muckamore? 14:01

A. There will be a programme approval document that the Inquiry can be provided with.

DR. MAXWELL: And does Mott McDonald assess the practice partners who are actually overseeing the practical skills. 14:01

A. Part of those programme approval visits they have to meet practice placement partners as well as academic staff.

DR. MAXWELL: Okay.

116 Q. MR. McEVOY: Chair, the Inquiry Secretary has indicated to me that it may be necessary to have a brief pause just to sort out the audio issues?

CHAIRPERSON: Yes, I'd rather do that, because it is quite distracting. As I know, Ms Richardson knows, a lot of movement. So I'm sorry, we're going to pause just for five minutes so we can sort out the technical problems and then we'll carry on hopefully without interruption. Sorry. 14:01 14:02

SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT, AS FOLLOWS: 14:05

CHAIRPERSON: Right. Sorry for that.

117 Q. MR. McEVOY: Ms. Foster, at 34 and 35 then, on page 7, the statement describes how:

"In 2018, following a commitment to undertake a strategic programme of change..." 14:06

-- you reviewed and updated new education and training standards, and those have all been very helpfully exhibited to the statement and provided thus to the Inquiry. 14:06

At 35 you say that:

"When we consulted on updating our standards we published an easy read version of the consultation document (also exhibited) to help people with learning disabilities to understand and respond to our proposals."

Given that it was seen fit to produce an easy read version of a consultation document, would it be a great task or a big task for the NMC to ensure that there is easy read versions, there are easy read versions of the material on its website, including, in particular, reporting of concerns, acknowledging of course that it's not within your remit strictly, but reporting of concerns and related issues. 14:06

A. It shouldn't be difficult, no. Just to add as well, there is an advice line. 14:07

118 Q. Yes.

A. That members of the public can also access.

119 Q. Yes. That's right. We have that evidence. Thank you. Turning then to page 8, and to standards of proficiency, the statement helpfully then sets out from (a) to (g) the standards of proficiency under seven platforms, being an accountable professional, promoting health and preventing ill-health, assessing needs and planning care, providing and evaluating care, leading and managing nursing care and working in teams, improving safety and quality of care and coordinating care. And then the outcome statements we're told for each platform have been designed to apply across all 14:07 14:07

four fields of nursing practice, and:

"Registered LD nurses must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen field of LD nursing practice."

Can you tell us a bit more about what that phrase means? What is the greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen field? 14:08

A. So an example of that could be when obtaining consent for treatment, that communicating with somebody who didn't have any additional needs would take a different set of communication skills from working with somebody who had specific communication and complex needs. So their assessment in practice would require them to be, it would require their skills to be applied to the practice context in which they were operating. 14:08 14:09

DR. MAXWELL: Is there any sort of document that lists those additional more advanced skills that would be expected within each field?

A. No, the standards of proficiency are the standards of proficiency. The test of competence for somebody returning to practice, or joining the Register having qualified outside of the UK, give the specific proficiencies, but not for a UK trained nurse. 14:09

DR. MAXWELL: So to the pre-registration UK students,

interpretation of the seven -- I can't remember what you called them?

MR. McEVOY: Platforms.

DR. MAXWELL: Platforms. Is at the discretion of the university or the education provider? 14:10

A. For the academic institution and practice placement provider.

DR. MAXWELL: So a student who was at let's say Queen's University here in Northern Ireland, the university would interpret the academic content, and the placement 14:10 provider would interpret the practice content. Do they do that together or separately.

A. It depends on how their curriculum is designed and how their link tutors -- I know at Queen's the link tutors are quite active in the practice placement areas, but 14:10 it would be specific to that programme and how that had been designed as a curriculum.

DR. MAXWELL: So potentially pre-registration LD nurses here may have the practice skills that they're required to rehearse and demonstrate determined by Belfast Trust 14:11 as the provider of the placement?

A. Yes.

DR. MAXWELL: Okay. Thank you.

A. The determination that its met, yes.

DR. MAXWELL: But the interpretation of it in practice. 14:11

A. Yes. So the proficiency document does need to be assessed by a supervisor and signed off, so -- and that portfolio is held by the Registrant, but the proficiency is determined by the standards from the

NMC. The assessment of competency against that is by the practice assessor.

DR. MAXWELL: Yes, but the point that I've been making is it used to be more specific what that was. Now it's a principle and it is open to interpretation, which may be a benefit and it might be... 14:11

A. Yeah. No, it's -- I think they're quite, they're quite specifically written, but you're right, they can be open to interpretation.

CHAIRPERSON: And can I just go back so that I have a better understanding of the education, and I'm afraid I'm going right back to paragraph 29? The statutory instrument states that entries in the Register are to include the Registrant's field of practice, and that UK students qualify in a specific field of practice as a Level 1 nurse and then can enter under one of the four fields. When they start their education, do they choose which field they want to do? 14:12 14:12

A. Yes.

CHAIRPERSON: Right. So let's say that somebody has chosen learning disability, do they do much of the same work, at least at the beginning, as somebody in adult, or children, or mental health, or are the four branches, as it were, completely separate and taught separately? 14:12 14:12

A. Again it would depend on how the curriculum is running. There is core elements for all of the fields and then specific elements that need to be taught separately by academically qualified LD.

CHAIRPERSON: Right. So, again, it's up to the institution how they manage that. They've got to deal with core --

A. Yep.

CHAIRPERSON: -- areas of training and then for each branch. 14:13

DR. MAXWELL: But there's no requirement for a core common foundation and then specialise?

A. No. No, it's changed again.

DR. MAXWELL: Although that was discussed at one point? 14:13

A. Yeah.

CHAIRPERSON: Right. So different nurses in different fields will have different core?

A. No, the core content is the same. It's how it's organised by the academic institution. 14:13

CHAIRPERSON: Yes. Yes. Okay. And if a nurse -- when Mr. McEvoy asked you in how many fields can a nurse register, you said four, but how would they do that if they hadn't had the education and training in each of the four? 14:14

A. Sorry, no, there are four options. So my --

CHAIRPERSON: One of four.

A. My NMC Register entry says "Registered Nurse - Adult".

CHAIRPERSON: Right.

DR. MAXWELL: And you would have to take a further training if you wanted to dual or triple the registration. 14:14

A. Yes.

CHAIRPERSON: Yes.

A. Yes.

CHAIRPERSON: So the paragraph reads "in one or more of the four fields".

A. Yes.

CHAIRPERSON: So you could actually qualify in all four if you wanted to spend the time? 14:14

A. You could.

CHAIRPERSON: Okay. Thank you. Sorry, Mr. McEvoy.

120 Q. MR. McEVOY: And at 48 and 49, the topic of internationally educated LD nurses and LD nurses returning to practice. 14:14

"Internationally educated LD nurses who wish to join our Register must have undergone training in nursing and passed a test of competence (TOC) to demonstrate that they have met the standards of proficiency for admission to the nurse part of the Register. 14:15

Our TOC therefore reflects our standards of proficiency for registered nurses and LD nursing applicants need to take a test that is specific to LD nursing." 14:15

The reason that I raise this, and I appreciate that it is not within the part of the statement that you have been tasked to specialise in for today, but if you look across to page 29 and to paragraph 144, and it might be helpful just to have your view from an education and standards perspective on what is said: 14:15

"Where we have conducted..."

- this is where the NMC discusses fitness to practise trends within practice units and so on within parts of the Register, and, for example, with regard to registered nurses in learning disability, and it says: 14:16

"Where we have conducted analysis in the past, we have seen that professionals do not necessarily work in their specific nursing fields." 14:16

Can you help us maybe join up those two, what is said there in terms of that finding on the basis of analysis then, and corresponding that then to what you have told us about the requirement to undergo tests of competence and to meet standards of proficiency, would that be a 14:16 concern?

A. So a test of competence is to enable entry to the Register.

121 Q. Yeah.

A. And for internationally educated nurses. Where the 14:16 Registrant then takes up employment, they will be accountable as individuals under their Code and their scope of practice, and accountable to the employer as to whether they have the skills, knowledge and skills to undertake the role in which they are to be employed 14:17 in, and where that gap may take place.

So, for example, as an adult trained nurse myself, if I developed a particular interest in autism and undertook

professional development in that area, that may deem me suitable to an employer to work in that field, they may then make an assessment of professional development or competencies that I might need to attain to be independently practising in that area, but on the Register my undergraduate education would be determined that I was an adult nurse. 14:17

122 Q. So that's a matter for the employer as the end user sort of speak to determine, as opposed to the NMC?

A. Yes. And, you know, there are many different configurations of clinical areas. As Dr. Maxwell mentioned, colleagues may well be qualified in two fields. So emergency nurses may well undertake mental health training to support the cohort of patients using that service. Equally, children's nurses may then go on to develop speciality mental health knowledge and skills. But the responsibility for delivery of those regulated activities sits with the employer for their recruitment of registered nurses. 14:17 14:18

PROFESSOR MURPHY: Can I just ask? We've heard a lot about Muckamore Abbey having problems with staffing, and it strikes me that, you know, as an employer you might be motivated to offer posts to people who weren't qualified in the specific area that you were looking for. Is that your experience in the NMC, that when people get desperate they just take, for example, mental health nurses when it's an LD context? 14:18 14:18

A. So my experience is from as an employer rather than from the NMC. I think in balancing the risk of

shortage of skills, and there are many different specialities where there is a national shortage of skills, neonatal nursing, other examples, employers do often work together to put education programmes on to support adult nurses, you know. So adult nurses with critical care backgrounds into neonates, adult nurses with specialist interests in learning difficulties to be supported into employment. So I think as an employer it would be on a balance of risk and how that risk could be mitigated. 14:19

DR. MAXWELL: I think we're confusing a couple of different things here. So your example about an adult nurse doing training in autism, that is a very specific specialist field, whereas being on the Register as a learning disability registrant is a broad field. 14:20

A. Mhm-mhm.

DR. MAXWELL: And I don't imagine you're saying that an adult nurse who has done specialist training in autism would then be competent to deal with everybody with learning disabilities? 14:20

A. No.

DR. MAXWELL: And the example of neonatal nursing, that's not a specific part of the Register. Given that the NMC's primary duty is to protect the public, I wonder what it's view would be of somebody working generally as an LD nurse, not within a specific speciality for which they had specific training, either because it was their interest or the skills shortage, given that the NMC clearly thinks that there is a need 14:20

for four different parts of the Register. So if I was working as a General Staff Nurse in LD, and I wasn't on that part of the Register, how -- what would the NMC's view of that be?

A. So the NMC's view is to publicly display a register that is clear, but the responsibility for employment sits with the employer. 14:21

DR. MAXWELL: Okay. We may come to this later, but as we're here, so in adult nursing there are a number of recordable post-registration qualifications. So you can have Intensive Care, as we both have had, and a whole load of others. There's the community specialist practitioner. Does the NMC have any recordable post-registration qualifications for learning disability nursing? 14:21 14:22

A. So the only recordable annotations are -- well there's four parts to the Register; registered nurse, registered midwife, nursing associate, and the specialist community nurse public health. There aren't any longer recordable qualifications as there were previously. 14:22

DR. MAXWELL: So there's no way of knowing, through looking at a nurse's NMC registration, whether they have specialist -- whether they're a general nurse with a specialist qualification in autism, or whether they are an LD nurse with a specialist qualification in managing people with mental health comorbidities? 14:22

A. No, I believe that was felt to be confusing to the public.

CHAIRPERSON: So you can't look somebody up on the Register and find out which field that they specialise in?

A. You can look up against the undergraduate education fields, but not postgraduate development, as it previously was. 14:23

CHAIRPERSON: Not once they're registered.

A. Not once they're registered.

DR. MAXWELL: And that's quite different from the GMC were they have Specialist Registers post -- 14:23

CHAIRPERSON: Sorry, just going back to Professor Murphy's question. It seems to be there are two sides to this; you've got the Registrant who has their personal responsibility to decide whether they are, as it were, comfortable moving into a particular role, and 14:23 then you've got the employer, who hopefully will ask if the Registrant has trained in a specific field, but if they haven't, they may nevertheless offer them the job, frankly, if they're -- I don't want to say desperate enough -- but they need the bodies enough. Is that the 14:23 reality? An employer could say to a nurse in any field at all "Come and work in LD. We'll employ you", and then it's up to the Registrant either to say "Well, I don't think I'm sufficiently qualified to do that", or not? Sorry, you're nodding. 14:24

A. That's right. Sorry. Yes.

CHAIRPERSON: Yes. So it's only going to go wrong, as it were, for the Registrant, if in fact there's a complaint and they find themselves in front of a

Fitness to Practise Panel?

A. Or an internal process, yes.

CHAIRPERSON: Or an internal process. And we heard this morning that on screening, the screeners won't look at which Register the nurse is registered on. So that won't make any difference? 14:24

A. Well, it depends on what the concern is.

CHAIRPERSON: Okay.

A. But then there would be, you know, the process would be, you know, an advert, a job specification. So there's an employment process that's required to see whether an individual meets the job description. 14:25

CHAIRPERSON: Yes. Yes, I do, I understand that. So it is then up to the Trust -- let's move away from the Belfast Trust -- any Trust in Northern Ireland. 14:25

A. Any Trust.

CHAIRPERSON: Or indeed in England, can employ people outside of their specialist fields, and if the Trust is acting perhaps appropriately, they will seek to ensure that that Registrant gets extra training, or whatever it is, in that specific field that they're moving into. But that's up to the Trust? 14:25

A. It is, yes. There are some specialities in nursing where there will be guidance on the percentage of registrants with a postgraduate qualification to meet certain standards to deliver services, but I am not aware of any in LD. 14:25

DR. MAXWELL: Who sets those standards?

A. So things like neonatal standards, is an example. The

BAPM Standards. So there are specialities that, you know -- Intensive Care is what I know most, and there are standards where a percentage of the establishment must have a postgraduate qualification in the speciality. They're not recordable with the NMC, but they are -- 14:26

DR. MAXWELL: But that's advisory?

A. Yes.

DR. MAXWELL: There's no statutory requirement for that? 14:26

A. No.

CHAIRPERSON: And it doesn't apply in LD?

A. No.

CHAIRPERSON: Thank you.

123 Q. MR. McEVOY: Maybe continuing on the sort of post qualification side of things and the post professional qualification side of things. In terms of revalidation, you deal with this, the statement deals with this at the bottom of page 13, paragraph 69, and here we're told: 14:26 14:27

"All those on our Register are required to renew their registration every three years. Since April 2016 this has been done through our revalidation process. Revalidation strengthens practice by ensuring that in addition to undertaking continuing professional development and practice hours, professionals also need to take part in reflective practice." 14:27

Pausing there. Do you know or can you help us understand whether revalidation requires the Registrant's CPD to be in the field in which they are practising?

A. No, a percentage has to be participatory, and that's the only requirement that's laid out. 14:27

124 Q. Okay.

DR. MAXWELL: So potentially an LD nurse could do a leadership course, or a quality improvement course, but not actually do anything specifically related to LD practice? 14:27

A. Yeah, I'd hope that they would apply.

DR. MAXWELL: Hopefully they would, but potentially...

A. But potentially.

DR. MAXWELL: ...they could submit something that had not been situated within their field of practice? 14:28

A. Yes.

MR. McEVOY:

"Revalidation ensures that those on our Register continually reflect and develop their practice in line with our Code and Standards of Proficiency. The revalidation requirements are set out in our revalidation guidance." 14:28

Again, helpfully exhibited at Exhibit 17. Then: 14:28

"To meet our revalidation requirements, every three years those on our Register must declare that they have

completed..."

- and then you set out (a) to (e) the required number of hours, 450, or 900 if renewing two registrations. 35 hours of CPD, including 20 hours of participatory learning, which you've just mentioned. Five pieces of practice related feedback, five written reflective accounts and (e) then finally, reflective discussion.

Does any of that revalidation process require reflection on involvement in a significant event, a complaint and/or feedback from patients? 14:28

A. It's not prescribed, but that would be good practice.

DR. MAXWELL: It is prescribed in the GMC, isn't it, for medical revalidation? 14:29

A. Yes.

DR. MAXWELL: Is there -- I recognise you've only been in post a year and that you aren't responsible for this, but has any consideration been given to aligning some of the requirements for revalidation with those of the GMC around this user involvement area? 14:29

A. Both the Code and revalidation are currently part of the corporate plan for refresh and strengthening.

CHAIRPERSON: But revalidation was introduced, wasn't it, post-Shipman I think, certainly for the GMC, and it came a bit later, didn't it, to the NMC? 14:29

A. Yes.

CHAIRPERSON: To try to have some system to ensure that doctors and nurses were still fit to practise through

their career, and presumably you take into account what CPD they'd done in the revalidation process?

A. Yeah, I think it's important to note that the NMC's revalidation process is not an assessment of fitness to practise at this time. 14:30

CHAIRPERSON: So what is the purpose of it?

A. The purpose is to encourage reflective practice, to be able to record ongoing professional development, to be able to demonstrate feedback, but it's not currently an assessment of fitness to practise. 14:30

CHAIRPERSON: And there's no -- unlike the GMC system, there's no responsible officer?

A. No.

CHAIRPERSON: So it's a sort of self-declaration?

A. It has to be confirmed by another Registrant, but we don't have the responsible officer system. 14:30

CHAIRPERSON: And is there anybody in the NMC who would sort of dip samples of these and has a look?

A. Yes.

CHAIRPERSON: But a Registrant could go through that whole process, having had a serious complaint upheld against them, and not reflect on that and... 14:31

A. Yes.

CHAIRPERSON: ...and not appear anywhere in the revalidation process? 14:31

A. Yes.

CHAIRPERSON: Thank you.

DR. MAXWELL: When you say it's not a fitness to practise assessment, can you help me out with when it

was -- because it's been through various situations, wasn't it? You know we were -- it was called "Prep" many moons ago.

A. Yep.

DR. MAXWELL: And then it transitioned into revalidation. I understand that the Prep bit was an encouragement to reflect and develop. Can you help me understand how revalidation is different from Prep if it isn't about fitness to practise? 14:31

A. I'm trying to remember back. 14:32

DR. MAXWELL: Well you may want to come back to me on that.

A. Yes, I might want to come back.

DR. MAXWELL: You know, I'm surprised to hear you say that given that there was a halcyon change in the process and the NMC didn't monitor Prep as much as they do revalidation. I'd just like to understand the reason for that change if it wasn't fitness to practise? 14:32

A. Yes. I think we'll need to come back to you, but I think -- and it's not unusual I think for colleagues to be surprised by that, but the information that we've submitted, and the NMC website is quite clear that revalidation is not an assessment of fitness to practise. You do, as you know, still have to submit a health and character declaration. 14:32

DR. MAXWELL: Yeah, but it would be useful if you could supply that later.

A. Yeah.

125 Q. MR. McEVOY: On page 16 at paragraph 78, Ms. Foster, we're told that:

"The NMC routinely review our standards to make sure that nurses, midwives, and nursing associates are equipped with the knowledge, skills and behaviours they need to deliver safe care now and in the future."

What governs the routine review? In other words, how routinely and what is the basis for any review? 14:33

A. So if I can give you a live example now? We've just launched a practice learning review. So upon exit from the EU, the NMC made a commitment to review practice learning hours, because we no longer have to conform to EU Directives. So in terms of governance, we've commissioned some independent research to look at current UK practice learning and global practice learning, appointed an independent Chair, and set up a programme of work that will look through the key lines of the Inquiry as an output of the independent research. Also undertake some pilot programmes with academic institutions, and then work through that programme of work and make recommendations to NMC counsel, should there be any changes recommended. 14:33

126 Q. And in terms of existing standards, and some of the examples you've given us there is, would you set a marker down? In other words, like a set of standards would have to be reviewed every, say for the sake of argument, two, three, five years. 14:34

A. I'll come back to you on the frequency of that.

127 Q. Yes.

A. Because I suspect there is. But it would depend on whether things were seen as sort of minor changes that had come to light, either because of potential misinterpretation or something that needed to be clarified, because the standards are written quite broadly to enable colleagues to apply the latest evidence base, but a major modification would require a wider consultation. 14:34

128 Q. Okay. So then on the question, and just finally then on the question of, and this is a bit of mouthful for me, specialist community public health nurses and SPQ post-registration standards review, and this begins at 81 and following, and there's a helpful discussion about the background to overhauling and reviewing standards around those areas. 14:35

At paragraph 93 on page 18, it says:

14:35

"Curricula for specialist community public health nurses and community nursing specialist practice qualifications may be flexible to accommodate opportunities for shared learning, but must be clearly tailored and relevant to individual post-registration student's intended field of SCPHN or community nursing SPQ practice." 14:35

I appreciate we're talking about two different

scenarios there, but would a similar degree of flexibility, would you hope to see a similar degree of flexibility being permitted and accommodated for nurses specialising in those kinds of post where learning disability is their field of practice? 14:36

A. Can you just explain the question again?

129 Q. Yes. I mean if I can put it this way; is flexibility, or would you hope that flexibility would be demonstrated for learning disability nurses to share learning opportunities and so forth? 14:36

A. Yes.

DR. MAXWELL: So is this paragraph saying that undertaking a specialist community or public health nurse qualification, you could do it in the field of learning disabilities? So you could be -- 14:36

A. Oh, sorry, no.

DR. MAXWELL: No.

A. No. No. And I think -- so the Inquiry requested information on post-registration qualifications that the NMC approve. 14:37

DR. MAXWELL: Yep.

A. So are you asking whether a specialist community nurse would have...

DR. MAXWELL: Field specific.

A. Field specific? I think I'll need to come back to you and just have a think a bit more about that. 14:37

MR. McEVOY: I don't have any further questions for Ms. Foster. Thank you very much.

A. Thank you.

DR. MAXWELL: I have one.

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

130 Q. DR. MAXWELL: So I know that you've recently starting leading a piece of work on advanced practice. Could you tell the Inquiry a little bit about that and how that might relate to learning disability nursing? 14:37

A. So, Advanced Nursing and Midwifery practice has been in existence for more than a decade, but there is some variation around the use of titles, the level of practice, therefore the NMC saw fit to undertake some independent research to look as to whether there was any public protection patient safety risks. The independent research demonstrated that there was variation in application of these roles. Therefore, not dissimilar to the practice learning, a similar governance structure was set up. The Nuffield Trust undertook some independent research which gave rise to key lines of inquiry. An independent Chair was appointed and a programme of work to explore those key lines of inquiry to consider whether additional regulation, so on top of those that are already regulated, would be required to meet an NMC standard. We explored a range of regulatory options, taking into account the PSA Frameworks for good regulatory practice, it needed to be proportionate, ranging from maintaining status quo, using existing regulatory tools such as revalidation through to the NMC determining the 14:37 14:38 14:38 14:38

standards of education for advanced practice.

The work concluded and the recommendation was made to Council in march that additional regulation for nurses and midwives practising at an advanced level was recommended. So Phase 2 of that work has just commenced. It made a recommendation that the NMC should determine the standards of education for advanced practice, that consideration around the potential for strengthening the revalidation process for enduring demonstration of competency should be considered, in addition to the consideration with the refresh of the Code in this area and, lastly, that the four countries should come together to collaborate and agree a single framework for advanced practice for nurses and midwives. 14:39 14:39 14:40

131 Q. DR. MAXWELL: So this will be the same -- this wouldn't be a field specific framework, it would be a framework for the level of practice and not the field?

A. But it would be an annotation on the Register that an individual was a registered advanced nurse or midwife practitioner. 14:40

DR. MAXWELL: Okay. Thank you.

132 Q. CHAIRPERSON: And that's been the recommendation, but where does it sit now? What are you doing with it? 14:40

A. So Phase 1 was to determine whether additional regulation should be recommended, that's been recommended and approved. Phase 2 now is to do the work on development of the standards, and working with

other regulators and the four countries to bring together one single framework for the definition and framework for advanced practice.

133 Q. DR. MAXWELL: And will you need new legislation? Because when the UK CC required... 14:40

A. No.

134 Q. DR. MAXWELL: ...wanted to bring in high level practice, they were told they couldn't without legislation.

A. No, we don't need to wait for regulatory reform for this. 14:41

CHAIRPERSON: I think that's us finished. Can I thank you very much for coming along to assist. You've answered everything as well as you can, and you may feel you've had a bit of grilling, but you understand it wasn't a grilling of you, as it were, it's a grilling of the NMC's practices and procedures. 14:41

So can I thank you very much for coming along to assist the Inquiry, and there may be some follow-up questions, as you appreciate, that we'll send to the NMC in due course. Thank you. Right. 14:41

MR. McEVOY: That concludes the evidence for today, Chair.

CHAIRPERSON: We're not sitting tomorrow? 14:41

MR. McEVOY: That's right.

CHAIRPERSON: We're sitting on...

MR. McEVOY: On Monday I believe.

CHAIRPERSON: Monday. And we're then on Monday...

MR. McEVOY: Back to...

CHAIRPERSON: ...reverting to staff evidence. Right. Thank you very much everybody. See you on Monday at 10:00 o'clock.

14:42

THE INQUIRY ADJOURNED UNTIL MONDAY, 3RD JUNE 2024 AT 10.00AM.