Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Meadhbha Monaghan
Chief Executive
The Patient and Client Council
5th Floor
14-16 Great Victoria Street
BELFAST
BT2 7BA

13 December 2023

By Email - [redacted]

Dear Madam

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring Witness Statement & the production of documents

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you as Chief Executive of the PCC. It relates to documents within the custody or control of the PCC. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. In addition, if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the PCC and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you, your officials and/or the Department's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

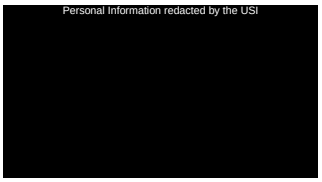
Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit your organisation must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait until you are in a position to fully comply with the Notice before you begin to send documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 28 of 2023]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: Meadhbha Monaghan
Chief Executive
The Patient and Client Council
5th Floor
14-16 Great Victoria Street
BELFAST
BT2 7BA

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

DOCUMENTS TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 17th January 2024.**

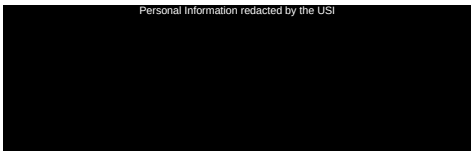
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 10th January 2024.**

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 13th December 2023

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 28 of 2023]

1. Please provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the PCC Solicitor, or in the alternative, the Inquiry Solicitor.

2. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Patient and Client Council ("PCC") – Role, duties and responsibilities

3. Please set out the statutory role, history, organisational structure, duties and responsibilities of the PCC.

4. Please explain how PCC carries out its functions to fulfil its role, duties and responsibilities.

5. Please set out the way in which patients and clients access the PCC and for what reasons? Are they signposted by the Trusts? If so, please explain how and the process that is then followed. Please provide examples which involve the Southern Trust if possible.

Organisational development

6. How has the organisational structure and development of the PCC (i) helped and/or (ii) hindered its ability to carry out its statutory remit?

7. How, if at all, do resources impact on the ability of the PCC to properly fulfill its statutory role regarding hospitals? Please explain your answer in full, providing examples as appropriate.

8. What, if any, other factors does PCC consider impacts its ability to fulfill its statutory role?

Role of PCC in complaints

9. Section 17 (c) of the *Health and Social Care (Reform) Act* 2009 provides that the PCC has the function of:

> *(c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible*.

Please set out how an individual making or intending to make a complaint becomes aware of the PCC. Is it the case that the individual must approach the PCC in order to trigger assistance? For example, can a Trust inform the PCC that a complaint has been made and notify them of the complainant so that PCC may offer assistance?

10. In the view of the PCC, does the manner in which their services may be triggered by an individual making or intending to make a complaint hinder the PCC in fulfilling its statutory functions of: representing the interests of the public, promoting involvement of the public, and providing assistance to individuals making or intending to make a complaint? If yes, in what way does it hinder and what is the impact of that? If no, does PCC consider that the current processes by which their services are accessed are optimal to fulfil PCC's statutory functions?

Urology Services and the Southern Trust

11. Please set out how the PCC engages and interacts with the Southern Trust in furtherance of its statutory duties and functions? This should include examples of engagement and any difficulties encountered.

12. When and how did the PCC first become aware of problems within urology services at the Southern Trust? What, if anything, did the PCC do at this stage and subsequently? In answering this question, please consider the Inquiry Terms of Reference, and set out a full chronology of all engagement with the Southern Trust, and other relevant bodies, regarding urology services. Your answer should include all relevant information, including but not limited to the following issues:

    i. When, if at all and in what circumstances did the PCC first receive information which identified or could have identified concerns regarding Mr. Aidan O'Brien's practice?

    ii. Was the PCC aware of any concerns in relation to Urology Services within the Trust, including service capacity or waiting list issues, or in relation to the practice of Mr. Aidan O'Brien in particular.

    iii. Did the PCC reach any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department, the HSCB or any other relevant body? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the PCC has not evaluated this issue, please explain why.

    iv. Did the PCC reach any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matters which gave rise to the need to issue an Early Alert? If so fully outline the view which was reached and

set out the reasons for the view which had been reached. If the PCC did not evaluate this issue, please explain why.

v. Detail what advice, if any, was given to the Trust by the PCC in response to any matters related to the Inquiry Terms of Reference.

vi. Detail any meetings or discussions between officials from the PCC and the Trust, the Department, the PHA, the HSCB/SPPG and RQIA and any other relevant organisation concerning the handling of the concerns raised or related issues. With regards to each meeting or discussion, specify:

a. The date;
b. The attendees;
c. The matters discussed;
d. Any decisions taken;
e. Any advice provided by the Department or received by the PCC;
f. Disclose or refer to any and all documentation relating to same.
g. Detail any communications the PCC had with any of the following persons/bodies as part of the process leading to the establishment of the public inquiry:
    1. The Trust;
    2. The Department;
    3. The PHA;
    4. The HSCB;
    5. Mr. O'Brien's representatives;
    6. Patients, clients or family members affected, and
    7. Any other relevant person or organisation.

13. Where not already addressed above, please set out in detail the PCC's ongoing role and steps taken, if any, arising out of the concerns about patient care and safety raised by the SHSCT.

14. What, if any, reforms are the PCC aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified, including patient engagement with the PCC?

15. Has the PCC engaged in any casework falling within the Inquiry's Terms of Reference? If so, please provide all details, including outcomes. If not, what is the view of the PCC as to why it has not done so?

16. If the PCC was not aware of problems within urology prior to the announcement of a public inquiry, what is PCC's view as to why the issues in urology did not reach it?

17. Does the PCC liaise with Trust Boards in furtherance of its statutory remit? If yes, please explain fully. If not, why not, and would formal engagement with Boards assist the PCC in fulfilling its role?

18. What is the PCC's view of the quality of engagement by (i) Boards, (ii) senior hospital staff (iii) medical staff (iv) general hospital staff, when they are assisting regarding a potential or actual complainant? Does the PCC consider there are barriers to effective engagement regarding complaints?

19. Does the PCC consider there remains outstanding work to be done by the Trust before its patient and client engagement structures are sufficiently robust to ensure effective access to the services of the PCC by those patients and clients who may benefit from such assistance?? Whether your answer is yes or no, please explain.

20. Has the PCC assisted individuals through the complaints process (including but not limited to Serious Adverse Incidents ("SAIs")) in the Southern Trust? If yes,

please set out a summary of those complaints, to include numbers, type of complaint, timeframes within which complaint was dealt with (or identify if outstanding) and outcomes. It would also assist the Inquiry to know the same detail for the other Trusts with which the PCC engages.

21. What is PCC's experience and view of engagement with the Southern Trust when assisting a potential or actual complainant? What works well, what does not work well, and what could be improved?

PCC and the third sector

22. Please set out PCC's relationships with third sector organisations whose role and remit overlap, mirror, or are tangential to the role of the PCC in complaints regarding health and social care. How effective are these relationships? What works well? What does not work well? How could the relationships be improved for the benefit of complainants?

23. Is PCC aware of whether any third sector organisation was made aware of the issues in urology services? If so, please provide full details. If not, what is PCC's view as to why the issues in urology did not reach these third sector organisations?

PCC and SAIs

24. What role does the PCC play in the SAI process? Your answer should include examples of PCC involvement and engagement with all other bodies regarding SAIs.

25. What is PCC's view of the efficacy of the SAI process generally and within the Southern Trust specifically?

26. The PCC website contains a Report by the PCC titled "Serious Adverse Incidents. A Thematic Review of Complaints Support Services Cases 2014-

2018", published in October 2019, and which contains- the following "Key Learning Points":

> 9. Key Learning Points
> Based on the information from the PCC Complaints Support Service database, further consideration needs to be given to whether current procedures for the investigation of Serious Adverse Incidents, and for engagement and communication with families, are adequate to meet the needs of families in these circumstances.
>
> A major concern is the lack of communication between the Trust and client. In many cases, the PCC has had to communicate on behalf of the client in order to elicit responses from provider organisations.
>
> Trusts involved in SAIs should maintain regular contact with the service users and carers involved, updating them on developments and notifying them about any delays and the reasons for such delays. Trusts should also time their contact with SAI complainants to take account of how recently a person has been bereaved and to ensure that any communication about a SAI happens after a person has been made aware that an SAI is taking place. Trusts should acknowledge the circumstances surrounding the incident to which the SAI relates, and give sufficient time for the relative or patient to process their situation before bringing them into the process.
>
> Delays in SAIs are also an issue and clients have described how these delays add avoidable stress to already difficult circumstances. Trusts should focus on providing more accurate estimates of SAI timescales, and also try to process SAIs more efficiently to relieve some pressure on those involved, while at the same time maintaining the thoroughness of the investigative process.
>
> Issues were also raised around SAI outputs. Some of these concerns reflected wider problems with the SAI process. However, there was a clear finding concerning the use of inaccessible language in SAI reports, making these difficult for SAI clients and their families to understand. These reports should be written using language which is as straightforward and succinct as possible, and avoid the use of technical jargon or acronyms.

Please answer the following –

(i) What was the trigger for carrying out this review?

(ii) To whom was the final Review report provided and what, if anything, was their response?

(iii) What, if any, action(s) arose from the "Key Learning Points" identified by the Review?

(iv) Does the PCC have an oversight or monitoring role of any action(s) taken? If yes, what does this entail and what are the outcomes? If not, why not and would such a role assist the PCC in fulfilling it's statutory remit?

(v) If no action(s) were taken following this Review, why was this the case?

(vi) What is the PCC's view of the action(s)/inaction following the publication of the Review?

(vii) Does the PCC consider it has sufficient powers to ensure that issues and key learning identified by them are taken seriously and properly implemented to address concerns regarding the quality of health and care services delivered in Northern Ireland.

27. Does the PCC have any other role directly with or touching upon governance within hospitals generally and specifically within the Southern Trust? If yes, please provide full details.

28. Please explain the way in which SPPG and the PCC interact in furtherance of the PCC fulfilling its statutory role?

29. Does the PCC consider that their engagement with SPPG is effective in achieving this aim? If not, what could be improved upon?

PCC and the SHSCT Lookback Review

30. Please detail what, if any, role the PCC has played (and continues to play) in the SHSCT Lookback Review.

Learning

31. From the information available to the PCC to date, what does it consider went wrong within the Trust's governance procedures and arrangements that resulted in lack of client and patient engagement with the PCC? Has the PCC reached any view on how such issues may be prevented from recurring? Has the PCC taken any steps with a view to preventing the recurrence of such issues?

32. Does the PCC consider that it did anything wrong or could have done anything differently which could have prevented or mitigated against a lack of client and patient engagement with the PCC regarding the issues arising within urology services and the governance failings of the Trust?

33. From the PCC's perspective, what lessons have been learned? Has this learning informed or resulted in new practices or processes for the PCC? Whether your answer is yes or no, please explain.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he

has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 28 of 2023

Date of Notice: 13th December 2023

Witness Statement of: Meadhbha Monaghan

I, Meadhbha Monaghan, will say as follows: -

1. I have been the Chief Executive Officer of the Patient and Client Council ('the PCC') since 13 March 2023. Prior to my appointment as Chief Executive Officer, I was the Head of Operations in the PCC from 15 May 2020 to 13 March 2023.

2. This statement is made on behalf of the PCC in response to the Section 21 Notice and related Schedule received from the Inquiry Team.

3. This is my first statement to the inquiry.

4. In exhibiting documents to this witness statement, I will use my initials "MM" so my first document will be "MM/1".

Patient and Client Council ("PCC") – Roles, Duties and Responsibilities

5. The PCC was established as an Arms Length Body (ALB) of the Department of Health (hereafter 'the Department') on 1st April 2009. The creation of the PCC was part of a major reform of health and social care in Northern Ireland, provided for by the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter 'the 2009 Act'). The functions of the PCC are described in the 2009 Act and have remained unaltered since 2009. Please see exhibit **MM/1**.

6. The Patient and Client Council, when it was established in April 2009, replaced four separate Health and Social Services Councils (HSSCs). A short paper is attached to provide some background information on the HSSCs for the purposes of the Urology Service Inquiry (see exhibit **MM/2**). As part of its response to requests from the Inquiry the PCC has included searches of those records which it inherited from the Councils for any records which may be relevant to the Inquiry.

Department for Health

7. The PCC is an Arms Length Body of the Department. This means that the PCC's statutory functions and powers are determined by the Department and that the PCC is accountable to the Department for how it uses its resources and how well it delivers on its functions. However, the PCC has a high degree of operational independence from the Department of Health and is wholly independent of all other HSC bodies. It is essential that the PCC not only speaks and acts with authority as an independent voice for patients and carers, but that it is perceived and trusted by the public to be independent from those who provide services and those who commission services. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the services provided by HSC Trusts. The Chief Executive is accountable to the PCC Council (Board). The Chair of the Council and its members are appointed by the Minister of Health and they are accountable to the Minister for how the Council discharges its oversight responsibilities within the PCC.

8. Under the current arrangements the PCC liaises with the Department through a nominated Departmental Sponsor branch. For the past several years the Department's Chief Nursing Officer (CNO) has been the lead Department official in respect of the sponsorship of the PCC.

9. The Department holds twice yearly accountability meetings with the PCC but on an ongoing basis the PCC management team engages regularly with its sponsor

branch. The PCC Management team have on occasions given evidence to the NI Assembly Health Committee and to other Public Inquiries and had regular contact with other statutory bodies such as the RQIA, Ombudsman, Children's Commissioner and Older People's Commissioner.

10. A review of PCC Council (Board) papers and Governance documentation has not identified any performance issues being raised with PCC by the Department which are relevant to the Terms of Reference for the Inquiry. The records held within the PCC indicate that the Department has accepted PCC mid-year assurance statements and also accepted PCC end year Reports and Accounts every year since the PCC was established.

PCC Accountability Arrangements

11. The accountability arrangements for the PCC are the same as those for all other Department ALBs including for example Health and Social Care (HSC) Trusts and the Regulation and Quality Improvement Authority (RQIA). The relationships between ALBs and their sponsoring Departments are managed under Department of Finance Guidance – Managing Public Money Northern Ireland (MPMNI). The Chief Executive of the PCC is appointed as Accounting Officer for the organisation by the Permanent Secretary of the Department. The Permanent Secretary is ultimately responsible for the expenditure of the Department and all of its ALBs.

12. The relationship between the Department and all of its ALBs is described in a 'Framework Document[1]' which was produced by the Department itself, to meet a requirement of the 2009 Act, and which has been subject to updates by the Department.

13. The specific relationship between the PCC and the Department is governed by a Partnership Agreement which sets out the relationship between Patient and

[1] DHSSPS Framework Document - September 2011 | Department of Health (health-ni.gov.uk)

Client Council (PCC) and the Department of Health (DOH). In particular, it explains the overall governance framework within which PCC operates, including the framework through which the necessary assurances are provided to stakeholders. Roles/responsibilities of partners within the overall governance framework are also outlined, thus it describes the role of the PCC and within the PCC the roles of the PCC Chair, PCC Council (Board) and the PCC Chief Executive. The Partnership Agreement also describes the role of the Department including the role of the Permanent Secretary in the Department. The effectiveness of the arrangements and the associated Engagement Plan will be reviewed each year by the Department and PCC in order to assess whether the partnership agreement is operating as intended and to identify any emerging issues/opportunities for enhancement. This can be carried out as part of existing governance arrangements. The Partnership Agreement replaced the former Management Statement in November 2023. The Management Statement, which was produced to comply with the requirements of MPMNI, has been subject to some updates over the past thirteen years.

14. The PCC produces its annual report and accounts which once approved by the PCC Council (Board) is submitted to the Department and then laid before the Northern Ireland Assembly. The PCC also participates in mid and end year accountability meetings with the Department. These are normally organised through the Department's Sponsor Branch for the PCC. The Annual Report summarises the PCC's main achievements and work undertaken in the previous year. It also describes any 'internal control divergences' which are issues which have arisen with the PCC's internal system of governance and for which additional steps need to be taken. There is no evidence in PCC annual reports (or in other Governance documentation) of control issues having arisen specifically in relation to the Southern Trust or Urology.

15. The PCC is a small organisation in HSC terms. Funding for the PCC comes solely from the Department of Health, as set out in the Framework Document, to ensure its independence. The PCC produces, for Departmental approval, an annual business plan demonstrating how these resources will be used. Between

2012/13 and 2019/20 the PCC has had significant reductions in its budget, as follows:

Year	RRL
2009/10	£1.751m
2012/13	£1.804m
2016/17	£1,405m
2018/19	£1.465m
2019/20	£1.436m

16. While it is recognised that all HSC organisations had to make savings over this period, the impact was greater on the PCC, coming out of such a small budget which covers both staffing and running costs. To put this into context, the budget allocation in 2019/20 was £368k less than it was in 2012/13; a reduction of approximately 20%, without taking account of the impact of inflationary cost increases. It is not therefore surprising in many respects that the PCC may have been less visible than it would have wished to be, given that it was increasingly constrained in the services it provided, during this period.

17. More recently the PCC budget has stabilised. The annual expenditure for the PCC in 2021/22 was £2.2m. However, it is important to note that this included ring-fenced funding for the office of the NI Mental Health Champion, for the provision of corporate services. As the PCC no longer 'hosts' the office of the Mental Health Champion, this additional ring-fenced funding is no longer included in the PCC budget.

18. A Stability Review of the PCC was undertaken in summer 2022. As a result of the Review, Council made the decision that a number of posts be made permanent. They were not funded within the PCC baseline and were funded non-recurrently, at risk to the organisation

19. The RRL for 2022/23 was approved at £1.948m. It is anticipated however that the PCC will receive non-recurrent in-year funding to support the PCC in representing itself to ongoing Public Inquiries. Moving forward additional permanent posts are required on the Operations side. Partial actioning of the stability review has helped the staffing situation; however, it is clear that more needs to happen. If the PCC is to function effectively, undertaking the increasingly complex work demanded, and operating more to its potential, some additional, highly skilled, professional staff are required.

20. PCC have raised concerns about the impact of financial resource in the Mid-Year Assurance Statement 2022-2023 and in the Annual Report 2022-23. PCC highlighted that an ongoing principal risk for PCC continues to be the level of funding within its core allocation, despite having secured additional recurrent funding in 2022-2023. PCC highlighted that any reduction in funding to PCC would have a high impact. Coupled with an increase demand for PCC services, and an increased complexity in the nature of the casework and support required from the public, PCC outlined that this poses an ongoing challenge for PCC in delivering on its statutory functions within existing resources.

21. The geographical remit of the PCC is all of Northern Ireland, across the breadth of health and social care including Family Practitioner Services as well as the services provided or commissioned by HSC Trusts. This presents challenges in managing competing priorities and defining the scope of roles within constrained resources in a small organisation the size of the PCC.

Role and Responsibilities

22. The 2009 Act dissolved the four Health and Social Services Boards (Northern, Southern, Eastern and Western) and the four Health and Social Services Councils (Northern, Southern, Eastern and Western), which were created under 1991 legislation and ceased to exist at the end of March 2009. The four Councils were not in their own right ALBs of the Department. Instead each of the Councils was embedded in its respective 'Host' Health and Social Services (HSS) Board. The Chief Executives of HSS Boards were also the accounting

officer for their respective Health and Social Services Councils ultimately responsible for the proper use of resources by the Council for which they discharged this Accounting officer role. Health and Social Services Council employees were recruited, paid and performance managed through the systems established by their host HSS Board.

23. The 2009 Act refers to a 'scheme of transfer' which governed the transfer of staff and assets from the legacy councils to the PCC. Under this arrangement a number of staff from the four Health and Social Services Councils were appointed to positions within the PCC on 'protected' Terms and Conditions. However, unlike the four HSS Councils the PCC was established as an Arms Length Body in its own right and the functions of the PCC were wider ranging than those of the Health and Social Services Councils. The PCC therefore succeeded rather than replaced the four Health and Social Services Councils (HSSCs).

24. As part of the transfer arrangements from the four HSS Councils to the PCC it was left to each of the four individual Health and Social Services Councils to determine what records and documents they should transfer to the newly established PCC. This accounts for disparities in what records the PCC inherited from each of the Health and Social Services Councils. Having reviewed all hard copy records which were transferred by the HSS Councils to the PCC in 2009, 4 cases relate to the TOR of the Urology Inquiry.

25. The PCC is a regional body which means that its' remit with regard to its statutory functions is Northern Ireland-wide. The PCC has local offices in Belfast, Lurgan, Omagh and Ballymena and its statutory functions under the 2009 reform Act are set out as follows (see exhibit **MM/1**):

Functions of the Patient and Client Council

17—*(1) The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland—*

(a)representing the interests of the public;

(b)promoting involvement of the public;

(c)providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

(d)promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

(e)such other functions as may be prescribed.

(2) In exercising its functions under subsection (1)(a), the Patient and Client Council must—

(a)consult the public about matters relating to health and social care; and

(b)report the views of those consulted to the Department (where it appears to the Council appropriate to do so) and to any other body to which this section applies appearing to have an interest in the subject matter of the consultation.

26. The Patient and Client Council (Membership and Procedure) Regulations (Northern Ireland) 2009[2] made under the Act make provisions concerning the membership of the PCC Council (Board). Amongst other corporate matters they prescribe that 16 persons shall be appointed to the PCC Council (Board) by the Department and that these persons shall include 5 members of district councils, 5 persons representing voluntary organisations with an interest in health and social care and one person representing a trade union. Two papers saved with PCC Council (Board) papers for a meeting on 9th March 2015 summarise a) the functions of the PCC (exhibit **MM/3)** and b) how the functions of the PCC compare with the functions of equivalent bodies in other UK Jurisdictions and in the Republic of Ireland (exhibit **MM/4)**. The functions and role of the PCC are also described in management statements/the Partnership Agreement and in PCC Annual reports.

[2] The Patient and Client Council (Membership and Procedure) Regulations (Northern Ireland) 2009 (legislation.gov.uk)

PCC Structures

27. Whilst the PCC's statutory functions have remained unchanged since 2009, the PCC's internal structures and the PCC's approaches to delivering its functions have evolved and changed over time. The way in which the management structure of the PCC has changed and adapted over time is illustrated by the PCC structure diagrams at Exhibit **MM/5**. The current PCC organisational structure is enclosed at Exhibit **MM/6**.

28. The PCC began in April 2009 with a management structure based on local district offices with five area managers. In more recent years, whilst some district offices are still in place including an office in Lurgan, the management structure has changed. The initial changes were instigated in 2013 in response to budgetary constraints and to provide a new model to reflect the functions of PCC. The area manager posts have been replaced by new management posts in 2013 reflecting PCC's regional operating model. In 2019 a further significant organisational review was undertaken and the practice model was subsequently revised.

29. Prior to the appointment of a new Chief Executive and Chair, (April 2019) the PCC had experienced a number of years of leadership instability, year on year decreases in its funding and had not taken time to formally review its strategic direction to test it against need and statutory function. It was against this backdrop that an organisational review was undertaken. As a result of various lessons learned exercises and organisational reviews the PCC has been significantly transformed since 2019. The post-2019 PCC practice model has increased its operational focus on matters such as:

    - Increased engagement with patients through a range of mechanisms including themed Engagement Platforms and localized Citizen Hubs;
    - Using data and evidence to drive and improve our policy functions;
    - Improved methodology with respect to how PCC supports members of the public across a continuum of advocacy interventions including around early resolution, complaints and SAIs.

30. The table below illustrates these changes by highlighting the Job Titles of posts below the Senior Management level pre and post 2019:

2009 – 2019		Development Phase 2019 - 2022	
Service	**Staff**	**Service**	**Staff**
Complaints	Complaints/Client Support Manager Complaints/Client Support Officers	Advocacy	Service Managers PCC Practitioners & Senior Practitioners
Involvement	Involvement Services Programme Manager Personal and Public Involvement Officers	Engagement	Service Managers PCC Practitioners & Senior Practitioners
Research	Research Manager Research Officers	Policy Impact & Influence	Senior Policy Impact and Influence Manager Research Officers
Bamford Project	External Relations Officer Personal and Public Involvement Officers Project Manager	Engagement & Advocacy ('Beyond Bamford')	Project Coordinator PCC Practitioner & Senior Practitioner

31. There are currently no senior or operational management staff in the PCC who were working in the organisation prior to 2019. This raises a potential issue of 'Corporate Memory' and some gaps in knowledge. As such, there may be some issues which the *current* PCC management will not be able to address. Nevertheless, PCC records pre-2019 are extensive and include:

- Corporate Governance documentation such as Annual Reports; Risk Registers; Business Plans; Corporate Plans; Internal Audit Reports;

and Assurance Frameworks providing extensive information about the operation of the PCC throughout its existence;

- Papers submitted or circulated to the PCC Council (Board) providing more detailed information on a range of PCC activity including advocacy; complaints; invitations to respond to public consultations; the PCC membership scheme; research projects etc.;

- Copies of policy documents and guidance manuals which underpinned the delivery of PCC services such as supporting members of the public to make complaints about Health and Social Care services;

- Documentation which identifies key individuals who were in post from April 2009 onwards; and

- Electronic and paper records of HSC complaints raised by members of the public for which PCC provided advice and support.

32. The information provided in this statement for the period prior to 2019 is based on this extensive range of documentation, a review of engagement work in the SHSCT post 2019 and a review of all case files based on the Terms of Reference of the Inquiry.

Practice Methodology 2009-2019

33. Advocacy for the PCC during this period meant working with or for patients, clients and carers to achieve change in health and social care. As defined in a 2009 paper to the PCC Council (Board), in practice this meant PCC Officers providing and/or supporting:

a) Independent Professional Advocacy
b) Collective/Group Advocacy.
c) Self-Advocacy

34. The distinction pre-2019 between the PCC's roles in providing or supporting advocacy and in supporting patients who wish to make a complaint was less clear than it is today. Whilst the terminology of 'advocacy', 'client support' and 'complaints support' is used throughout documentation over time in the organisation, and used interchangeably, the methodology of the practice and the nature of support this refers to varies.

35. Based on a review of available records and the Complaints Support Service Handbook that was in existence, the PCC approach to advocacy and complaints support pre-2019 was predominantly administrative. Significant developments in advocacy practice generally and the PCC organisational review has created a new model of practice referred to in paragraph 43 onwards. As set out in the Complaints Support Service Handbook (2015) for the organisation, the role of PCC Complaints Support Officers as advocates were described as follows:

'Activities as an Advocate

The specific activities of the Complaints Support Officer in support of clients are described in the HSC Complaints Process – Standards and Guidelines and include:

- *providing information on the complaint's procedure and advice on how to take a complaint forward*
- *discussing a complaint with the complainant and drafting letters*
- *making telephone calls on the complainant's behalf*
- *helping the complainant prepare for meetings and going with them to meetings*
- *preparing a complaint to the Ombudsman*
- *referral to other agencies, for example, specialist advocacy services*
- *help in accessing medical/social services records'*

PCC role in any broad strategies or policy development with respect to health and social care

36. During this period, the PCC regularly organised engagement events seeking the views of patients and clients. An example is PCC roadshows organised across Northern Ireland. As an organisation the PCC engaged with community sector organisations involving them in PCC led events. The PCC's area offices also organised and undertook engagement with stakeholders in their local areas.

37. During this period, the PCC was sent consultation documents on a routine basis by the Department, HSCB, PHA, HSC Trusts and other organisations. Details of these consultation documents, including which consultation documents the PCC intended to respond to were provided on a regular basis to PCC Council (Board) meetings in an 'information paper' entitled 'Consultations request list'.

38. These requests included consultations on Government priorities e.g. the Department's Priorities for Action and proposals for major changes to HSC service e.g. the 'Transforming Your Care' Health Review led by John Compton which began in 2011.

39. In addition to seeking views from those registered with the PCC's membership scheme the PCC organised its own consultation events seeking the views of stakeholders in response to Government and HSC proposals. The PCC also regularly organised consultation events on behalf of Department and its Arms Length Bodies.

40. The PCC Chief Executive and Senior Staff also participated as members of some steering and implementation groups established by Department and its Arms Length Bodies.

41. The PCC promoted and actively sought to identify the involvement of service users on groups established by Department and its ALBs.

42. The PCC's role was not confined to reacting to consultation proposals issued by the Department and its ALBs. The PCC worked alongside the Department and ALBs during the development stage of policy and proposals, organising engagement events and promoting the participation of service users on groups established to develop new proposals or policy. An example from this period is the '*People's Priorities for Transforming Your Care'* report produced in 2012.

43. The PCC also sought to routinely influence the agenda and priorities being set by Department and its ALBs by undertaking research, an example being work to engage with the general public to identify their priorities. This included '*People's Priorities' and 'Young People's Priorities'* reports. During this period, the PCC also commissioned research into specific topics, services and issues.

<u>2019 – Organisational Review</u>

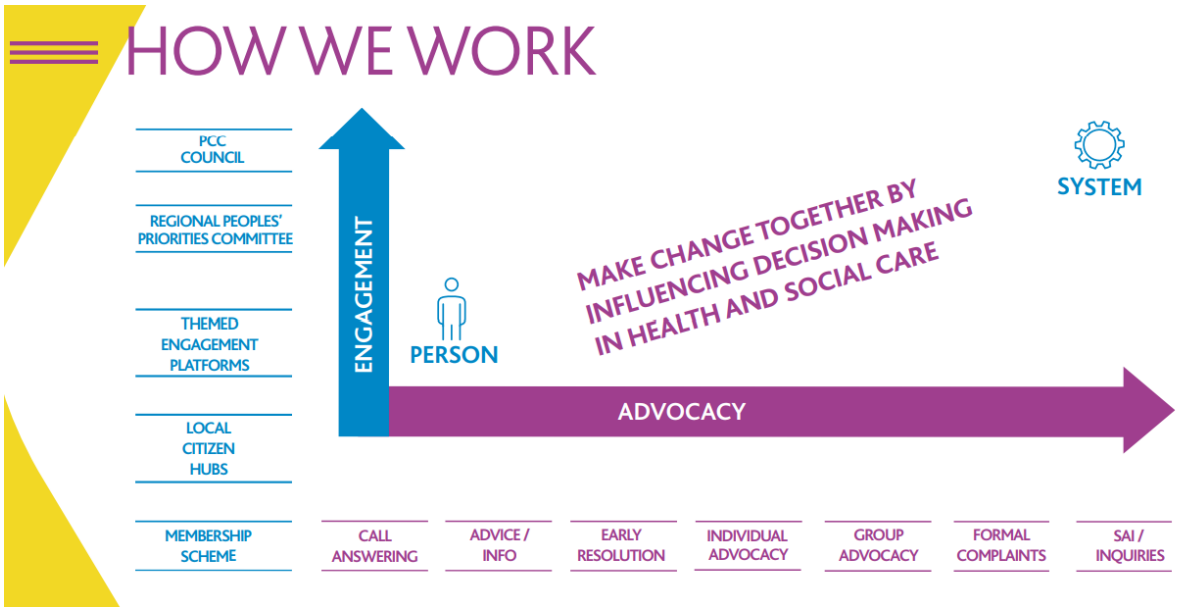
44. In the summer of 2019 the PCC commenced a significant organisational review and change process. The HSC Leadership Centre was commissioned to undertake the independent organisational review with the aim of assessing how PCC delivered on its functions and to propose new organisation design structures. The review findings proposed a number of recommendations, which set out the need for a significant change process. Key to the changes required was a refocus on the PCC's statutory and legislative base alongside a subsequent realignment of the organisation's operational functions and practice. This directed the development and re-design work undertaken in relation to:
    a. Purpose and Core Business
    b. Roles and Responsibilities
    c. Capacity and Capability
    d. Systems and Processes
    e. Estate

45. A new Executive Team and Operational Management Team have led and supported the organisational change process. Whilst there have been further changes in personnel since then with a new Chair Ruth Sutherland (15 May 2023) and a new Chief Executive (myself) (13 March 2023) the current arrangements and operation of PCC reflects the changes introduced in response to the 2019 review.

Post-2019 Practice Model

46. The new practice model, introduced in response to the outcome of the 2019 review, updated and re-designed how the PCC provide support to the public across three core functions; advocacy, engagement and policy impact and influence.

47. The following diagram illustrates the new practice model:



Advocacy

48. Advocacy is provided across a continuum. This ranges from; advice and information over the phone or via email, to signposting and 'supportive

passporting' to appropriate services to meet immediate need, to individual and group advocacy casework, through to advocacy in formal processes including formal complaints, SAIs and Inquiries.

49. Our advocacy and support begin with the first point of entry to the PCC, which can often involve the provision of ***advice and information to the public*** over the phone or via email. PCC contact details are widely available across a number of different sources including the NI Direct website (the official government website for Northern Ireland citizens), within the HSCNI Complaints Procedure, within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support, on the PCC website, social media platforms and in literature shared by PCC.

50. Our focus is on seeking ***early resolution of issues*** through facilitated conversations with parties involved in a particular case. This can include a wide range of other service providers, HSC bodies and individual professionals. Our advocacy and support can include signposting and 'supportive passporting' of members of the public to appropriate services to meet immediate need.

51. Where immediate early resolution cannot be achieved our advocacy and support carries through *to* ***individual and group advocacy casework***. The formal complaints process can be onerous and difficult for members of the public. Therefore, the PCC focus is on assisting members of the public to achieve a resolution to their complaint where possible without invoking the formal aspects of the complaints process.

52. In 2022-23 the PCC Advocacy Service opened 569 new cases in 2022-23 of which 453 related to HSC Trusts alongside providing advice and information to 837 people. A 'case' is defined as an issue the public need advocacy support to address, that cannot be resolved through advice or information, and which needs casework support from a member of the PCC practice team to try and resolve. A case can range from early resolution and individual advocacy through to engagement with the formal HSC complaints process and support in Inquiries.

45% of all cases closed in 2022-23 were resolved prior to formal complaint stage.

53. In some instances, the support and advocacy provided in cases will, of necessity, progress to formal complaint processes including where individuals wish to escalate their complaint to the NI Ombudsman. This can also include the provision by PCC of independent advocacy services within SAIs (serious adverse incidents), and Public Inquiries.

54. We adopt an approach across our practice which centres on relationship building and a partnership approach, placing co-production and user voice at the centre of our work. This is critical in fulfilling our purpose of promoting the involvement of the public and representing their interests. Adopting this approach, employing advocacy and mediation skills and techniques on an individual and group basis, enables us to provide assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care in the most effective way.

Engagement

55. In developing a new practice model, PCC have developed a range of engagement structures which provide the public with a variety of opportunities to get involved according to their interest in health and social care, across different levels of complexity.

56. The foundation for our engagement is our PCC Membership Scheme for those interested in regular updates about more general information and developments in health and social care. We view this as a mechanism of '***keeping in touch'*** engagement with PCC and health and social care. The membership of the PCC Membership Scheme currently numbers approximately 8,000.

57. This baseline 'keeping in touch' engagement with PCC and health and social care is enhanced at the next level with our ***PCC Citizen Hubs***, which offer a

more interactive and two-way process for engagement. From 2020 – 2022 PCC Citizen Hubs operated in each of the Trust areas. During this period, Citizen Hubs provided an opportunity for involvement locally, embedding a ***'network of networks'*** approach at a local Trust level by providing a forum for network development, regular updates, connections, discussions and capacity building. PCC Citizen Hubs were advertised through the PCC Membership Scheme, on the PCC website, across social media platforms and by direct email invitation to the local network contact lists (comprising of statutory, voluntary and community sector organisations and interested individuals within the particular Trust area).

58. Citizen Hubs offered the PCC the opportunity to connect with the general public on a range of topics relating to the health and social care system in Northern Ireland. They facilitated an environment for monthly updates, discussions, information sharing and opportunities for involvement in Health and Social Care at a local level. The Hubs were virtual gatherings providing an opportunity also for participants to raise issues, concerns and questions with the PCC. A total of 32 citizen hub meetings were held in 2022-23, with 109 attendees in total, a number of whom represented voluntary and community sector organisations. Themes for discussion and key issues arising included; Reform of Adult Social Care, South Eastern HSCT's consultation on the temporary changes to the urgent and emergency care services at Lagan Valley Hospital, and a Review of Assistive Technology Services, as well as A&E waiting times, staff shortages, and people using private healthcare because of pressures on the system.

59. At the next level, the focus of the work becomes more subject-specific. Our PCC ***Engagement Platforms*** offer the opportunity to engage in theme-based, task-oriented work at a more strategic level, with representation from the public, as well as the health and social care, and voluntary and community sectors. An Engagement Platform is a space to bring together a group of people, with a common theme or interest and lived experience, to work together and make change in health and social care. Engagement Platforms allow participants to communicate their experiences and thoughts with the PCC, as well as being able to share their views directly with decision-makers in health and social care.

Examples include engagement platforms for Care of Older People, Mental Health, Grief and Bereavement, Learning Disability and Neurology.

60. The engagement platform model of practice has been welcomed by the third sector, DOH and the other ALB's.

61. In January 2023, PCC decided to halt the operation of the Citizen Hubs in order to carry-out a review of how they were working in keeping with PCC's 'plan, do, review' approach and ensuring ***that PCC maximise our limited staffing resource***. Our experience demonstrated that our uptake in numbers of participants was higher at Engagement Platforms, which are regional and theme-based and where participants come into direct conversation with decision-makers, than at locality-based Citizen Hubs where numbers of attendees were lower and often constituted by repeat attendees. This pause also allowed PCC to take stock of the developments and build an engagement model in the Integrated Care Systems (ICS NI) programme.

62. The ICS (Integrated Care Systems) NI Programme brings together a range of partners to take collective responsibility for planning health and social care services, improving health and well-being and reducing health inequalities in Northern Ireland. Health and social care professionals, working with local councils, the community and voluntary sectors, patients, carers and service users, will plan and deliver health and social care services based on the needs of the local population. As part of the programme, across NI new Area Integrated Partnership Boards (AIPBs) are being set up which will use local knowledge to plan integrated and continuous health and social care services for local communities. It is timely for PCC to review the operation and delivery of its Citizen Hubs in this overall context.

63. PCC Citizen Hubs and Engagement Platforms can also offer the opportunity for participants to raise issues and concerns with the PCC. Online technology allows the PCC team to place a participant into a separate virtual room, during these discussions, where they can in private or on a one-to-one basis seek advice and discuss concerns with PCC staff. Running alongside our engagement and involvement structures is the continuum of advocacy and support that the PCC

offer in meeting our core statutory function of providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care. This is described at paragraph 46 to 54. Therefore, individuals who contribute their experience through PCC engagement structures in order to shape health and social care services can also be supported through PCC advocacy and supported on an individual basis as the need arises.

64. The intelligence we gather about what the public tells us about health and social care, the issues and concerns they need support with, and the policy initiatives they want to impact and influence, formulates and guides the policy influencing work PCC undertake in our Policy Impact and Influence function.

Policy Impact & Influence

65. The PCC aim to utilise the data gathered through its advocacy and engagement work to undertake a policy advocacy role. This is the process of negotiating and mediating a dialogue through which influential networks, opinion leaders, and ultimately, decision makers take ownership of the ideas, evidence, and proposals, presented by PCC on behalf of the public and subsequently act upon them. Examples of this in 2022-23 included work on the Autism Strategy, Advanced Care Planning and the Engagement on the Public Consultation on the Future of Muckamore Abbey Hospital. In this year PCC met with the Regulation and Quality Improvement Authority (RQIA) Inspection Teams for Maternity Services and Prison Health Care to highlight people's experience in these areas and any issues in care.

66. The PCC's approach today is that it will contribute to and seek to influence policy and service developments by the Department and HSC bodies. The PCC will do so by attending and contributing to groups and meetings established to take forward such work; by engaging with service users and members of the public to seek their views; and by submitting evidence. This evidence is based on what those engaging with PCC tell us as well as the practice experience of our staff who provide advocacy and support to the public.

Ensuring independence

67. The PCC does not join such groups as a member, where membership includes having a decision-making role or function in relation to the planning, commissioning and delivery of health and social care services and is not party to decisions made by such groups reserving the right to highlight any concerns regarding decisions made. The PCC believes that it has to remain separate from and independent of the HSC system if it is to then represent the interests of service users or families etc. who may be adversely affected by services and policies developed by such Departmental or HSC groups or bodies.

Access to PCC Services

68. The PCC provides an advocacy and support service to members of the public who wish to make a complaint about health and social care services as set out above in paragraphs 46-54. These complaints mostly arise through direct contact being made by an individual or their representative with the PCC. In some cases the individual will have been referred to the PCC by a member of HSC staff, a third sector organisation or by word of mouth from someone who has experienced PCC's services. The PCC are named within the HSCNI Complaints Procedure under which all of the HSC Trusts operate, and often within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support. The HSC complaints process is described in more detail below (Para 84-94). Under the process HSC Trusts are expected to advise complainants on the types of help available to them including through the Patient and Client Council (PCC).

69. In some cases an individual will raise an issue in the course of engagement work organised or facilitated by the PCC across the range of engagement structures set out at paragraphs 55-64 e.g. during an Engagement Platform. This may be in the course of the event itself and as part of group discussions. This can also happen after the session or event has concluded when PCC staff are

approached by an attendee to raise an issue or complaint they have. In these cases PCC staff would offer the individual support and advocacy to assist to address the issue they have raised during engagement. It is not possible to separately identify these issues or complaints, flagged up to PCC staff in the course of engagement work, from complaints raised directly with the PCC by telephone, email or letter.

70. In April 2023 the PCC launched its **'Positive Passporting Initiative'** which it has developed in partnership with a range of statutory bodies and with third sector partners. The initiative is intended to meet the needs of service users engaging with the PCC, who may require services that PCC may not provide.

71. The PCC's goals in establishing this initiative are to:

- Explain PCC's role supporting the public in independent advocacy and engagement, underpinned by a ***'network of networks'*** approach
- Gain a better understanding of the role and function of our partner organisations/ network
- Explore the merit of developing a referral pathway with each partner organisation, with the goal of establishing a Memorandum of Understanding for future joint working
- Create an N. Ireland wide framework for collaborative working

72. The range of partner organisations involved in this initiative includes the Information Commissioner's Office; Children's Commissioner; Commissioner for Older People; the Law Centre; Children's Law Centre; Ulster University Law Clinic; Advice NI; the Homeless Prevention Forum; a group of 19 organisations working around homelessness and housing rights who offer a range of supports related to housing issues within N. Ireland including a prisoner support program; Disability Action; British Deaf Association; Migrant Help; Macmillan; SANDS etc.

73. Whilst not exhaustive, the focus began with these organisations, to ensure that all service users have access to support in their first point of contact with PCC. The aim would be to expand these issue-specific areas of support to allied agencies, statutory and non-statutory agencies, public and private sector and charitable organisations, to establish a working agreement which breaks down barriers to accessing support and reach more individuals within N. Ireland. A number of these organisations have specialist expertise which will help to ensure members of the public who contact PCC for support have access to expert advice for their specific issue beyond a health and social care concern. This is particularly valuable when an individual may need support or accompaniment to a particular appointment and PCC may link in with the relevant partner organisation to ensure the individual has additional support.

74. Through this process of relationship building with external agencies and providers, PCC aims to create a more inclusive environment for individuals accessing HSC services and as a by-product of this, expand positive experiences through positive outcomes for those individuals. The hope is that PCC may contribute to building a lasting framework of support for people that exists beyond HSC and improves access to services, service development and user experience within N. Ireland. The arrangements which the PCC is establishing with these partner organisations are reciprocal meaning that over time more individuals will be aware of PCC services and may also be passported to the PCC by these partner organisations.

Governance, Complaints and Serious Adverse Incidents

75. The next section sets out PCC's understanding of Governance, Complaints and Serious Adverse Incidents and how they have informed and underpinned PCC's service delivery and the decision-making processes within this.

76. In the course of its Section 21 request the Inquiry has posed a number of questions regarding Governance, Complaints and Serious Adverse Incidents. Whilst some elements of these processes are underpinned by statute,

overwhelmingly the detail of what the Department of Health requires from its ALBs is specified in circulars, guidance and standards. In advance of addressing the specific questions the PCC believe it would be helpful to explain PCC's understanding of how these three elements relate to each other, what the requirements are of the HSC Trusts and what PCC's role is. These requirements often predate the establishment of the PCC in 2009.

77. The origins of the current arrangements date back to the publication by the Department of Health of a consultation document called "Best Practice – Best Care" circa 1999[3]". Subsequently, in October 2002, the Department published a circular[4] setting out its expectations of many of its Arms Length Bodies in relation to Clinical and Social Care Governance.

78. The purpose of the circular was to provide guidance specific to clinical and social care governance and to enable organisations, including what are now called HSC Trusts, to formally begin the process of developing and implementing clinical and social care governance arrangements. The circular defined clinical and social care governance as a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. Clinical and social care governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care. This emphasis on the responsibility of the corporate body which provides or commissions services is reflected in the HSC complaints process which has been in place since 2009.

79. Whilst the 2002 circular was not prescriptive on an exact model to be used, it did however, set a framework for action which highlighted the roles, responsibilities,

[3] PCC does not have a copy of the Best Practice – Best Care publication

[4] HSS (PPM) 10/2002 - GOVERNANCE IN THE HPSS – Clinical and Social Care Governance: Guidelines for Implementation

reporting and monitoring mechanisms that were necessary to ensure delivery of high quality health and social care. This framework was intended to bring a number of components, including arrangements for responding to complaints, together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice. This would ensure that high quality, effective treatment and care is delivered and that where things do go wrong, they are quickly addressed and lessons are learnt to help prevent re-occurrence.

80. The circular also explained that clinical and social care governance arrangements within organisations which provided or commissioned services would be underpinned by a **statutory duty of quality**. The introduction of this duty would mean that accountability for the quality of services provided, including commissioning, was comparable with the statutory duty that exists on HPSS bodies in relation to the financial management of their organisations.

81. The statutory duty of quality was included in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The duty of quality is set out in Article 34 of the Order and has been amended on a number of occasions. However, the duty of quality has applied to the five HSC Trusts since they were established in 2007. The current wording in the order is as follows:

34. (1) Each HSC trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—

(a) the health and social care which it provides to individuals; and
(b) the environment in which it provides that care.

82. Article 35 of the Order establishes that the RQIA has a number of functions relevant to the statutory duty of quality including conducting reviews of the arrangements organisations, subject to the duty of quality, have in place to monitor the quality and safety of services. The RQIA also has the function of carrying out investigations into, and making reports on, the management,

provision or quality of the health and social care for which statutory bodies have responsibility. The PCC is not in a position to comment on the discharge of these functions by the RQIA. However, for the purposes of clarity whatever reviews and inspections the RQIA undertakes do not meet the statutory responsibility of Trusts to put in place arrangements to monitor the quality of services they provide and to respond to any failings in the quality of that care. Whilst Article 34) (1) of the 2003 order focuses on the services which organisations 'provide', on the basis of circular 10/2002 the PCC's understanding is that the statutory duty of quality also extends to services which Trusts commission from other providers including the third sector, private sector and each other.

83. In January 2006 the Department of Health issued guidance to its Arms Length Bodies on Establishing an Assurance Framework[5]. The guidance was non mandatory and preceded the establishment of the PCC in 2009. However, in 2009 the Department issued an updated version of this guidance[6] for mandatory adoption by its Arms Length Bodies. The guidance was heavily linked to an Australia/New Zealand risk management model which is no longer in use on the same basis. However, at the time the guidance stated:

> *"Reducing risk is not just about financial or management probity. It is also – indeed, it is primarily – concerned with improving the safety, quality and user experience of services. This means that equal priority needs to be given to the obligations of governance across all aspects of the business, whether financial, organisational or in clinical and social care, together with a need for governance to suffuse each organisation's culture. Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements – in other words, a sound system of organization-wide risk management."*

[5] The PCC does not have a copy of this guidance.

[6] An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies

84. There is a particular focus in the guidance on the role of Board members. However, the guidance also states *"2.8 Board members will, however, wish to bear in mind the fact that responsibility for managing risk lies not with them but with the executive team."* Of course, in the case of HSC Trusts a number of members of the Executive Team are also Board members. There are three specific references in the guidance to the response to complaints:

- Para 6.5: *"the risk register will be linked to risk assessment and inspection programmes and regimes, incident reporting systems and complaints and legal case handling procedures."*
- Appendix 2 includes a Directorate level objective: *"To ensure the availability of an accessible easy-to-use complaints process, geared to providing patient/client/user satisfaction and enabling learning from complaints received to be shared within and without the organisation."*
- Appendix 3 includes a 'key control': *"Systems in place to learn from adverse incidents/ litigation and complaints"* and an associated potential gap in controls: "*Learning from complaints system needs to be reviewed to ensure learning is across the whole organization".*

85. In April 2009 the Department of Health issued both guidance and a 'Direction' to HSC bodies setting out the procedures to be used for dealing with Health and Social Care complaints. The same guidance and procedures, although subject to some amendments since 2009, are still in place today. The 2009 Direction to the Department's Arms Length Bodies was subject to three subsequent amendments:

a. 2 September 2013: To set out how complaints should be dealt with when the complaint has been escalated to a Serious Adverse Incident (SAI);
b. 22 March 2019: To replace references to the NI Commissioner of Complaints with references to the Northern Ireland Public Services Ombudsman; To replace references to the Protection of Vulnerable Adults Policy or Procedures with references to the adult safeguarding policy or procedures; and to replace references to the Department of Health, Social

Services and Public Safety with references to the Department of Health; and

c. 27 October 2022: To replace or remove references to the HSC Board; and to replace references to the Data Protection Act 1988 with references to the Data Protection Act 2018.

86. The amendment to the Direction on 2 September 2013 sets out the approach when a complaint is escalated to a Serious Adverse Incident. In these circumstances a complaint shall not be investigated or the investigation shall cease except in respect of any element of the complaint which is outside the scope of the SAI review. The most recent versions of the Department's guidance and standards have been amended to reflect this position.

87. In order to have a clear understanding of what this Direction looks like today, the PCC had developed a word version of the Direction **(exhibit MM/7)** updated to reflect these amendments (including insertions, deletions and wording amendments) with the amendments highlighted in red font. With the exception of the addition of references to the Serious Adverse Incidents in 2013 these amendments have not materially affected the underlying operation of the complaints procedure and roles and responsibilities within the procedure.

88. The 2009 Direction issued to the Department's Arms Length Bodies (ALBs) was underpinned by powers in three separate pieces of primary legislation which gave the Department the power to issue said Direction to its ALBs. Under these powers these ALBs must comply with the content of the Directions given to them by the Department and give due regard to the content of any accompanying guidance. The Direction included three specific references to the Patient and Client Council with which ALBs including HSC Trusts must comply:

a. Acknowledgement and record of complaint – Article 12

12.—(1) The complaints manager shall send to the complainant a written acknowledgement of the complaint within 2 working days of the date on which the complaint was made.

(4) The acknowledgement sent to the complainant under sub-paragraph (l) must include information about the right to assistance from the Patient and Client Council.

b. Annual Reports – Article 17

17.—(1) Each HSC body shall publish a report annually on its handling and consideration of complaints under these Directions which shall be sent to—

(b) the Patient and Client Council;

c. Publicity – Article 18

18.—(1) Each HSC body shall take such steps as are necessary to ensure that—

(a) any person connected with the provision of care by, or on behalf of that body;

(b) staff working for that body;

(c) the Patient and Client Council;

are fully informed of the arrangements for dealing with complaints and are informed of the name of the complaints manager and the address at which he can be contacted.

(2) The requirement to provide information specified in sub-paragraph (l) includes a requirement to provide information on the services which the Patient and Client Council offers to persons who wish to make complaints.

89. The Direction also states:

19. Each HSC body must ensure that its staff are informed about and appropriately trained in the operation of the complaints arrangements.

90. The Department's guidance issued in April 2009 and subsequent updates including the most recent version issued in April 2023 include a set of complaints standards which service providers, including Health and Social Care Trusts, are expected to adhere to. The guidance places an emphasis on seeking early and fair local resolution of complaints. The Departments states that the complaints system: "is *designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and*

improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs."

91. Consistent with the requirements imposed by the statutory duty of quality the guidance and standards issued by the Department places the responsibility for establishing and operating this complaints procedure on the organisations providing the service. In the case of HSC Trusts, the Chief Executive is accountable for the handling of consideration of complaints. It is the responsibility of the organisation providing the service to ensure that all of their staff are familiar with the HSC complaints process.

92. The Department guidance and standards place the onus on the organisation providing services to provide support to the complainant during the complaints process. It is not expected within the complaints process that all complaints will need or want to enlist the support of the PCC to fairly resolve their complaint. If that was to happen it would most likely indicate one or more of - a failure to operate an effective complaints procedure; a significant failure of internal control divergences and risk management within the organisations system of governance; a failure to comply with the Department's Direction and guidance on complaints; a failure to meet the requirements of the statutory duty of quality.

93. On the basis of the Department's Direction, standards and guidance the PCC does not have any power to require HSC Trusts to provide the PCC with the information set out at section 18(1) of the Direction. The PCC has no power to compel or require Trusts to adopt specific content when referring to the PCC and its role and there is no requirement for Trusts to seek PCC agreement as to the content of references to PCC in Trust correspondence, Trust resources e.g. pamphlets or on Trust digital media. It would however be challenging for the PCC within current funding levels to review such Trust material etc. on an ongoing basis.

94. The Department of Health publishes data on the numbers of HSC complaints each year. The most recent data is for the year 2022/23, and excluding the NI Ambulance Service, shows that the total number of complainants who raised complaints with HSC Trusts was 4,826. In the same period the number of complainants who sought casework support from the PCC in regard to services provided by these HSC Trusts was 453, or 9.4% of the total. Casework support refers to circumstances where we provide advocacy support to individuals, and, or families, including formal HSC complaints and SAIs. The PCC is not in a position to comment on whether or not all of these contacts are recorded by Trusts on their systems as complaints. In 2022/23 the PCC provided a further 837 people with advice and information.

95. The following table shows the total number of complainants by Trust and the percentage of complainants in each Trust supported by the PCC. Comparisons between Trusts may be affected by the different range of services provided by each Trust. The Belfast Trust for example provides a wide range of regional services. There are also differences in the demographics between Trusts and there may be differences in the availability of advocacy services from third sector providers between different Trust areas. It is not possible to say what impact these differences have on the figures in these tables.

Complaints to HSC Trusts in the Year 2022/23			
Trust	**Total Number of Complaints made by members of the public 2022/23**	**Total Number of PCC cases[7] in 2022/23**	**PCC Cases as a % of Total Trust Complainants**
Belfast Trust	1,633	155	9.5%
Northern Trust	840	95	11.3%
South Eastern Trust	865	95	11.0%
Southern Trust	830	60	7.2%
Western Trust	658	48	7.3%
NI Total	**4,826**	**453[8]**	**9.4%**

96. The PCC remit is not confined to hospital complaints. It covers both health and social care services and services provided in primary care for a population of 1.9 million. The PCC budget is £1.9m and its whole time staff equivalent is 34.9 staff when all posts are filled, to discharge all of its functions. The PCC is not resourced to provide advocacy support beyond the current caseload. The PCC is not resourced to provide independent advocacy in SAIs. More importantly, the PCC believes that it is essential that service provider organisations take the lead for, are responsible for and should be held to account for maintaining an accessible, supported, fair complaints process which supports learning as part of the expectation that they will provide a safe and quality service. There are many circumstances in which members of the public will wish to be supported by the PCC as an independent advocacy organisation but the PCC does not wish to see the responsibilities and accountability of service provider organisations weakened or diminished.

[7] In 2022/23 the PCC provided a further 837 people with advice and information. Cases refer to circumstances where we provide involved advocacy support to individuals, and, or families, including formal HSC complaints and SAIs.

[8] There were a further 116 cases which were attributed to Dental, GP, NIAS, Other or were unspecified

97. The PCC is not an inspectorate and does not have a direct role in the inspection or review of Health and Social Care Services. The PCC can however raise and support service users to raise concerns and issues directly with the Department, the RQIA, the Ombudsman, Children's Commissioner or Commissioner for Older People all of which do have powers to investigate or review different aspects of HSC Trusts services and to hold Trusts to account.

98. An example is a SHSCT Family who are members of the PCC SAI Engagement Platform. This case relates to the homicide in the community of two members of the public by a male person. Following submission of the first SAI Review Report to the HSCB and as a result of criticism of the investigation and the process for the reporting and management of an SAI by the family of the victims, the Director of Nursing (PHA) commissioned an independent review of the SAI process. The family have experience of 2 SAI's and a SAI Process Review. Over a 5-year period from 2018 the family were supported by the PCC to engage with the Trusts, HSCB / PHA and the Department in the implementation of the recommendations of their SAI. This included:

- Public Apology – the Permanent Secretary made a public apology to the Family following their meeting.
- At a meeting with the Chief Executives of the Health and Social Care Trusts, the Permanent Secretary for Health, Richard Pengelly, will make it clear that the SAI guidance must be followed; this includes the clear guidance about the involvement of families. It will also be made clear that the definition of "families" does include those such as the family, who had been the victims of an act committed by an individual under HSC care. While the guidance is currently being reviewed to ensure that there is no scope for misunderstanding, Chief Executives will be held accountable for ensuring that this underlying ethos is met immediately.
- The Department of Health (DOH) will make clear to Trusts that in circumstances such as that of this family, that the offer of contact and support should be made proactively by the HSC Trust as soon after the incident as

possible. The DOH will write to each HSC Trust asking them to ensure that this is actioned.

- DOH will write to the Chief Executives of all HSCNI organisations to advise that legal advice is not instruction and that they will need to follow their own judgement before following it.
- Facilitating meetings with all family members and the SHSCT Senior Management in Nov and Dec 2019 to explain and explore how the family felt that they were treated by the Trust as outsiders to a personal traumatic event, in which three family members had been directly present. In the absence of information, engagement with the HSC Trust and answers to their questions, the family set out on a journey to understand what happened. This had caused significant distress. Central to going forward it was essential for the senior Trust personnel to hear and understand how actions taken by Health and Social Care Services impacted on the entire Family.
- RQIA met the Family who then engaged with the SAI Review Team and further discussions following publication of the report.
- PCC engaged with HSC Trusts to assist family to access trauma support
- Joint working with the Mental Health Champion and RQIA in driving forward public engagement in SAI's, the development of policies and procedures and giving recognition to all victims when things go wrong.

99. It is important that members of the public, the PCC, the Department of Health and other stakeholders have regular independent assurance that HSC Trusts are operating the HSC complaints process in a manner which is consistent with the intent of the policy and consistent with the Department's Direction, guidance and standards. There is currently not a specific requirement for any review at specified dates or intervals of the operation of HSC Trusts complaints procedures by any specific statutory body.

1. HSC Trust Staff and the staff of organisations commissioned to provide services by HSC Trusts should be trained and have familiarity with HSC complaints processes

2. A failure to operate an effective complaints procedure will increase the risk to both the Trust and to patients and may be an indication of issues of gaps in governance and internal control/divergence issues.

3. Although the PCC has a broad range functions in relation to HSC, competing functions need to be balanced against an increasingly constrained budget.

Serious Adverse Incidents

100. The Hyponatraemia Inquiry report published in January 2019 made a number of recommendations which are relevant in terms of Trust governance and Trust adherence to various processes. A number of these recommendations were specific to the SAI process and in some instances would more closely align the SAI process with the operation of the complaints procedure. These are as follows:

Serious Adverse Clinical Incident Reporting

31. Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').

32. Failure to report an SAI should be a disciplinary offence.

Serious Adverse Clinical Incident Investigation

33. Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.

34. The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.

35. Failure to co-operate with investigation should be a disciplinary offence.

36. Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.

37. Trusts should seek to maximise the involvement of families in SAI investigations and in particular:

(i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.

(ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.

(iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.

(iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.

(v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.

(vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.

(vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.

(viii) Family GPs should, with family consent, receive copies of feedback provided.

(ix) Families should be formally advised of the lessons learned and the changes effected.

(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation.

38. Investigations should be subject to multi-disciplinary peer review.

39. Investigation teams should reconvene after an agreed period to assess both investigation and response.

40. Learning and trends identified in SAI investigations should inform programmes of clinical audit.

41. Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.

42. In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.

Trust Governance

69. Trusts should appoint and train Executive Directors with specific responsibility for:

(iii) Learning from SAI related patient deaths.

72. All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.

80. Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.

81. Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.

82. Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.

83. Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.

Department

86. The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.

101. There may be other recommendations from the Hyponatraemia Inquiry, in addition to those included in this statement, which would be of interest to the Urology Services Inquiry. A number of these recommendations are relevant to addressing underlying issues with the SAI review system. In the context of the PCC's role in the SAI process, which is focussed on providing advocacy services for individuals and their families, and promoting their engagement, Recommendation 37(iv) is particularly relevant:

37. Trusts should seek to maximise the involvement of families in SAI investigations and in particular:

(iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.

102. The PCC strongly supports the introduction of this advocacy service which whilst it will not address other underlying problems with the SAI process will at least mean that service users can be routinely properly supported through the SAI process.

103. The complaints system is focussed on ***seeking a resolution to complaints*** raised by individuals and their families. The SAI review process is different in that it is a system mechanism designed to ***identify learning*** when something has gone wrong. Whilst some SAI reviews arise out of a complaint made by a service user or their family, many SAIs are initiated without a HSC complaint having being made.

104. Our understanding, based on a review of available information, is that in the cases of some of the SAIs initiated in regard to Urology in connection with Mr O'Brien, they were initiated in response to concerns raised by staff and management, in response to a professional regulatory process such as Maintaining High Professional Standards (MHPS) or in response for example to issues identified as part of a Lookback exercise.

105. The Serious Adverse Incident system operates separately from the complaints system under guidance issued by the Health and Social Care Board (SPPG). The Serious Adverse Incident policy and procedure is currently subject to a review by the Department of Health and they have established a project structure to undertake this work, including a redesign group. As stated in paragraph 67, the PCC is not a decision-making member of DoH/HSC bodies groups thus ***ensuring independence***. We can, and should, given our statutory functions and the HSC Framework objectives, participate and provide information, commentary, advice and input, particularly based on hearing directly from the public and from our (PCC staff) experience in working with the public, but our operational independence requires that the PCC is not a member of the SAI redesign group. PCC do attend meetings and provide input.

106. The objective of the PCC is to provide a powerful, independent voice for patients, clients carers and communities on health and social care issues through the exercise of its functions. To meet this objective, we have designed and created a ***theme-based engagement platform*** (para 59) dedicated to this SAI redesign process. The members are a small number of families who have had a direct experience of the SAI process. Their experience includes complex SAI's, engagement with the Trusts, HSCB and the Department in the implementation of the recommendations of SAIs.

107. The PCC only has access to information that is publicly available. Based on the transcripts from Inquiry hearings involving patients and family members in

June and September 2022; it does appear that a number of SAIs may have been initiated by the Trust without families having made a complaint or even being aware that there were issues with the care provided by the Trust's urology service.

108. SAI reviews can also be prompted by issues such as data breaches and estates failures as opposed to the direct care provided to a patient or service user. The SAI process is governed by guidance issued by the HSCB/SPPG in 2016. The process is not underpinned by legislation or a Department Direction and although the guidance issued by the HSCB (now SPPG) refers to the PCC, the PCC role is not specified in the same way it is in the Complaints Direction issued by the Department of Health. The SAI system is managed and monitored by staff in SPPG whilst staff in the Public Health Agency also play a role in the process.

109. There are approximately 400 - 450 SAIs notified by HSC Trusts each year. The Trust's categorises each as either level 1, Level 2 or Level 3. Level 1 reviews are subject to a desk top review within the Trust; Level 2 reviews are subject to review by a panel established by the Trust and Level 3 reviews are subject to review by a panel independent of the Trust. The SPPG can query the Level ascribed by a Trust to a SAI. Their assessment will largely be dependent upon the description of the incident or issues provided to the SPPG by the notifying Trust.

110. The PCC has recently responded to a Department of Health initial consultation on the outcome of an Independent Review of Children's Social Care Services. The final review report includes two recommendations for the development of Independent Advocacy Services. The PCC response included the following which we believe should underpin the provision of advocacy services within the Health and Social Care system by the PCC or any other provider including in relation to both SAI reviews and Inquiries:

- *Advocacy services should be commissioned as regional services and provided independently of HSC Trusts;*
- *Advocacy services should be commissioned independently of HSC Trusts;*
- *Advocacy services should be commissioned on the basis of agreed standards which include addressing the role of these advocacy services in dealing with complaints and concerns raised by clients, responding to safeguarding issues and systems of regulation of services and the workforce.*
- *The service specification with providers commissioned to provide advocacy services should specify how these service providers relate to the Patient and Client Council in the discharge of its statutory roles (where the PCC is not the provider or commissioner of the service).*
- *The same specification should specify a minimum data set to be collected by the service provider both for the purposes of monitoring the providers performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts.*
- *Access to these advocacy services should be client led and not solely dependent on a referral by HSC Trust.*
- *The PCC also believe that part of the role of advocacy service providers for advocacy services should include the development of information packs for clients and potential clients which explain to them roles and responsibilities, their rights and identify to service users other bodies where they can access support.*
- *It is also the view of PCC that the Department should ultimately place any specialist or targeted advocacy services (e.g. as part of the SAI process) on a statutory footing at the earliest possible opportunity either through amendment to the PCC's primary legislation functions or elsewhere if it is not determined that the PCC should lead on the provision and/or commissioning of these services.*

111. The PCC is currently supporting a limited number of service users and families through the SAI process. This is challenging within the PCC's current resources. Any new SAI advocacy service must be adequately resourced. (para 15-21)

Other Powers of the PCC

112. Articles 17 to 20 of the 2009 Reform Act specify the functions and other matters connected to the PCC's discharge of those functions. Whilst over the past several years resourcing (Refer to paragraph 15-21) has been an issue for the PCC as it has been for other HSC Bodies it is important to understand the limitations of the legislation and the parameters within which the PCC discharges its functions. The articles are as follows:

- Article 17 – Functions of the Patient and Client Council;
- Article 18 – Duty to co-operate with the Patient and Client Council;
- Article 19 – Public involvement and consultation; and
- Article 20 – Public involvement: consultation schemes.

113. The 'bodies' which come within the remit of Articles 18, 19 and 20 apply includes both the Department of Health and HSC Trusts.

114. Article 17 specifies a range of functions of the PCC which in addition to supporting clients who wish to make a complaint about Health and Social Care services also includes:

(a) representing the interests of the public;

(b) promoting involvement of the public;

(d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

115. Article 18 requires these bodies to co-operate with the PCC in the discharge of its functions. Whilst this article requires these bodies to consult the PCC, this is only in respect of matters and on such occasions as these bodies ***'consider appropriate'***. Similarly, whilst the PCC can essentially require these bodies to provide the PCC with information which the PCC requires in line with the PCC's functions, the information provided is subject to whatever conditions the ***providing body decides upon***. This Article also gives the PCC Council a power of entry to premises controlled by any of these bodies. However, this power applies to members of the Council i.e. the PCC Board and does not extend to PCC staff and can only be exercised in connection with the PCC's functions. Finally, under Article 18 these bodies must pay 'due regard' to the views of the PCC but are ***essentially free to ignore those views*** if they so wish.

116. Article 19 places requirements on these bodies to take steps with regard to public involvement and consultation but it is for the bodies themselves to decide what steps are appropriate. The same article required these bodies to prepare a consultation scheme for the Department to approve. Although this would be after consultation by the Department with the PCC it does not require that the PCC's views must be taken account of.

117. Article 20 requires that the consultation scheme must make it clear how it will involve and consult the PCC (amongst others) in regard to planning services etc. and must pay due regard to the views of the PCC (amongst others).

Organisational development

118. The PCC is a small organisation which currently employs less than 35 whole time equivalent staff (when all posts are filled). The structures and development of the PCC in the period 2012/13 until 2019/20 were undoubtedly affected by financial constraints which applied to the entire health and social care system. As described in paragraphs 15 to 21. In maximising the limited powers of the PCC, we can engage with and work with other statutory bodies which do have a wider range of powers to investigate, inspect, review and regulate health and social care services and the workforce employed in the sector. In the last four

years the PCC has had the opportunity to reflect on its practice model, and how it maximises and targets its resources, and as a consequence has introduced the new practice model described at paragraphs 46 to 74.

119. The PCC has an extremely limited role or contribution to make in respect of the governance of HSC Trusts as set out in Department of Health Circulars, guidance, and regulations.

120. The PCC would wish to expand its role to focus more effectively on public involvement within the health and social care sector. The PCC considers an expanded role would be both in the public and patient's interest. Subject to the availability of resources the PCC hopes to be able in the future to develop more capacity to engage with HSC Trusts regarding the involvement of the public, patients, services users, carers within the planning and service delivery arrangements within each HSC Trust.

121. NISRA population figures and projections, show that the population of NI has risen steadily over the past 20 years, with an increasing growth in the older (65+) population, and the population is still continuing to increase. In 2010 the population was 1.8m and by 2020 had increased to 1.9m.

122. The PCC budget reduced significantly from £1.804m (2012/13) to £1,435,984 in 2019/20. To set this in context, this represented a reduction of circa £368,000 over that seven-year time period without taking into consideration inflationary costs. The expected increases in line with inflation were circa 2% each year, thus in net terms the expected PCC budget allocation in 2019/20 was worth 40% less than the 2012/13 allocation. This level of funding requires us to exercise a great deal of prudence in terms of resource allocation and means we take an evidence-based approach to designating resource given the opportunity cost of dedicating resource on a challenging budget. Paragraph 15-21 sets out in detail the history of the reduction in funding to the PCC and the current budget.

1. The PCC believes that the HSC system would benefit from greater public involvement and participation. Hearing directly from the public experience and harnessing this information could provide an opportunity for trends to be spotted sooner and for issues to be resolved before they turn into systemic crises and thus leading to costs savings across the HSC system. PCC would require a significant resource investment and a review of the legislative powers to maximize this opportunity.

2. The PCC budget has operated against a 40% decrease in budget, in net terms, over the past decade and in circumstances of increased demand and more complex cases.

123. The PCC has a clearly defined role in providing advocacy services to service users and the public who wish to make a complaint about health and social care services (para 46-54). The feedback from those to whom we provide this advocacy support is positive. The PCC has pursued a range of initiatives (paras 49, 57, 71-74) designed to increase our footprint in the community and expand the range of opportunities available to the general public, service users and the public to become involved in policy and service planning / development / improvement initiatives being progressed by the Department of Health and HSC Trusts.

124. The Framework documents sets out in paragraph 2.47 *"The PCC's relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to discharge its statutory functions efficiently and effectively on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC*".

125. Paragraph 2.47 of the Framework Document summarises the constructive tension at the heart of the PCC's functions – balancing on the one hand,

remaining independent to be able to exercise a challenge function on behalf of the public, whilst on the other hand retaining constructive relationships with the wider HSC is critical in enabling the PCC to maintain influence.

126. This demonstrates how the PCC has very limited statutory powers with which it can directly influence the provision of Health and Social Care Services (para 115). Therefore, the PCC is partly dependent on building constructive and productive relationships and arrangements with service providers, the third sector and other statutory bodies who have powers to investigate and take enforcement action where there are problems with the quality and availability of health and social care services. The limitations of statutory powers coupled with the PCC's size and budgetary constraints means that the PCC can lack the desired leverage when seeking to achieve positive change. Potential opportunities to maximise influence on behalf of the public is compromised as a result.

127. The approach of establishing partnerships and building relationships with others can mean that the PCC is able to exercise a positive influence on the sector – albeit via soft skills such as, mediation and collaboration rather than though hard statutory obligation. However, this approach requires a significant commitment of time and resources for a small organisation like PCC and can take longer to reach a point when results are being achieved.

1. Despite the limitations of the PCC's statutory powers, the PCC has been innovative in increasing opportunities for families to engage with policy planning and development.
2. As such the PCC is very much a learning organisation and has sought to increase its effectiveness, despite its modest budget, through this innovation and evolution.
3. The absence of statutory tools means the PCC has to use collaboration, cooperation and discussions to ensure changes in HSC sector that reduce patient risk and/or improve the quality of service and the user experience.

Urology Services Inquiry

Role of PCC in complaints

128. The PCC provides a support service to individuals who have an issue with health and social care services or who wish to make a complaint about health and social care services. The ways in which service users and the public can access PCC services are described at paragraphs 46-49, 57, 71-74 above. However, the involvement of PCC in supporting a complainant mostly arises through direct contact being made by an individual or their representative with the PCC. In some cases, the individual will have been referred to the PCC by a member of HSC staff or been advised of the PCC role by HSC staff. As set out above, the PCC are named within the HSCNI Complaints Procedure and Departmental complaints direction under which all of the HSC Trusts operate, and often within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support.

129. The complaints procedure is clear in setting out the role of the Chief Executive, Directors and complaints managers within Trusts. Any assessment of the role of Trust Boards, Trust management and general hospital staff needs to take account of what training and information is provided within Trusts on how to respond to complaints. This is not just about providing training; it is about the content of that training. The experience of service users who seek assistance from the PCC is that the response to complaints by Trust staff is variable. However, it also has to be recognised that at times it is not within the gift of front-line staff to deal with the complaints being made to them.

1. It is not always evident that HSC Trust staff have been trained on the appropriate complaints process and this potentially increases risk to patient's safety and a collapse of the proper procedural requirements.
2. The PCC considers that a greater knowledge of the PCC and the complaints process will reduce confusion and inconsistency in complaints.
3. Although a HSCNI standardised process is set out it is not always apparent that this process has been followed.

130. The current complaint system places the onus on the service provider to address and resolve fairly the complaint. The PCC believes that this is the correct approach. The PCC would welcome changes to the system which provide more independent assurance that HSC Trusts are adhering to the requirements of the Department's Direction on complaints and Departmental guidance and standards on complaints as well as SPPG guidance on SAIs.

131. The PCC would also welcome changes to the governance requirements placed on HSC Trusts to require them to report to their Boards on a regular basis, hard data and evidence against the requirements of complaints guidance and standards and the Complaints Direction including the Training of HSC Trust staff and the monitoring of contractual arrangements with organisations commissioned to provide services on behalf of a Trust. This would have the twin benefits of providing the Boards with assurance on the operation of the complaints procedure within their Trusts whilst reasserting the primary responsibility of Trusts to address the concerns raised by complainants. Action taken by Trust Board's to review the data would enhance their ability to monitor the quality and safety of the services they provide

1. PCC would welcome an amendment to the Departmental Direction and update to the Guidance to require Trust Boards to report on how they have met the specific requirements in the Complaints Direction, Standards and Guidance.

132. The PCC is working to strengthen further how it works more closely with third sector organisations to utilise their networks to increase knowledge and understanding of the role of the PCC (para 70). We are also working to raise awareness with the public and the Trusts. This will involve engaging with Trusts to jointly review the material and communications that Trusts send or provide to complainants to ensure that references to and information about the PCC receive sufficient prominence and provide clarity on how to easily contact the PCC.

133. The PCC are aware that any initiative which increases the number of service users and the public seeking advocacy from the PCC has implications for its resourcing and in those circumstances would need to engage with the Department through a business case. Whilst understanding the current financial situation in Health and Social Services, patient safety should not be jeopardised due to financial barriers.

134. It is not possible to comment further on how well access to PCC worked without research into the topic.

PCC Engagement with SHSCT

135. PCC engages and interacts with the Southern Trust, as it does with all HSC Trusts, in furtherance of its statutory duties and functions across the range of activities PCC undertakes in advocacy and engagement. Please refer to the description of the post-2019 practice model described at paragraph 46 - 74.

136. In respect of our statutory role to provide assistance to those who have issues in health and social care, this engagement occurs with respect to individual casework relating to Southern Trust cases. In these instances, individual practitioners would contact the relevant Southern Trust staff to address issues as per the PCC practice model.

137. An example of where PCC engaged with the Southern Trust on a group advocacy basis, and in advising on the best methods to engage and involve the public, was in relation to the **SAI Level 3 Nosocomial Covid Infections in Craigavon Hospital and Daisy Hill Hospital.** In October 2020 the PCC met with the SHSCT to provide advice on planning patient and family engagement in the above-named SAI which impacted 32 individual patients' families. The PCC engaged with the Trust to advise on designing engagement in the SAI with those affected, based on our previous experience working with families. The PCC also identified a named Senior Practitioner to support and engage with impacted

families providing independent advocacy support, working in conjunction with the SHSCT Family Liaison Officer. The SAI was completed in 2022 with some patients' families continuing to engage with the PCC thereafter. Throughout the course of the SAI the PCC continued to engage with the Trust to ensure that patients and families were communicated with regularly and to ensure bereaved families were afforded appropriate support services.

138. In respect of our statutory role to represent the interests of the public and promote involvement of the public in health and social care, PCC also facilitate engagement across a range of programmes regionally, in the course of which staff would engage with the Southern Trust.

139. A recent example of this has been our work in learning disability. PCC's facilitation of our Learning Disability (LD) Engagement Platform for Carers highlighted various concerns raised by carers in the SHSCT. Many carers expressed satisfaction with the previous carer's forum running in SHSCT, which allowed them to share their concerns with the Trust and felt it led to more positive outcomes. Unfortunately, the forum was disbanded with no support available for some time. Following on from this, the SHSCT created two carer consultant roles, but some members of the LD engagement platform feel that two individuals cannot fully represent all carers' experiences. They are seeking more meaningful engagement avenues.

140. In November 2023, the PCC met with Managers and the Head of Specialist Services in Learning Disability to discuss engagement opportunities for carers in the Southern Trust. The role of the carer consultant was explained as well as engagement opportunities to date and we discussed issues raised on the PCC LD Platform. These issues included day centre closures for training purposes, infection control and opening times. We agreed that further engagement with the LD Platform is crucial to ensure all carers' voices are heard, and this work will continue into 2024 with a meeting between families and the SHSCT.

141. A further example of this would be PCC's attendance at the Southern Trust's Patient and Client Experience Committee (PCEC). A PCC representative attended the SHSCT's PCEC in June 2021, December 2021 and March 2022. At these meetings the PCC provided a paper to the Committee, which gave a high-level update of the Patient and Client Council's regional engagement and advocacy work.

142. PCC's understanding is that as of June 2021, when the Committee's Terms of Reference were updated, the Committee is a sub-committee of the Board of the SHSCT with the stated role to:

- Provide assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient, client and carer experience and involvement;
- Identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience;
- Ensure that patient, client and carer experience improvement initiatives are in place to address identified shortcomings and that these are monitored.

143. Prior to 2021, our understanding is that this Committee had less of a focus or role in providing assurance to Trust Board on the patient experience and more on providing assurance that the Trust is meeting its PPI responsibilities.

144. PCC's capacity to attend and regularly engage in this Committee, and in similar Committees in other Trusts is significantly limited by resource.

Urology Services and the Southern Trust

145. In preparation for responding to the Inquiry's request to understand how, when and what action the PCC took in relation to becoming aware of the problems within the urology services at the Southern Trust, I contacted and requested input from Ms Vivian McConvey, CEO (from April 2019 – April 2023)

and Mr Johny Turnbull, Service Manager (May 2020 - Nov 2022). They had taken the lead in communications with the Trust.

146. Our understanding is that Minister Swann informed the Stormont Assembly on 24 Nov 2020 of a further occurrence of serious concerns about the clinical practice of a hospital consultant having been notified to his Department by one of the Health and Social Care Trusts. This incident concerned the clinical practice of a urology consultant, Mr Aidan O'Brien, who earlier that year retired from the Southern Trust. On 31st July 2020 the Southern Trust contacted his Department to report an Early Alert concerning the clinical practice of the consultant. The PCC is not copied into early alerts provided to the Department and would not normally be contacted by the Department to establish what intelligence the PCC holds which may be relevant to an early alert. The Trust informed the Department that on the 7th June 2020 it became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of the consultant urologist employed by the Trust.

147. The first communication received by the PCC was received on 1st Dec 2020, when Ms McConvey (CEO) received an email from Ms Caroline Cullen, Senior Commissioning Manager, SHSCT writing on behalf of Paul Cavanagh Interim Director of Planning and Commissioning HSCB in his role as chair of the SHSCT Urology Coordination Group. Ms Cullen stated that as a group they would be most keen to have the PCC involved. The Trust did not clarify or specify the assistance required.

148. The Southern Co-ordination Group was to provide oversight of the Urology Inquiry in respect of patients identified as previously being under the care of Consultant 'A' i.e. Mr O'Brien. The Group was also to be responsible for providing the DOH with assurance regarding the rigour of approach pursued by the Southern Trust and the timeliness of patient review.

149. Specifically, the role of the Group was to:

- Coordinate and provide oversight of the operational work necessary to complete the enquiry and a review of patients affected.

- Establish subgroup(s) as deemed necessary to complete specific pieces of work.
- Work with Southern Trust to clarify their assessment of the numbers of people who may be affected.
- Work on identifying patients who Consultant A may have treated privately and review if necessary and work with DOH and HSE on ensuring these patients are considered.
- Ensure a consistent approach to the recall and review of people affected, including producing consistent aggregate summaries of the outcomes of these recalls and reviews.
- Seek assurance regarding the ongoing capacity available to ensure timely review.
- Ensure good communication on issues that need to be addressed.
- Seek assurance on the arrangements in place to maintain service continuity in the Southern Urology Service.
- Draft a report on the activity of the enquiry and the outcomes, to be submitted to the DoH for approval and subsequent publication. Provide regular assurance to DOH.

- Complete an IPT on the staffing support required to meet the needs of the patients identified during the enquiry, including support for the information line, clinical activity and activity/data gathering. To be submitted to the HSCB for approval and subsequently to the DOH.

150. Ms McConvey followed up with a phone call to Ms Cullen and then responded by email to Ms Cullen on 3rd Dec 2020, sharing examples of communication to families. A zoom meeting was scheduled for 17th Dec 2020, though this was subsequently cancelled. The meeting was rescheduled for 2pm on 25th Jan 2021and was cancelled on 21st Jan 2021

151. The extent of the PCC's subsequent engagement with The Southern Co-ordination Group is as follows:

- 23rd Feb 2021 – meeting attended by Paul Cavanagh Director of Hospital Commissioning, HSCB and Caroline Cullen, Senior Commissioning Manager, HSCB. Ms McConvey was provided with an overview of the action being taken by the SHSCT and the HSCB in response to the concerns about the practice of Dr O'Brien. Ms McConvey shared the experience of the PCC in relation to supporting previous Inquires. At this point, the Trust and the PCC were to consider what happens with the Public Inquiry, the role of the PCC and explore patient engagement.
- 8th April 2021- Meeting attended by Patricia Grimley, HSCB, Paul Cavanagh, HSCB, Sylvia Irwin, HSCB, Caroline Cullen, HSCB, Vivian McConvey, PCC, Melanie McClements, SHSCT, Emma Stinston, SHSCT, Michael O'Neill, DOH, Annemarie Boville, DOH. The Southern Trust provided an update on the action being taken. They set out their support with families.
- 27th April 2021 - the PCC received an email from Mc Cullen apologising for not having been in touch. They provided a SHSCT Update Report.
- 5th May 2021 - a follow up email from Ms Cullen apologised for the lack of contact and difficulty in setting an agreed date for the proposed informal workshop. She suggested a smaller group meet and prepare in advance of the meeting on 20th May 2021.
- 13th May 2021 - PCC Service Manager met with Ms Cullen to discuss the Trust engagement with the families.
- 20th May 2021 - the PCC met with the HSCB, DOH and SHSCT. Paul Cavanagh, HSCB, (Chair), Sylvia Irwin, HSCB, Caroline Cullen, HSCB, Vivian McConvey, PCC, Jonny Turnbull, PCC, Melanie McClements, SHSCT, Patricia Kingsnorth, SHSCT, Michael O'Neill, DOH, Paula Ferguson, DOH. The Trust gave a brief overview of the progress to date and noted the review to date covered the period January'19 to June'20 and the following main points were noted. The PCC staff were

exploring what assistance the Trust would additionally require to support the patient engagement they already had in place. Throughout the meeting advice was provided in relation to key areas including leaflets for families, communication and psychological support.

- 6th Oct 2021 - Ms V McConvey, CEO & M Monaghan, Head of Operations met with Anne Donnelly, Inquiry solicitor to provide an update on PCC role in supporting public engagement in a Public Inquiry
- 17th Dec 2021 - Ms V McConvey, CEO & M Monaghan, Head of Operations met with Ms Laura McMahon, USI, Ms Fiona Marshall, USI and Ms Anne Donnelly USI to share insights and understanding of patient perspective in public inquiries and the role of PCC in supporting the public during an Inquiry process.

1. PCC was involved with the SHSCT Urology Coordination Group where the PCC advised on patient engagement.
2. PCC engaged with the Inquiry Team to discuss and agree how the PCC would potentially support public engagement.

152. The Inquiry's Section 21 notice, requested the PCC to set out how the PCC liaises with Trust Boards in furtherance of our statutory remit.

153. The PCC does engage with HSC ALBs through for example NICON. In the past the PCC has attended Board meetings of HSC Trusts and in some instances was afforded speaking rights at those meetings. The PCC believes that it would be more helpful to the Boards of HSC Trusts if the PCC had a role in contributing to for example annual quality report so that Board members were receiving more information directly from an independent source. However, the essence of the statutory duty of quality is that the Trusts must themselves establish effective systems of Governance and it should never be the case that the PCC are raising issues with a Trust Board that has not already been flagged up to them through their internal governance arrangements.

154. One proactive measure would be to include within the Department's guidance on governance a requirement for the PCC to provide direct feedback e.g. on an annual basis to Trust Boards based on the experience of service users gathered from the PCC's role in SAIs, complaints etc. Whilst this might be a useful addition to Trust governance arrangements, the PCC does not currently have the resources or budget to provide such a service. However, the ability for the PCC to meet this requirement could only be achieved through the provision of a dedicated resource to provide an independent review of the Trust Quality Reports.

155. In response to the Hyponatraemia Inquiry the Department of Health developed extremely detailed guidance for Board members of ALBs. As yet, new training centred on this new guidance has not been developed although this has to be understood in the context of the COVID pandemic when understandably the Department's resources were heavily focussed on the pandemic response. The PCC would welcome the development of such a training course for Board members. Through the engagement of patients and service users providing a direct input to this training course, Board members would be alive to their experience and the need to have that voice amplified when monitoring patient safety. PCC would welcome the opportunity to participate in the development and delivery of this training.

1. Training should be provided to Board members on good practice in monitoring complaints, SAI and incidents and listening to service users.

156. The Trusts publish annual quality reports which describe the work they are doing to sustain and improve the quality of their services. This includes developments in relation to public involvement. As stated in paragraph 115, Article 18 requires these bodies to co-operate with the PCC in the discharge of its functions. Whilst this article requires these bodies to consult the PCC, this is

only in respect of matters and on such occasions as these bodies ***'consider appropriate'***. In the absence of independent evaluation, the PCC is not in a position to comment on how effective or impactful the changes described in the SHSCT reports are and PCC has no role in providing input or commentary to these reports from the perspective of service users who have been assisted by the PCC. The Southern Trust's most recent three annual quality reports make no mention of the PCC. However, there are some references to the PCC in the 2019/2020 annual quality report in relation to a project to deliver training to Service Users and carers on participation and engagement.

157. The Inquiry's Section 21 notice requested the PCC to reach a view on the effectiveness of the corporate and clinical governance and arrangements within the Trust.

158. Department of Health Arms Length Bodies are expected to include in their annual reports and accounts details of 'Internal Divergence (Control)' issues. An internal control divergence is essentially a service failure which existing governance arrangements have not prevented and in many cases has failed to detect for some time. As part of the report, ALBs are expected to report on what actions they have taken to address these failures in internal control divergence. However, it is for each ALBs to determine which internal control issues they report, how they describe these internal control issues and what actions they have taken. These annual reports including the identification of control issues are an essential part of the accountability arrangements between an ALB and the sponsoring Department.

159. On the basis of evidence to the Inquiry as included in Counsel to the Inquiry's opening statement on 6 September 2022 there were a number of SAIs initiated in 2017 and 2018 and an MHPS investigation reported in 2018 upheld the concerns in regard to Mr O'Brien "*related to the failure to triage large numbers of referrals; the failure to dictate clinical correspondence following outpatients clinics for large numbers of patients; the retention of large numbers of patients' notes at home or in his office; and the advantaging of some private patients. It was determined, following*

this investigation, that Mr. O'Brien should appear before a conduct hearing and that a further action plan with monitoring and a job plan should be formulated. It was also determined that there should be an independent review of administrative arrangements because of systemic management failings. Only the latter recommendation was carried out; that is the review of the systemic management failings. Only that was carried out and even this took almost two years to commence. The actions in relation to Mr. O'Brien were not addressed at all."

160. A failure to follow through on the recommendations of the MHPS investigation that Mr. O'Brien "*should appear before a conduct hearing and that a further action plan with monitoring and a job plan should be formulated*" could be a significant failure in internal control. The fact that it took two years to initiate a review in relation to '*systemic failings'* could also be an internal control issue. However, with issues involving staff performance and professional regulation etc. there may be other factors etc. which have negatively affected the speed with which the Trust was able to progress these matters. The impact of this is set out in paragraph 197.

161. These comments are made on the basis of limited information and it is not the PCC's understanding that every divergence control issue is included in an annual report. You would however expect to see an issue described as a systemic management failing in 2018 reflected in reports to Trust senior management and the Trust Board and recorded on risk registers including details of actions/measures taken to mitigate risks and subsequent reports on steps taken to address these failings.

162. The PCC has included these comments by way of illustration of the relationship between an ALB and the sponsoring Department. The PCC has no role in this in respect of the internal Governance of Trusts or the Department's sponsorship of Trusts.

163. In instances where the PCC becomes aware of specific issues with a Trust, the PCC will engage directly with the Trust or can alert other statutory bodies such as RQIA. This relates to casework or group advocacy. The PCC believes that strengthening the requirement for Trusts to provide information to the public on actions they have taken to address issues identified in response to complaints and SAIs will provide further clarification on action taken and how this will protect the public in the future. However, more of this information should be in the public domain through the annual quality reports.

1. More robust independent monitoring of Trust responses to SAIs and complaints is required.

Review of PCC casework/complaints relevant to the Inquiry

164. To assist the Inquiry, the PCC has reviewed the records PCC holds and identified any complaints relevant to the Urology Services Inquiry. The case evidence will be provided in three sections. Pre-2009, 2009 to 2019 and 2019 to 2024, reflecting periods of change in the PCC's operations and practice model, detailed later in this statement. The PCC has forwarded to the Inquiry the documents which PCC holds about each of these complaints.

165. From 2012 PCC implemented a case management system called 'Alemba' to record case files in relation to complaints referred to the organisation. The PCC is also in possession of a number of hard copy case files transferred from the legacy Health and Social Services (HSS) Council when PCC was set up in 2009 or that were dealt with by PCC from 2009 until the 'Alemba' case management system was introduced in 2012. All case file record sources, either Alemba or hard copy, were reviewed. The table below sets out the number of complaints relevant to this Inquiry.

Year	SHSCT cases
Pre-2009 – HSC Councils	4
2009 – 2019 PCC	26
2019– present day PCC	7
Total	37

166. In relation to the **4 cases from pre-2009**, 1 case, dating back to 2001, related to a patient under the care of Mr O'Brien, however, the quality of Mr O'Brien's care was not the subject of the case, which focused on waiting times and the attitude of staff. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.

167. In relation to the **26 cases from the period 2009-2019**, 8 cases related to patients under the care of Mr O'Brien, or Mr O'Brien was referenced within the case notes. 6 of these 8 cases related to waiting times or a delay in follow up procedures. From a review of the case documentation recorded at the time, the PCC worked with the Trust and the patients/clients, and the issues were resolved to the client's satisfaction. 1 case related to concerns about out- and in-patient care at Craigavon Area Hospital. This case was investigated by the Trust, who concluded the treatment was appropriate. The client subsequently elected to take legal action, and the case was closed by the PCC, which is a pre-legal service. The remaining case related to a patient who, through a private appointment with Mr O'Brien, was advised he would be placed on the NHS list, but this did not occur. The case was resolved, with support of PCC, with an NHS appointment for surgery received by the patient.

168. Of the remaining 18 cases, which were not under the care of Mr O'Brien; 10 related to waiting times or delays in procedures, with the remaining covering issues concerning diagnosis, vaginal mesh and care quality. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.

169. Of the **7 cases identified from 2019 – present**, none referred to Mr O'Brien. 3 cases related to waiting times or delays in procedures; 2 concerned support and information provision regarding SAIs. A further case was a general query from a third party concerning the Urology Inquiry. Advice was provided regarding PCC services and support, however, no direct support from PCC was sought by the third party or a member of the public. The final case related to a patient who wished to complain about care and treatment during a day procedure. The patient did not follow up on initial contact, or respond to PCC, and the case was closed. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.

170. In conclusion, from our analysis of the limited number of cases relating to Urology services, which span over a 20-year period in the SHSCT area, it would be difficult if not impossible to have identified systemic issues in general, and specifically to the Urology Services Inquiry's Terms of Reference. The concerns raised regarding waiting times, delays in procedures and quality of care, were similar to those shared across all programmes of care and Trusts in Northern Ireland.

171. On the basis of the evidence available to the PCC only a small number of complainants have approached the PCC seeking assistance in raising a complaint about Urology services in the Southern Trust. The nature of most of these complaints is typical of complaints about other services particularly in relation to waiting lists and waiting times for example. On the basis of the evidence provided to the Inquiry, the majority of the concerns about Urology and Mr O'Brien were identified by management and through reviews of cases by the Trust through lookback exercise and clinical records reviews. These cases would not have come to the notice of the PCC in our role under the complaints

procedure and the Southern Trust engaged 'Inspire' rather than the PCC to support service users through the lookback exercises. Inspire is an all-Ireland charity and social enterprise providing services to people living with mental ill health, intellectual disability, autism and addictions to ensure that they live with dignity and realise their full potential. Department of Health guidance on Lookbacks does not require HSC Trusts to engage with PCC as part of these Lookbacks.

1. The majority of the cases in the Southern Trust were discovered due to Look Back Reviews rather than through patient complaints.
2. The PCC was not alerted by the Trust at the time when the Lookback Review was initiated

172. PCC provide a break down and analysis of our advocacy and support work, including complaints and SAIs in our Annual Reports[9]. PCC do not, however, provide this information broken down by HSC Trust in our Annual Reports. To assist the Inquiry, PCC have provided in the table below our 2022-2023 data broken down by HSC Trust area, and the Programme of Care to which cases related.

[9] See links to our annual reports in 2022-23, 2021-22 and 2020-21, 2019-20. Annual Reports prior to 2020-21 did not record PCC advocacy support by Contacts and Cases.

- PCC-Annual-Report-and-Accounts-2022-23 (4).pdf
- Annual-Report-and-Accounts-2021-22 (3).pdf
- Annual-Report-and-Accounts-2020-21.pdf
- Annual-Report-and-Accounts-2019-20 (2).pdf

173. In the 2022-23 year, PCC had 569 client cases, 453 relating to the five HSC Trusts[10], of which 60 related to the Southern Trust (SHSCT). The table below outlines the number of cases[11] relating to each Programme of Care:

PCC Cases by Health and Social Care Trust - 1st April 2022 – 30th March 2023						
Programme of Care	**BHSCT**	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
POC 1 - Acute	104	30	29	21	20	204
POC 2 - Maternity and Child Health	3	6	3	5	1	18
POC 3 - Family and Child Care	7	9	13	4	4	37
POC 4 - Elderly Services	12	11	12	15	11	61
POC 5 - Mental Health	12	24	14	5	7	62
POC 6 - Learning Disability	3	6		2	3	14
POC 7 - Sensory Impairment and Physical Disability	2	3	7	2	1	15
POC 8 - Health Promotion and Disease Prevention	-	-	1	-	-	1
POC 9 - Primary Health and Adult Community	12	6	16	6	1	41
Grand Total	**155**	**95**	**24**	**60**	**48**	**453**

[10] An additional 116 cases, related to GPs, Dentists, NIAS, or were categorised as 'other' and 'unspecified', were recorded during 2022-23, making the total overall cases in 2022-23 569.

[11] The table only represents PCC Cases. Support provided by the PCC to the public is recorded in two different categories; cases and contacts. Cases are defined as advocacy support provided to the public for the early resolution of general issues/concerns, formal HSC complaints, SAI's and Public Inquiries. Contacts are calls from the public which involve the provision of advice and information. We do not record contacts by Trust area.

PCC and the third sector

174. The PCC engages with the third sector around a wide range of issues including individual complaints, SAIs, consultations and involvement. Third sector organisations are a reservoir of expertise and experts (often by experience) in a wide range of areas where Trusts provide health and social care services. Given the breadth of the PCC remit across health and social care, it is critical that within our individual and group advocacy work we take account of any networks, complementing the role of other professionals or advocates working within a case, particularly where they might have a specialist or expert role in an area. Key to added value the PCC brings to this network is our independence and the statutory functions and powers of the PCC. A number of the larger third sector organisations can link into National resources in terms of intelligence and research. Many third sector organisations are able to maintain their own policy resource in NI either individually or by acting collaboratively through networks such as Children in Northern Ireland.

175. The PCC has a role in representing the views of the public who use HSC services. The PCC recognises however that service users do not all have the same views and can have a range of diverse and sometimes conflicting views on various issues and this is to an extent reflected in the multitude of different third sector organisations of different shapes and sizes. Part of the mission of the PCC is to ensure that these organisations are assisted where they need assistance to have their views heard. A number of third sector organisations are represented on PCC engagement platforms.

176. The PCC also recognise the valuable contribution which advocacy services provided by third sector organisations make to meeting the needs of service users. The PCC knows that meeting the needs of service users for advocacy support sometimes requires an understanding of complex legislation, professional practice, Trust structures and Trust policies, procedures and administrative procedures. There are third sector organisations which have specialist knowledge and expertise in a range of different areas and which the

PCC utilises in providing advocacy services to some service users. For example, in an advocacy case which the previous Chief Executive was the lead advocate, she worked alongside two national specialist charities advocates to support a group of patients. The role of the PCC was to add value through utilising the statutory functions and powers of the PCC.

177. The PCC's initiative on ***positive passporting*** (para 70) is one way in which we hope that strengthening our collaborative working with the third sector can benefit service users including where third sector organisations are best placed to provide assistance.

178. There are many positives to the PCCs relationships with the third sector. The PCC also recognise that there is a tension arising from the fact that many of the same third sector organisations can be commissioned by Trusts to provide services, particularly but by no means exclusively social care services. The concern would relate to structural, financial and psychological independence of the voluntary sector provider given the Trust pay for the advocacy service. To the knowledge of the PCC only one regional contract for advocacy is commissioned by the SPPG thereby ensuring separation of service provider and commissioner. This contract resides with a children's voluntary sector organisation. Further detail is contained in paragraph 205.

179. The Trusts are to be commended for finding resources within a difficult funding climate to fund advocacy services from third sector organisations. However, the PCC believes that such services should not only be independent of the commissioner and service provider they should demonstrably be so and we have set out how we believe such advocacy services should be commissioned in order to ensure this. The commissioning of advocacy services by individual Trusts also results in fragmentation and a lack of co-ordination of the advocacy services provided by voluntary and community sector organisations and the PCC. Different organisations are commissioned by different Trusts even to the point that in shared facilities several different third sector organisations can be

commissioned to provide advocacy services by the different Trusts in a single facility.

1. The PCC assist Third Sector organisations in having their views heard.
2. Commissioning Advocacy services should remain independent of the HSC Trusts enabling providers to assert structural, financial and psychological independence.
3. Delivery of advocacy services should remain independent of HSC Trusts.
4. Supporting the development of advocacy services, a regional network would enhance communication, training and development.

Advocacy, engagement and the public

180. The PCC has sought on an ongoing basis to establish and maintain relationships with the voluntary and community sector. Third sector organisations which advocate on behalf of service users, carers and families are regularly invited to be represented at engagement and consultation events including citizens hubs and engagement platforms. This would include events targeted at specific services and issues. It would also include events targeted at the wider Health and Social Care system e.g. NICON and those identifying priorities or proposals to change Health and Social Care Services generally.

181. For example, in relation to the care of older people early into the COVID pandemic, families were deeply concerned about their loved ones residing in Care Homes. In response the PCC established a Care Homes Engagement Platform. Members came from a range of community and voluntary groups including, Age NI, Northern Ireland Rare Disease Partnership, (NIRDP), Care Homes Advice and Support NI (CHASNI), Relative of Dementia Care Group, Alzheimer's and COPNI. The participants were facilitated to engage directly with decision makers from DOH, HSCB, RQIA, HSC Trust's and the PHA. Critical issues addressed included:

- Care Partners (ongoing from Sept 2020)

- Visiting Regulations (ongoing from Nov 2021)
- The Regional Falls in Care Homes Project
- Duty of Candour (Jul,2021);
- Adult Protection Board (Aug, 2021);
- Integrated Care Systems (Sep, 2021);
- Future Planning (Nov, 2021);
- Adult Protection Bill (Nov, 2021);
- Intermediate Care Services (Jan, 2022);
- Statement of Strategic Intent (Jan 2022);
- Reform of Adult Social Care (May 2022);
- GMC Good Medical Practice (May 2022).

PCC SAI Practice Model

182. The SAI process is governed by guidance issued by the HSCB/SPPG in 2016. The process is not underpinned by legislation or a Department Direction and although the guidance issued by the HSCB (now SPPG) refers to the PCC, the PCC role is not specified in the same way it is in the Complaints Direction issued by the Department of Health.

183. The Patient and Client Council (PCC) was a member of the IHRD SAI Workstream 5 established under the Hyponatremia Implementation Programme to ensure the implementation of Recommendation 37. See paragraph 100 - 103

184. Having contacted the former PCC Complaints Manager who was a member of the Workstream to check the purpose of the report, "*A Thematic Review of Complaints Support Services Cases 2014-2018*", published in October 2019, he stated that he had the report produced to provide a patient voice, inform the workstream through describing the key themes in SAIs experienced by families supported by the PCC. The data was sourced from the PCC Complaints Service database. The data was analysed and reviewed to explore:

- The background and nature of SAIs (between 2014 and 2018);
- Why individuals come to the PCC when dealing with a SAI;
- How SAIs have been dealt with by Trusts and whether there are any recurring issues in SAI management;
- Nature of support provided by the PCC.

185. The Report was submitted to the Chair and members of IHRD Workstream 5to inform their work going forward particularly in relation to the development of the Statement of Patient and Family Rights.

186. The Report was presented by the Complaints Manager at two regional workshops hosted by the Chair of Workstream 5. The presentation explored, *"What do service users and carers tell us about their experience in the Serious Adverse Incidents (SAIs) process*"?

187. A further workshop on 6th November 2019 was facilitated by the Complaints Service Manager. The Patient and Client Council wrote to the 58 families that it had assisted in a Serious Adverse Incident Review Process since 2014. Ten families attended the workshop. The write-up was also presented to the Chair and members of Workstream 5. The purpose of the workshop was to engage with families with experience of the Serious Adverse Incident Review Process and of the Patient and Client Council in its role of providing support to such families. The subjects of the engagement were:

- The Draft Statement of What You Should Expect in Relation to a Serious Adverse Incident Review produced to meet the requirement of Recommendation 37 (i) of the Report of the Independent Inquiry into Hyponatraemia Related Deaths which states:

"Trusts should publish a statement of patient and family rights in relation to all SAI Processes including complaints"

- Recommendation 37 (iv) of the Report of the Independent Inquiry into Hyponatraemia Related Deaths which states:

188. Whilst the PCC does its best to try to support families through the SAI process, SAI cases in particular can consume a considerable amount of time and resource against competing priorities and finite resources. The PCC is only able to support even this small number of cases because the senior management team including myself as Chief Executive act as the advocate in the complex casework.

189. The demand for independent advocacy support from the PCC in Serious Adverse Incidents has increased year on year. The number of families seeking assistance with the SAI process from PCC has increased sharply in the last four years. As reported in the Accounts & Annual Report 2022/23, a total of 33 new SAIs were referred to the PCC in 2022-23. The upward trend is as follows:

Number of new SAI's				
2018/19	2019/20	2020/21	2021/22	2022/23
16	26	31	25	33

190. With a number of SAIs the support to families can be ongoing for up to five years, given the complexity of the support required, during and post the actual review. In cases where a SAI has been initiated in response to serious incidents which may have caused death or serious harm to a patient or service user, the timeframes taken to complete a SAI are an indication of the weakness of the current system. Some of these SAIs where the PCC are supporting families were originally complaints which have been escalated to be SAIs. Others are cases which were notified and reviewed as SAIs without a complaint being made or in place of a complaint. In other cases which may have been through one or more failed SAI review the relationship between the Trust and patients/families has

become so fractured that the Trust has approached the PCC to ask for our help in supporting the patients and families.

191. In reviewing the families receiving advocacy support from the PCC in SAI's, just under half (48%) of all SAIs in 2022-23 were Level 3 SAIs compared to 4% in 2021-22. However, Level 1 and Level 2 SAIs have decreased. The nature of support to families navigating the SAI process is such that one case can involve support to multiple members of a family. Of the 33 new SAIs in 2022-23, this represented 63 individuals seeking support from the PCC. There continues to be an increasing demand for advocacy and support to families involved in SAIs.

192. Within 2022-23 the PCC responded to the need to support a group of families involved in a collective SAI related to a review of Radiology in the Northern Trust. The PCC are currently engaged with seven families directly regarding radiology (which represents 14 individuals).

193. From 2020, PCC put in place a dedicated SAI Senior Practitioner to commence the development of a new model of advocacy practice for families.

194. Learning from our previous experience, we decided that in 2022-23 the allocation of support to families in an SAI process should be provided by a specific group of Senior Practitioners within the PCC who have the experience required, and knowledge of the SAI process, to support the families involved.

195. The PCC's continued development, in 2022-23, of working relationships with colleagues in the five HSC Trusts has served to improve the support to families and indeed to having case issues escalated to Senior Managers in Trusts if the SAI process is not running to the satisfaction of the families involved. Complex case meetings chaired by a Service Manager in the PCC allowed Senior Practitioners an opportunity to discuss these particular cases, seek advice and

peer support as well as seek escalation both within the PCC and within Trusts if they were encountering challenges.

196. While there continues to be a waiting time for support from PCC, any SAI cases with a time constraint are allocated immediately. At year end, 2022/23, eight SAI cases were awaiting allocation as soon as resources were available. In all cases the families had been in contact with the PCC, had a conversation with a PCC practitioner and were aware that they would be supported once the resource was available. At the time of writing my statement all cases had been allocated.

197. An example of partnership work in driving forward a change agenda for the SAI process involved the PCC working with the Mental Health Champion and the RQIA. On 21st March 2023, a joint letter was forwarded to the Permanent Secretary offering to develop an Involvement Charter in support of the work which is commencing to refresh the systems and processes for learning following the occurrence of an SAI. In response the Permanent Secretary stated that Departmental policy colleagues are actively commencing this important work and that the Department will facilitate the overall SAI Redesign programme to refresh the SAI learning system and will work in partnership with the HSC and key stakeholders as their input is crucial to the process. He stated that they were keen to avoid creating a separate process for the Involvement Charter and had asked colleagues to work with RQIA, the Mental Health Champion and the PCC to develop a complementary approach. The Department also noted that it was important that the work also appropriately takes account of and builds on the valuable and substantial involvement work and outputs already taken forward under the SAI Workstream of the IHRD Implementation Programme. This includes work progressed on the draft *Statement of Patient and Family Rights*.

198. In Response the PCC designed and established an SAI Engagement Platform with a small number of families who had extensive experience of the SAI processes.

199. There are significant issues with the operation of the SAI process which the PCC hope the current review by the Department of the process will address. The PCC view is that there is a need to implement the recommendations of the Hyponatraemia Inquiry set out at paragraph 100 101 above.

200. To set in context the examples of SAI practice experience it is essential to understand the starting point for the PCC. The majority of the public who seek support from the PCC have experienced harm resulting from the service received from statutory providers. They have described a negative and distressing engagement experience when trying to find a resolution with the statutory body. Whilst this may not be true for all service users, it is for the those who have availed of the PCC advocacy service.

201. The PCC reached out to families in advance of completing this Corporate Witness Statement requesting permission to highlight their experiences. Paragraph 97 details one family's experience over a 5-year period with the PCC assisting them to engage across the system, including the SHSCT. The second family experienced a Level 2 SAI review which was conducted following the death of daughter / sibling by suicide, while under the care of the Southern Trust. The following sets out their experience on being advised that an SAI was to take place;

- No information was provided as to how Trust/GP records could be obtained, this would have made the initial meeting with the Chair of the review panel more productive.
- SAI was deemed Level 2 without any discussion with the family.
- Terms of reference of the SAI were presented to the family but at the early stage of the process it was not made clear that these could be challenged,
- The family had no independent advice.
- Initial contact person within the governance office was absent for a prolonged period of time, and the family were not provided with a suitably senior alternative in his absence.

- The family had requested a meeting with the lead professional, prior to issue of the draft SAI report, this request was never passed to him by the governance office.
- There was a lack of regular updates thus had to constantly seek information.
- Family input was not considered to be an integral part of the review process,
- Support from PCC at this time was intermittent as the officer worked part time and then left on Personal Information redacted by the USI leave.
- Lack of confirmation that draft report would be available on the date promised.
- The Trust insisted on meeting with us to explain the report content despite the family telling them on multiple occasions that we would take the report, read it, respond and then ask for a meeting.
- A series of meetings with the Southern Trust, facilitated by the PCC eventually took place, virtually, including a meeting with a new Chair of the SAI panel.
- Following the finalisation of the SAI, the family were offered an opportunity to escalate our concerns with the office of the Public Service Ombudsman.
- The Ombudsman accepted our case for investigation.
- The SAI process certainly caused further harm to my family, not the investigation itself but the lack of engagement and communication, lack of openness and willingness to answer all questions asked. We were not treated as equals.
- On reading the RQIA review of the systems and processes for learning from SAIs (June 2022) it is obvious that what we were asking for from the Trust should have been delivered, we were not asking for anything that was unreasonable.
- Many straightforward questions remain unanswered in the final SAI report.
- The family requested that their response to the draft report be included as an Appendix to the final report, this did not occur.

202. The timeframes of SAI's usually relate to the actual time required to complete an SAI Review. This does not take into consideration the timeframe to

implement recommendations which are critical to prevent re-occurrence of the issue. In his opening statement to the Inquiry 8 November 2022, Counsel to the Inquiry referred to a Southern Trust SAI report which was finalised in 2018, which recommended a review of administrative arrangements because of systemic management failings. The opening statement states that this review took two years to commence. This potentially highlights issues with the governance and oversight of SAIs within the Trust. For example, apart from the delay in commencing the review, during the two years it took to initiate the review and the subsequent period of time before the review reported and its recommendations were implemented, a question could be asked about what risks did the Trust record in its risk register in relation to these systemic management failings and what steps did it take to mitigate those risks during that period of time.

203. There is a fundamental issue with the SAI process that the emphasis on the review process's purpose of identifying learning can sometimes be at the expense of an emphasis on describing the facts of what happened in clear and unambiguous terms. In reporting SAIs to SPPG and in the reports of SAI reviews, the families have stated that the Trusts can be reluctant to use clear and unambiguous language and to be completely forthright in describing service failures. This clarity, the use of unambiguous statements to describe the facts of what happened is the one thing that families consistently want. It is obvious that without a detailed factual understanding of what happened it is problematic to identify all of the learning that should be identified.

204. There are also questions about the level of resourcing of SAIs within Trusts both in having a pool of trained potential SAI panel members available and in providing protected time, administrative support, analytical and other expert staff to support SAI reviews. The PCC believes that implementation of the Hyponatraemia recommendations will go some way to addressing the current weaknesses of the SAI system

205. Independence is at the core of the effectiveness and efficacy of advocacy. This in particular is of relevance to the third sector providers. It may be helpful for the Inquiry to note the Scottish Independent Advocacy Alliance (SIAA) /www.siaa.org.uk . Their aim is to ensure that independent advocacy is available to anyone in Scotland. A similar body does not exist in NI. It is funded by the Scottish government planning division. The principles and standards adopted by the SIAA ensure that advocacy is of the highest possible standard. The SIAA define '***Independent advocacy'*** as being structurally, financially and psychologically separate from service providers and other services, which means it is a separate organisation in its own right, has its own funding and is true to the principles of independent advocacy as described below:

- **Structural;** an independent advocacy organisation is a separate organisation in its own right. For example, it is registered as a charity or company and has its own Management Committee or Board of Directors. Everyone in the organisation recognises that it is separate and different from other organisations and services.
- **Financial;** an independent advocacy organisation has its own sources of funding that does not cause any conflict of interest and does not compromise the work it does
- **Psychological;** everyone in the organisation knows that they are only limited in what they do by the principles of independent advocacy, resources and the law. It is important to recognise that although there may be conflicts of interest present, psychological independence is vital.

As stated by the SIAA Principles and Standards; '*Psychological Independence, independence of mind is equally as important as structural or financial independence. Some independent agencies are funded partly or wholly by statutory agencies and therefore have a responsibility to account to their funders for how they are spending the money. But independent minded advocates do not ask the funders for permission to disagree with them. Instead they challenge agency policy and practice where these are compromising the rights and wellbeing of the people they represent. They do not expect to be popular with everyone, but they do seek to ensure they are respected for the quality and*

integrity of their work. Effective independent advocacy organisations do not seek confrontation but they maintain the principle of primary accountability to the people they serve'.

1. Recognising the critical nature and urgency for review and change within the SAI process the PCC has established a bespoke engagement platform with membership drawn from families with extensive experience of the SAI process.
2. From 2020, PCC has been developing an SAI advocacy support model for families. Thus far PCC have been unable to secure the additional funding to enable a service to meet the demand and complexity of this work.
3. In contrast to the Complaint's Direction, the PCC's role is not clearly defined or set out in the HSCB's SAI Guidance.
4. Trust Reports need to use clear and unambiguous language and to be completely forthright in describing service failures.
5. From serious incident to SAI review and implementation of recommendations and service change can be an extensive amount of time. In the interim patient safety can be at risk.
6. Increased advocacy support should be independently commissioned to support families through the SAI process as stated in Recommendation 37 of the Hyponatraemia Inquiry report.
7. Advocacy providers require to be commissioned in a manner that ensures they can be true to the principles of independent advocacy.

206. As set out at paragraph 106 PCC are working with individuals who have experience of the SAI process with the intention to inform the Departmental review of SAI policy and procedures which is ongoing. Issues identified by members of this engagement platform to date include, but are not limited to, the following:

When harm or death occurs through action or omission on the part of the HSC, patients, victims, their families and the general public want an investigation that is:

- *Independent, and seen to be independent of the Trusts involved in the incident.*

- *Respects and involves Patients, Victims and Families.*
- *Learns what went wrong and why.*
- *Where appropriate holds people to account for their actions or omissions.*
- *Makes Recommendations to, where possible, prevent the incident happening again.*
- *Ensures those recommendations are acted upon.*
- *Provides Independent verification that new processes/procedures have been implemented and are in use and understood by staff on the ground who have received appropriate training.*

207. Over the last 3 years the PCC has been continually engaging with the HSCB / SPPG and the PHA with regard to:

- Escalating individual advocacy casework with regard to SAI's that the advocate has experienced challenges. The Chief Executive and Head of Operations have escalated the individual cases and met with lead staff in HSCB/SPPG and PHA to address concerns.
- The development of the PCC new practice model. The PCC have facilitated round table discussions with DOH, DOH Sponsor Branch, HSCB / SPPG, the PHA and HSC Trust governance leads to present the developing PCC SAI advocacy model, build working relationships, understanding the key roles of each DOH policy branch, the HSCB and PHA.
- Learning from SAIs, the central concern for the PCC was the lack of a safety framework that seeks to triangulate SAIs, incidents and other feedback from public to indicate a problem. This requires the development of a dashboard evidencing trends and patterns which sets out strategic actions and outcomes to address, and track implementation.

208. PCC did not play a role in the SHSCT Lookback Review.

Learning

209. We understand that the Inquiry will take a lessons learned approach and seek to make recommendations. The Inquiry has requested in its Section 21 notice that the PCC consider;

- what went wrong within the Trusts governance procedures and arrangements that resulted in a lack of client and patient engagement with PCC;
- Does the PCC consider that it did anything wrong or could have done anything differently which could have prevented or mitigated against a lack of client and patient engagement with the PCC regarding the issues arising within urology services and the governance failings of the Trust; and
- From the PCC's perspective, what lessons have been learned and has this informed or resulted in new practices or processes for the PCC.

210. Throughout the corporate witness statement, we have addressed learning and given opinion on areas as requested in the Section 21 Notice. We have distilled the points in Summary Boxes.

211. We have further reflected on the information provided in my corporate witness statement, the experience and practice within the PCC and the key messages from patients, families and advocates and would add to our statement with the following.

212. From 2019, the PCC has been on a significant journey of change and development in its practice. This is a continual ongoing process as we gather, understand and integrate our learning from our practice, reviews, inquiries and research.

213. Central to this change has been the development of advocacy support. We know that effective advocacy clearly plays an important role in helping to empower patients, their families and carers. We have learnt that advocacy

support can be provided through a range of models, that is independent advocacy, peer advocacy, self-advocacy and family advocates. Critical to the successful promotion of patient and family engagement with advocacy services is to a large degree determined by the DOH and HSC system's commitment to an investment in advocacy. Listening and hearing people's experience is the first line of defence when safeguarding vulnerable people. Access to advocacy plays a fundamental role in governance and assurance. Trusts as the first point of contact when things go wrong, and a complaint or SAI has been enacted, need to inform and direct the public to the support available from PCC.

214. The PCC have developed an advocacy model that is provided across a continuum. This ranges from; advice and information over the phone or via email, to signposting and 'supportive passporting' to appropriate services to meet immediate need, to individual and group advocacy casework, through to advocacy in formal processes including formal complaints, SAIs and Inquiries.

215. Supporting advocacy services also provides a level of assurance that Trusts are committed to being learning organisations, committed to meeting their statutory duty of quality and appropriately invested in the duty of candour and a culture of openness and transparency.

216. The SAI process is governed by guidance issued by the HSCB/SPPG in 2016. The SAI process is not underpinned by legislation or a Department Direction and although the guidance issued by the HSCB (now SPPG) refers to the PCC, the PCC role is not specified in the same way it is in the Complaints Direction issued by the Department of Health. From 2020, PCC has been developing an SAI advocacy support model for families. Although the PCC has a broad range functions in relation to HSC, competing functions need to be balanced against an increasingly constrained budget. Thus far PCC have been unable to secure the additional funding to enable a service to meet the demand and complexity of advocacy work in SAI's.

217. The PCC has recently responded to a Department of Health initial consultation on the outcome of an Independent Review of Children's Social Care Services. The final review report includes two recommendations for the development of Independent Advocacy Services. The PCC response sets out what we believe should underpin the provision of advocacy services within the Health and Social Care system by the PCC or any other provider including in relation to both SAI reviews and Inquiries. (See paragraph 85-94).

218. PCC believe that ultimately advocacy has the potential to lower systemic costs as potential problems would be addressed early and possibly more constructively. Trusts engaging proactively with advocacy providers and user experience could provide an opportunity to be alerted to emerging trends before they become costly scandals. This is of overall benefit to the public and to service providers. Understanding that advocacy provision may not be able to fully prevent a crisis, it can certainly help to deal with it at an earlier stage through improved patient engagement and contribution to system-wide trend spotting.

- Trusts should invest in training for staff in:
  - understanding the role of advocacy in safeguarding vulnerable people, the different advocacy models, be that independent advocacy, peer advocacy self-advocacy and family advocates;
  - understand how advocacy can be integrated into the different decision-making fora in the patient's journey whilst in their care, particularly when things go wrong;
  - Voice and Choice. Patients and families require clear information about how to make a complaint, who is there to support them, including an introduction to the PCC. Where there are a range of advocacy services the public must be given space and time to choose how and which service they wish to avail of;

- Trust staff taking the lead in complaints / SAI's and advocacy providers require an understanding of each other's role, the legislation, policy and guidance thus ensures that patients and families are fully informed and guided through the complaints / SAI process.

219. Commissioning and delivery of advocacy services should be independent of the HSC Trusts enabling advocacy providers to assert structural, financial and psychological independence.

220. The development of advocacy services, should be supported and nurtured through a regional network that would enhance communication, training and development.

221. It is not always evident that HSC Trust staff have been trained on the appropriate complaints process and this potentially increases risk to patient's safety and a collapse of the proper procedural requirements. Therefore, HSC Trust Staff and the staff of organisations commissioned to provide services by HSC Trusts should be trained and have familiarity with HSC complaints processes. Without this there will be a failure to mitigate risk through appropriate patient care monitoring.

222. We have learnt from patient and family engagement that the PCC needs to increase its public awareness. This is something the PCC are actively progressing. This starts at the point when things go wrong. Those closest to the person should promote the PCC and take a pro-active approach, and hopefully this will reduce confusion and inconsistency in complaints.

223. Trust Boards play a critical role in overseeing safe practice in their Trust.

224. Training should be provided to Board members on good practice in monitoring complaints, SAI and incidents and listening to service users.

225. The PCC would welcome an amendment to the Departmental Direction and update to the Guidance to require Trust Boards to report on how they have met the specific requirements in the Complaints Direction, Standards and Guidance.

226. The PCC would need additional resource as set out in paragraphs 15-21 in order to maximise its statutory functions in relation to this learning.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____ 

_____

Date: _____17th January 2024_____

Urology Services Inquiry

List of Exhibits (Meadhbha Monaghan)

MM/1 Provisions of the Health and Social Care (Reform) Act (Northern Ireland) Act 2009

MM/2 Background Paper – Health and Social Services Councils

MM/3 Patient and Client Council legislation

MM/4 Legislation Underpinning Organisations Established to Represent Patient and Public Views Of Health And Social Care Services

MM/5 Key Officials – PCC and HSS Councils

MM/6 Current PCC Organisational Structure January 2023

MM/7 The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009 [updated to reflect amendments made in 2013 (SAIS), 2019 (OMBUDSMAN) AND 2022 (HSCB)]

Urology Services Inquiry

MM/1

PROVISIONS OF THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) ACT 2009

The Patient and Client Council

16—(1) There shall be a body corporate to be known as the Patient and Client Council.

(2) Schedule 4 applies in relation to the Patient and Client Council.

Commencement Information

I1 S. 16 wholly in operation at 1.4.2009; s. 16(2) in operation for certain purposes at Royal Assent see s. 34(2)(e); s. 16 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Functions of the Patient and Client Council

17—(1) The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland—

(a) representing the interests of the public;

(b) promoting involvement of the public;

(c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

(d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

(e)such other functions as may be prescribed.

(2) In exercising its functions under subsection (1)(a), the Patient and Client Council must—

(a) consult the public about matters relating to health and social care; and

(b) report the views of those consulted to the Department (where it appears to the Council appropriate to do so) and to any other body to which this section applies appearing to have an interest in the subject matter of the consultation.

(3) In exercising its functions under subsection (1)(b), the Patient and Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body

to which this section applies which would or might affect (whether directly or not) the health and social well-being of the public.

(4) In exercising its functions under subsection (1)(c), the Patient and Client Council shall arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision (by way of representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.

(5) The Patient and Client Council shall—

(a)undertake research and conduct investigations into the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care; and

(b)provide advice regarding those methods and practices to bodies to which this section applies.

(6) The Patient and Client Council must publish any report under subsection (2)(b) in such manner as the Department may direct.

(7) In this section “the public” includes individuals, a group or community of people and a section of the public, however selected.

(8) This section and sections 18 and 19 apply to—

(a) the Department;

(b) the Regional Board;

(c) the Regional Agency;

(d) HSC trusts; and

(e) special agencies.

(9) For the purposes of this section and sections 18 to 20 a body is responsible for health and social care—

(a) if the body provides or will provide that care to individuals; or

(b) if another person provides, or will provide, that care to individuals—

(i) at that body's direction;

(ii) on its behalf; or

(iii) in accordance with an agreement or arrangements made by that body with that other person;

and references to the provision of care include references to the provision of care jointly with another person.

Commencement Information

I2S. 17 wholly in operation at 1.4.2009; s. 17 in operation for certain purposes at Royal Assent see s. 34(2)(f); s. 17 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Duty to co-operate with the Patient and Client Council

18—(1) A body to which this section applies must co-operate with the Patient and Client Council in the exercise by the Council of its functions.

(2) In particular, such a body must—

(a) consult the Patient and Client Council with respect to such matters, and on such occasions, as the body considers appropriate, having regard to the functions of the Council;

(b) furnish to the Council, subject to such conditions as the body may specify, such information as the Council considers necessary to enable it properly to exercise its functions; and

(c) have regard to advice provided by the Council under section 17(5)(b).

(3) Regulations may make provision authorising members of the Patient and Client Council to enter, for the purposes of any of the Council's functions, premises of a kind described in subsection (4).

(4) Those premises are—

(a) any premises controlled by a body to which this section applies or by a person providing primary medical services or general dental, pharmaceutical or ophthalmic services under Part 2 or 6 of the Order of 1972; and

(b) premises of such other description as may be prescribed.

(5) Any power of entry conferred by regulations under subsection (3) is exercisable only so far as is necessary for the purpose of enabling the Patient and Client Council to exercise its functions, and is subject to such conditions as may be prescribed.

(6) A body to which this section applies shall have due regard to any views expressed by the Patient and Client Council regarding health and social care for which that body is responsible.

Commencement Information

I3S. 18 wholly in operation at 1.4.2009; s. 18 in operation for certain purposes at Royal Assent see s. 34(2)(g); s. 18 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Public involvement and consultation

19—(1) Each body to which this section applies must take such steps as it considers appropriate—

(a) to promulgate information about the health and social care for which it is responsible;

(b) to obtain information about—

(i) the needs of persons to whom that care is being or may be provided; and

(ii) the efficacy of that care;

(c) to encourage and assist persons to whom that care is being or may be provided—

(i) to avail of that care in an appropriate manner, having regard to the need to use resources in the most economic, efficient and effective way; and

(ii) to maintain and improve their own health and social well-being.

(2) In particular, each body to which this section applies must, before the end of the period of 9 months beginning with the day appointed for the coming into operation of this section, or, if later, the establishment of the body concerned—

(a) prepare a consultation scheme in accordance with section 20; and

(b) in the case of a health and social care body, submit the scheme to the Department.

(3) The Department may direct any health and social care body to which this section applies to submit a revised scheme to it.

(4) The Department may, after consulting the Patient and Client Council, approve a consultation scheme submitted to it under this section with or without amendments.

Public involvement: consultation schemes

20—(1) A consultation scheme must make it clear how the body to which the scheme is to apply will make arrangements with a view to securing, as respects health and social care for which it is responsible, that the following are (directly or through representatives) involved in and consulted on the matters mentioned in subsection (2), namely—

(a) the Patient and Client Council;

(b) persons to whom that care is being or may be provided; and

(c) the carers of such persons (that is to say the individuals who provide a substantial amount of care on a regular basis for such persons but who are not employed to do so by a health and social care body).

(2) Those matters are—

(a) the planning of the provision of that care;

(b) the development and consideration of proposals for changes in the way that care is provided; and

(c) decisions to be made by that body affecting the provision of that care.

(3) The consultation scheme must provide for the body to which it is to apply—

(a) to have due regard to any comments submitted to it in response to the consultation; and

(b) to prepare a written statement which—

(i) summarises the comments received; and

(ii) sets out the body's response to those comments.

(4) The consultation scheme must provide that the body to which it is to apply shall take such steps as in its opinion will give adequate publicity to the statement.

Urology Services Inquiry

MM/2

BACKGROUND PAPER – HEALTH AND SOCIAL SERVICES COUNCILS

7 January 2024

Introduction

1.1 The Patient and Client Council (PCC) was established from 1st April 2009, replacing four separate Health and Social Services Councils (HSSCs). The purpose of this paper is to provide some background information on the HSSCs for the purposes of the Urology Service Inquiry.

1.2 There are currently no senior staff working within the PCC who had previously worked in one of the four HSSCs. This paper is based on records inherited by the PCC from the four HSSCs. Unfortunately, these records are not complete. Each of the four Health and Social Services Councils individually decided what records they would transfer to the newly formed PCC in April 2009. The records from the Southern Health and Social Services Council are most likely to be relevant to an Inquiry focussed on services provided by what is now the Southern Health and Social Care Trust including services provided at Craigavon Area Hospital.

Health and Social Services Councils

2.1 Up until the end of March 2009 there were four Health and Social Services Councils in Northern Ireland; Eastern, Northern, Western and Southern. They were established under Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1991. Article 4 stated:

Health and Social Services Councils

4.—(1) The Department shall establish a council, to be known as a Health and Social Services Council, for the area of each Health and Social Services Board.

(2) Schedule 1 shall have effect in relation to Health and Social Services Councils.

2.2 The detail of how the four HSSCs were to operate was set out in Schedule 1 to this Order which stated that their role was to:

(a) to represent the interests of the public in the health and personal social services in the Council's area;

(b) to perform such other functions as may be conferred on it by virtue of paragraph 2.

2.3 Section 2 to schedule 1 states that:

Regulations may make provision as to:

(a) the membership of Councils (including the appointment or election of a chairman of each Council);

(b) the proceedings of Councils;

(c) the appointment and proceedings of committees of Councils;

(d) the staff, premises and expenses of Councils;

(e) the consultation of Councils by Health and Social Services Boards, special agencies and HSS trusts with respect to such matters, and on such occasions, as may be prescribed;

(f) the furnishing of information to Councils by Health and Social Services Boards, special agencies and HSS trusts on such subjects and subject to such conditions as may be prescribed;

(g) the right of members of Councils to enter and inspect premises controlled by Health and Social Services Boards, special agencies and HSS trusts, subject to such conditions as may be prescribed;

(h) the consideration by Councils of matters relating to the operation of health and personal social services within their areas, and the giving of advice by Councils to Health and Social Services Boards and special agencies on such matters;

(i) the preparation and publication of reports by Councils on such matters, and the furnishing and publication by Health and Social Services Boards and special agencies of comments on the reports;

(j) the functions to be exercised by Councils in addition to the functions exercisable by them by virtue of paragraph 1(a) and the preceding provisions of this paragraph;

(k) the collaboration by Councils with each other in the exercise of their functions;

(l) such other matters in connection with Councils as the Department thinks fit.

2.4 Section 3 to Schedule 1 states that:

Regulations made under paragraph 2(a) shall provide for the members of Councils to be appointed by the Department and shall secure, as respects each Council, that:

(a) at least one member of the Council is so appointed on the nomination of each district council of which the area or part of it is included in the Council's area;

(b) the other members of the Council are so appointed in such manner and after such consultation as may be prescribed.

2.5 The four HSSCs were co-terminus with the four Health and Social Services Boards (HSSBs) which existed up until the end of March 2009 and which were themselves replaced by the regional Health Social Care Board (HSCB). As the Inquiry will be aware the HSCB itself was dissolved at the beginning of April 2023 and became part of the Department of Health.

2.6 The four HSSCs were not Arms length Bodies. Each of the four HSSCs was hosted by their respective HSSBs. All corporate support including accommodation, IT and Human Resource functions, staff payment, finance, funding etc. were provided to them by their respective HSSBs. Under these arrangements the Governance arrangements for the Southern Health and Social

Services Council came under the Southern Health and Social Services Board. Therefore the Chief Executive of the Southern Health and Social Services Board was the Accounting Officer for the Southern Health and Social Services Council.

2.7 The PCC are unable to find, within its own or HSSC records, copies of regulations made by the Department in relation to Sections 2 and 3 of Schedule 1. On the basis of discussion with a former Eastern HSSC staff member it is our understanding that:

- The Councils were made up of
  - 1/3 Locally elected representatives
  - 1/3 Community and Voluntary sector representatives
  - 1/3 lay representatives
- These were all appointed through the Public Appointments process.
- Each Council had a Chair elected from their number by secret ballot
- Councils differed in size with the Eastern Council being the largest at 30 members
- The Councils met monthly in the evening with meetings open to the public advertised through the local press.

2.8 The paper documents which PCC inherited from the HSSCs include limited information on how the four HSSCs discharged the functions described in Schedule 1. For example, the PCC cannot find copies of business plans for any of the four HSSCs. The PCC are also unable to find copies of HSSC's annual reports.

Urology Services Inquiry

MM/3

Patient and Client Council legislation

Patient and Client Council

Your voice in health and social care

Patient and Client Council legislation

The Patient and Client Council is a Non Departmental Public Body with a Sponsor Branch in the DHSSPS

The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland as set out in the Health and Social Care Reform Act NI 2009. S16-17

a) representing the interests of the public;

In exercising this function, the Patient and Client Council must

I. consult the public about matters relating to health and social care; and

II. report the views of those consulted to the Department (where it appears to the Council appropriate to do so) and to any other body to which this section applies appearing to have an interest in the subject matter of the consultation.

b) promoting involvement of the public;

In exercising this function the Patient and Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body to which this section applies which would or might affect (whether directly or not) the health and social well-being of the public.

c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

In exercising this function the Patient and Client Council shall Council shall arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision (by way of representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.

d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

The Patient and Client Council shall

e) undertake research and conduct investigations into the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care; and

f) provide advice regarding those methods and practices to bodies to which this section applies.

S18 sets a Duty to co-operate with the Patient and Client Council

A body to which this section applies must co-operate with the Patient and Client Council in the exercise by the Council of its functions. In particular, such a body must consult the Patient and Client Council with respect to such matters, and on such occasions, as the body considers appropriate, having regard to the functions of the Council;

g) furnish to the Council, subject to such conditions as the body may specify, such information as the Council considers necessary to enable it properly to exercise its functions; and

h) have regard to advice provided by the Council.

i) Regulations may make provision authorising members of the Patient and Client Council to enter, for the purposes of any of the Council's functions, premises of a kind described in subsection

Other Legislative models

The following table sets out the background to several other consumer/public representative bodies, namely, The Children's Commissioner, The NI Ombudsman, The Consumer Council for NI and the Consumer Panel of Ofcom.

hildren Commissioner	**Ombudsman**	**Consumer Council**	**Ofcom and Communications Consumer Panel**
The Commissioner shall be appointed by the First Minister and deputy First Minister acting jointly **Role established as body corporate** The principal aim of the Commissioner in exercising his functions under this Order is to safeguard and promote the rights and best interests of children and young persons.	**mbudsman appointed by Her Majesty. The Ombudsman is independent of the Assembly and of the government departments and public bodies all of which he has the power to investigate.** **Role established as body corporate** Ombudsman deals with two types of complaints: • complaints about public services • complaints about the conduct of councillors	**e Consumer Council was set up in 1985 as a non-departmental public body (NDPB) sponsored by the Department of Enterprise, Trade and Investment.** egislation confers a statutory obligation on the Consumer Council to promote and safeguard the interests of consumers in Northern Ireland, with additional responsibilities in relation to energy, water, transport, food and, from April 2014, postal services.	**m was established as a body corporate by the Office of Communications Act 2002. Ofcom operates under a number of Acts of Parliament. Ofcom regulates the TV and radio sectors, fixed line telecoms, mobiles, postal services, plus the airwaves over which wireless devices operate.** Communications Consumer Panel was set up in accordance with the Communications Act 2003 as part of Ofcom's duty to establish and maintain effective arrangements for consultation with consumers. .

Urology Services Inquiry

Functions	Functions and powers	Functions	Functions
The Commissioner may - undertake, commission or provide financial or other assistance for research or educational activities - issue guidance on best practice in relation to any matter concerning the rights or best interests of children and young persons. - conduct such investigations as he considers necessary - make representations or recommendations to any body or person about any matter concerning the rights or best interests of children and young persons. - examining the state and management of, and the treatment of children or young persons on, any premises managed - Provide advocacy in complaints -	e Ombudsman may only investigate - a written complaint is duly made to a member of the Assembly by a member of the public who claims to have sustained injustice in consequence of maladministration in connection with the action so taken; and - the complaint is referred to the Ombudsman, with the consent of the person who made it, by a member of the Assembly with a request to conduct an investigation into it. Ombudsman may require— - any person who in his opinion is able to furnish such information or produce such documents, to furnish information or produce documents relevant to the investigation. - the attendance and examination of witnesses, including the administration of oaths or affirmations and the examination of witnesses Ombudsman may appoint such officers as he may determine with the approval of the Department of Finance and Personnel as to numbers and conditions of service.	• to promote and safeguard the interests of consumers in Northern Ireland; • consider any complaint made to it relating to consumer affairs and, where it appears to the Council to be appropriate having regard to any other remedy which may be available to the complainant, investigate the complaint and take such further action in relation thereto as the Council may determine; • carry out, or assist in the carrying out of, inquiries and research into matters relating to consumer affairs; • promote discussion of, and the dissemination of information relating to, consumer affairs; • report to a Northern Ireland department on any matter relating to consumer affairs which is referred to the Council by that department. e Consumer Council is also a designated body for the purposes of **supercomplaints,** which means that it can refer any consumer affairs goods and services issue to the Competition and Markets Authority (formerly the Office of Fair Trading), where it feels that the market may be harming consumers' best interests	Memorandum of Understanding establishes the principles that both Ofcom and the Panel agree to adopt in their relations and dealings with each other. It supplements, but does not replace, the statutory framework and affirms the independence of the Panel from Ofcom. The principles are; **Consultation and advice** Ofcom and the Panel agree to engage early and often in full, frank and open dialogue on issues of emerging or current consumer and citizen concern **Collaboration** Ofcom and the Panel agree to adopt a collaborative approach to furthering consumer and citizen interests, using resources efficiently **Openness** Ofcom and the Panel agree to equip each other with sufficient knowledge of respective policies, statements, positions and advice in advance of their reaching the public domain **Information provision and confidentiality** Ofcom and the Panel agree to maintain and make available relevant and up to date information of relevance to consumer and citizen interests, and to respect the confidentiality of all information **urce provision including budget** Ofcom and the Panel agree to ensure appropriate resources are available to develop and maintain effective working arrangements

Urology Services Inquiry

MM/4

Legislation Underpinning Organisations Established To Represent Patient And Public Views Of Health And Social Care Services

Patient and Client Council

Your voice in health and social care

LEGISLATION UNDERPINNING ORGANISATIONS ESTABLISHED TO REPRESENT PATIENT AND PUBLIC VIEWS OF HEALTH AND SOCIAL CARE SERVICES

BRIEFING PAPER

Introduction

There are a number of organisations involved in liaising between patients, the public and health and social care organisations across the UK and Ireland. Each country has its own structures in place to represent the views of patients, carers and the public.

This paper outlines the range of bodies involved in these roles. There have been various changes over the last decade but this paper will concentrate on existing provision and the legislation which underpins them.

Each of the following sections will focus on each country's arrangements for ensuring that patients and public views and issues are addressed

England

Healthwatch

As in all the jurisdictions, there have been a number of changes in England in terms of ensuring the views and experiences of patients and the public are heard. The most recent change was brought into effect by the Health and Social Care Act (2012). Under Part 5, Chapter 1, the Act details how people will be represented and involved in the health and social care system. Under this legislation the Care Quality Commission will include a statutory Healthwatch England committee which has the remit to provide information and advice to the Secretary of State, the National Health Service Commissioning Board, and English Local Authorities on:

"(a) the views of people who use health or social care services and of other members of the public on their needs for and experiences of health and social care services, and
(b) the views of Local Healthwatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved".

Local Healthwatch groups (which replace the LINks groups) will also be set up and funded by local authorities. The latter have the scope to determine the best services for their community in setting up a local Healthwatch and also have responsibility for commissioning services to aid people to make a complaint about health and social care:

"Each local authority may make such other arrangements as it considers

appropriate for the provision of services in relation to its area providing assistance to individuals in connection with complaints relating to the provision of services as part of the health service". (Health and Social Care Act Part 5 Chapter 2, p.194).

These bodies are in place from April 2013.

Northern Ireland

Patient and Client Council

The Patient Client Council (PCC) was established as a result of the Health and Social Care Reform (Northern Ireland) Act 2009. It is a regional body with local offices and its functions under the legislation are set out as follows:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;
- promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;
- such other functions as may be prescribed.

The legislation also details how the above functions may be exercised; for example, the Patient and Client Council (PCC) must consult the public and report their views to the Department where appropriate. The PCC must also promote the involvement of the public in processes leading to decisions by health bodies which may have an impact on health and wellbeing.

The PCC also supports people wishing to make a complaint.

Scotland

The Scottish Health Council

This was launched by the Scottish Executive in April 2005 under The NHS Quality Improvement Scotland (Establishment of the Scottish Health Council) Regulations

2005 to promote patient-centred care and public involvement in NHS services. Specifically it was established to:

"promote improvements in the quality and extent of patient focus and public involvement in the NHS in Scotland. It supports and monitors work carried out by NHS Boards to involve patients and the public in the planning and development of healthcare services, and in decisions about those services".

The Scottish Health Council is part of Healthcare Improvement Scotland (the latter was established in April 2011 through the Public Services Reform (Scotland) Act and was formerly Quality Improvement Scotland).

Its role is to ensure that patients' and public views are considered by the health boards, and it can comment on how well the health boards perform in this respect.

The Council has a local office in each Health Board area (there are 14 in Scotland). Until 2011, each local office had a Local Advisory Council, made up of volunteers, but this has been replaced by a countrywide "panel" which can be accessed depending on their interests and expertise.

The Scottish government has also produced a Charter on Patient Rights and Responsibilities through the Patients Rights (Scotland) Act 2011 which sets out clearly what patients should expect from the service. This includes a section about making a complaint – if assistance is required, the PASS service (run by the CAB) is designated to provide support to people going through a complaints' process

Wales

Community health councils (CHCs)

Community Health Councils were established in 1974 in Wales and remain in place to this day although they have gone through a series of reviews. In 2006 the NHS (Wales) Act provided for the continuation of the Community Health Councils, but also gave ministers the powers to abolish and reform CHCs.

Currently, there are 8 CHCs in Wales (reduced from 19 in 2010) These were established in April 2010 through the National Health Service, Wales, The Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010 and The National Health Service, Wales, The Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010). CHCs are concerned with all aspects of the Health Service and can give advice to the public. Their work may include: Involvement and consultation, e.g. with local groups.

- Representing local interests, e.g. proposing improvements or challenging plans for change.
- Research and information, e.g. surveys of local need.
- Advice for patients, e.g. information about local NHS services, and patients' rights.

CHC members are volunteers drawn from local authority nominations and from the voluntary sector. The CHC may co-opt additional members locally if needed. The arrangement for membership numbers was reviewed in 2012, the outcome being that CHCs would remain although some changes may be made to strengthen CHCs in the future.

According to the NHS Wales website, the Community Health Councils across Wales will:

- provide help and advice if you have problems with or complaints about NHS services
- ensure that your views and needs influence the policies and plans put in place by health providers in your area
- monitor the quality of NHS services from your point of view
- give you information about access to the NHS

Republic of Ireland

Health Services Executive, Irish Patients Association and Community Information Centres

The Health Act 2004 established the Health Services Executive as well as putting in place a system for assisting people to give feedback or make a complaint about health and social care services. The Health Services Executive has a national Advocacy Unit in place and Complaints Officers across the country to deal with complaints.

People seeking to make a complaint also have access to support through a number of organisations which provide advocacy services (such as Citizens Information Centres or the Irish Patients Association). These can be easily accessed from the HSE website.

While there appears not to be any specific legislation about personal and public involvement the HSE consulted with patients to create the “National Strategy for Service User Involvement in the Irish Health Service 2008-2013”. As in Scotland the Irish government has produced a Statement of Commitment about what people should expect from health and social care, entitled “National Healthcare Charter: You and Your Health Service” in 2008.

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www.wales.nhs.uk/sitesplus/899/home (last accessed 27 August 2013)

MM/5

Key Officials – PCC and HSS Councils

The PCC has structure diagrams for most years from 2010 until 2020. These diagrams reflect the changes in PCC structures which took place during this period in time and also identifies the names of senior staff. Information from PCC Board minutes and these structure diagrams identifies PCC Board Chairs and senior staff.

Health and Social Services Council members were appointed by the Department. Council staff were employed through host Health and Social Services Boards. The PCC does not have records of Council members and staff. However, it would be possible to identify the names of some Council members and staff using minutes of Council meetings for the Northern HSS Council (2005 to 2009) and the Eastern Council (1993 to 2009). There are also a small number of minutes of four Council Chief Officers and complaints managers meetings which identify names of participants.

The tables below set out lead officials in PCC from April 2009 onwards:

Post	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Chair	John Keanie	Brian Compston	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson	Dr Maureen Edmondson
CEO	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Maeve Hully	Dr Glynis Henry
Head of Operations	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly	Louise Skelly
Head of Corporate Services	Sean Brown	Sean Brown	Sean Brown	Sean Brown	Sean Brown	Sean Brown	Sean Brown	Sean Brown	Jackie McNeill	Jackie McNeill
Policy Planning Manager	Marie Hughes	Marie Hughes	Marie Hughes	Marie Hughes	Marie Hughes	Post made redundant in restructure				
Bamford Project Manager	Gillian McMullan	Gillian McMullan	Gillian McMullan	Gillian McMullan	Gillian McMullan	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick
Northern area Manager	Jackie McNeill	Jackie McNeill	Jackie McNeill	Jackie McNeill	Jackie McNeill	Post made redundant in restructure and became Service Manager				

Post	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Belfast Area Manager	Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon					
Southern Area Manager	Stella Cunningham	Stella Cunningham	Stella Cunningham	Stella Cunningham	Louise Skelly					
South Eastern Area Manager	Raymond Newman	Raymond Newman	Raymond Newman							
Western Area Manager	Vacant	Maggie Reilly	Maggie Reilly	Fiona McCourt						
External Relations & Policy Manager	post created				Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick
Involvement Manager	New posts created					Jackie McNeill	Jackie McNeill	Jackie McNeill	Jackie McNeill	Margaret Anderson
Complaints Manager						Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon
Advice & Informatio	New post created				Deepak Samson	Deepak Samson	Deepak Samson	Deepak Samson	Deepak Samson	

Post	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
n Manager										
Research Manager	New post created				Vacant	Vacant	Susanne McKenna	Susanne McKenna	Susanne McKenna	Susanne McKenna

Post	2019	2020	2021	2022
Chair	Christine Collins	Christine Collins	Christine Collins	Christine Collins
CEO	Vivian McConvey	Vivian McConvey	Vivian McConvey	Vivian McConvey
Head of Operations	Vacant	Meadhbha Monaghan	Meadhbha Monaghan	Meadhbha Monaghan
Head of Business Support	Jackie McNeill	Jackie McNeill	Jackie McNeill	Jackie McNeill
Involvement Manager	Nigel Warburton	Johny Turnbull	Johny Turnbull	Johny Turnbull
Complaints Manager	Richard Dixon	Richard Dixon	Katherine McElroy	Katherine McElroy
Research Manager	Colm Burns	Colm Burns	Post made redundant	
Snr Policy Impact Manager	New post created		Ruth Barry	Ruth Barry

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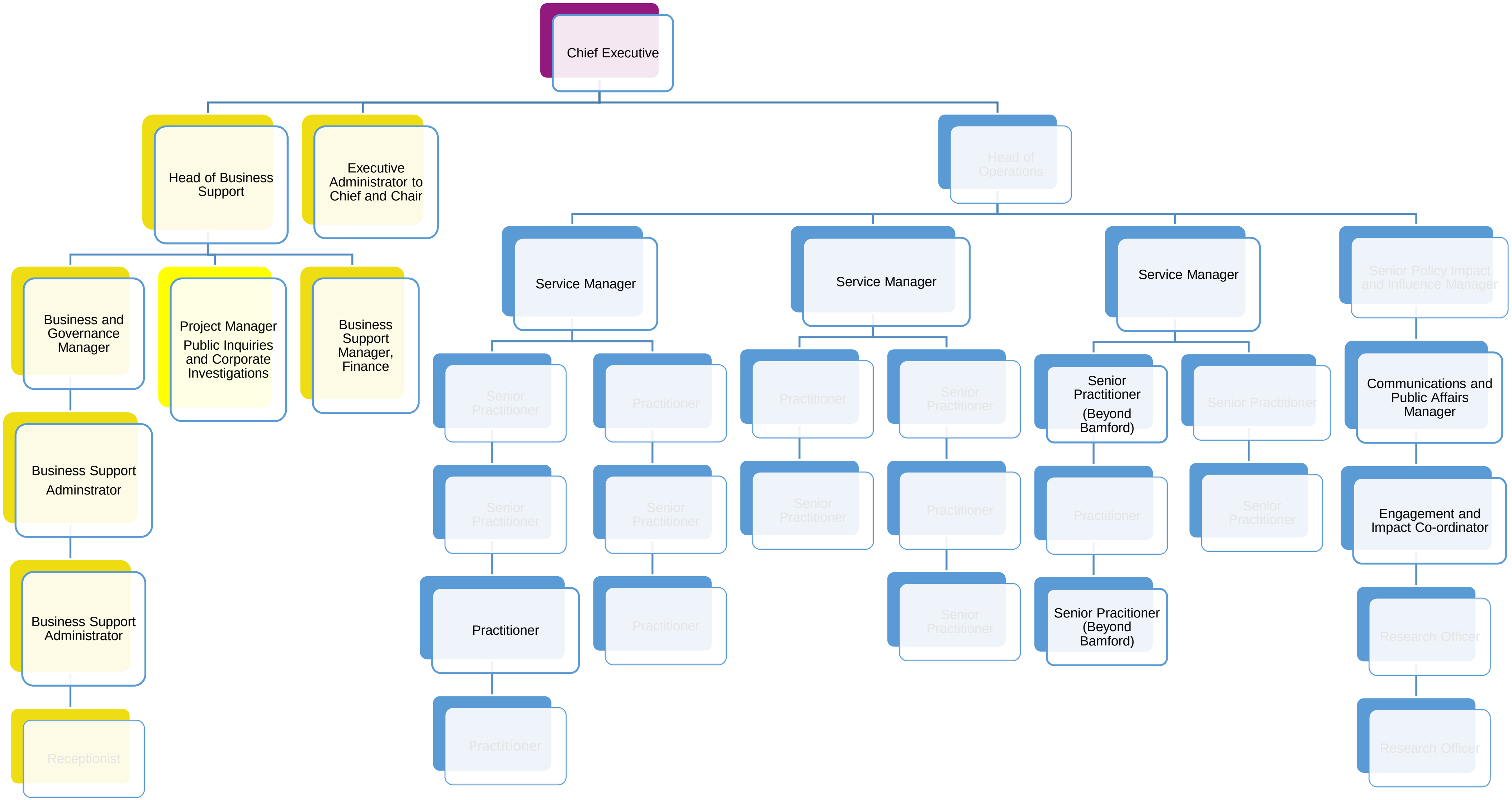
Current PCC Organisational Structure January 2024



Received from Meadhbha Monaghan on 17/01/2024. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

MM/7

The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009 [updated to reflect amendments made in 2013 (SAIS), 2019 (OMBUDSMAN) AND 2022 (HSCB)]

[UPDATED TO REFLECT AMENDMENTS MADE IN 2013 (SAIS), 2019 (OMBUDSMAN) AND 2022 (HSCB)]

THE HEALTH AND PERSONAL SOCIAL SERVICES (SPECIAL AGENCIES) (NORTHERN IRELAND) ORDER 1990

THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1991

THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009

The Department of Health, Social Services and Public Safety, in exercise of the powers conferred by Section 8 (l) (b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (a), Article 10 of, and paragraph 6 of Schedule 3 to, the Health and Personal Social Services (Northern Ireland) Order 1991 (b) and Article 4 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (c), hereby direct as follows:

ARRANGEMENT OF DIRECTIONS

PART 1

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES

(a) 2009 c. 1 (N.l.)
(b) S.l. 1991/194 (N.l. l)
(c) 1990/247

PART 1

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

Citation and commencement

1.These Directions, which may be cited as the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009, shall come into operation on 1 April 2009.

Interpretation

2. In these Directions —

"the 2009 Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"arrangements" means the arrangements which are required to be made under these Directions;

"care" (except in paragraph 9 (4)) means "health care" and "social care", other than care provided under the Children (Northern Ireland) Order 1995(a);

(a) provided by a HSC body, or which it is a duty of a HSC body to provide; or

(b) provided in a hospital, regulated establishment or agency or other facility which is managed by a person (whether an individual or a body) who is not a HSC body, and with whom any such body has made arrangements for the provision of care;

"complaint" means a complaint about any matter connected with the provision of care by a HSC body, and "complainant" shall be construed accordingly;

(a) 1995/755

"complaints manager" means the person appointed under paragraph 6 (l) (b);

"disciplinary proceedings" means —

(a) any procedure for disciplining employees adopted by a HSC body;

(b) any reference of any matter to a representative body having disciplinary powers over members of a profession;

(c) any reference of any matter to the police; and

(d) any inquiry under the Inquiries Act 2005(a);

"former Directions" means the Directions specified in paragraph 21 ;

"healthcare" has the meaning given to it in section 2 (5) of the 2009 Act;

~~"HSC Board" means the Regional Health and Social Care Board established under section 7 of the 2009 Act;~~

"HSC body" means a Health and Social Care body which for the purposes of these Directions (except in paragraph 5 (l are ~~the HSC Board,~~ HSC trusts and special agency;

"HSC trust" means a Health and Social Care trust established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 ;

"independent provider" means a body who is not themselves a HSC body but with whom a HSC body has made arrangements for the provision of care;

~~"NI Commissioner for Complaints" means the NI Commissioner for Complaints appointed in accordance with the Commissioner for Complaints (Northern Ireland) Order 1996(b) ;~~

'Northern Ireland Public Services Ombudsman" means the Northern Ireland Public Services Ombudsman appointed in accordance with section 3 of the Public Services Ombudsman Act (Northern Ireland)2016;"(

"Patient and Client Council" means the Patient and Client Council established under section 16 of the 2009 Act;

"patient or client" means a person who is receiving, or has received, care provided by, or on behalf of, a HSC body;

"person subject to complaint" means any person or persons against whom a complaint is made or, where the complaint does not identify a named person against whom the complaint is brought, a person who, in the opinion of the complaints manager, is best able to deal with the matters which are the subject of the complaint;

"RQIA" means the Health and Social Care Regulation and Quality Improvement Authority established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (c);

"relevant person" means— (a) a patient or a client;

(b) any person who has been refused any care;

(a) 2005 c.i2
(b) s.l. 1996/1297 (N.1.7)
(c) 2003/431
(d)

(c) any person who is receiving, or has received, any care from, or is affected by any action, omission or decision of, a HSC body.

"relevant HSC body" means the HSC body which —

(a) provides the care;

(b) has the duty to provide the care;

(c) takes the action, omission or Decision, which is the subject of the complaint.

"Serious Adverse Incident" (SAI) means any incident falling within any of the criteria currently set out in paragraph 4.2 of the ~~HSC Board's~~ "Procedure for the reporting and follow up of Serious Adverse Incidents" of April 2010 or as revised from time to time."

"social care" has the meaning given in section 2 (5) of the 2009 Act;

"special agency" means the following special health and social care agency established under Article 3 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 —

(a) The Northern Ireland Blood Transfusion Service.

Application of Directions

3.These Directions apply to any complaint made on or after I st April 2009 in respect of the HSC bodies specified above.

PART 11

HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES

Requirements to make arrangements

4.—(1) Each HSC body shall make arrangements in accordance with the provisions of these Directions for the handling and consideration of complaints.

(2) The arrangements must be such as to ensure— (a) that

the complaints procedure is accessible;

(b) that complaints are dealt with efficiently;

(c) that complaints are properly investigated;

(d) that complainants are treated with respect and courtesy;

(e) that complainants receive, so far as reasonably practicable .

(i) assistance to enable them to understand the procedure in relation to complaints; or

(ii) advice on where they might obtain such assistance;

(f) that complainants are, as far as possible, involved in decisions about how their complaint is handled and considered;

(g) that complainants receive a timely and appropriate response; (h) that complainants are told of the outcome of their complaint; and (i) that action is taken in light of the outcome of a complaint.

(3) The arrangements shall be in writing and a copy of the arrangements shall be given, free of charge, to any person who makes a request for them.

(4) Where a HSC body makes arrangements for the provision of care with an independent provider, it must ensure that the independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of care as if these Directions applied to it.

(5) Each HSC body shall make arrangements in accordance with Part IV (Monitoring and Publicity) of these Directions for monitoring the effectiveness of and for publicising the arrangements for dealing with complaints.

General duty to co-operate

5.—(1) The arrangements under these Directions must be such as to ensure that a full and comprehensive response is given to a complainant and to that end there is all necessary cooperation in the handling and consideration of complaints between —

(a) different HSC bodies as defined in section 1(5) of the 2009 Act;

(b) the RQIA; and

(c) ~~the NI Commissioner for Complaints.~~ Northern Ireland Public Services Ombudsman

(2) The general duty to co-operate required by sub-paragraph (l) includes in particular, a duty to —

(a) answer questions reasonably put by the body carrying out the investigation;

(b) provide any information relating to the complaint which is reasonably requested by the body carrying out the investigation; and

(c) attend any meeting reasonably required to consider the complaint.

Responsibility for arrangements and complaints manager

6.—(1) Each HSC body must appoint—

(a) a senior person within the organisation to take responsibility for ensuring compliance with the arrangements made under these Directions and for ensuring that action is taken in light of the outcome of any investigation; and

(b) a person, in these Directions referred to as a complaints manager—

(i) to perform the functions of the complaints manager under the arrangements;

(ii)to perform such other functions relating to the investigation of complaints as the HSC body may direct; and

(iii) generally to co-ordinate and manage the operation of the procedures for dealing with complaints under the arrangements.

(2) The functions of the senior person appointed under sub-paragraph (l) (a) may be performed personally or by a person authorised by the HSC body to act on his behalf.

(3) The functions of the complaints manager appointed under sub-paragraph (l) (b) may be performed personally or by a person authorised by the HSC body to act on his behalf.

No investigation of complaint

7.—(1) The following complaints are excluded from the scope of the arrangements made under these Directions and shall not be investigated, or shall cease to be investigated—

(a) a complaint made by a HSC body which relates to the exercise of its functions by another HSC body;

(b) a complaint made by an employee of a HSC body about any matter relating to his contract of employment;

(c) a complaint made by an independent provider about any matter relating to arrangements made by a HSC body with that independent provider;

(d) a complaint arising out of a HSC body's alleged failure to comply with data subject requests made under the Data Protection Act 2018 ~~1998~~(a) or a request for information under the Freedom of Information Act 2000(b);

(e) a complaint about which the complainant has stated that he intends to take legal proceedings;

(f) a complaint about which a HSC body is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person subject to complaint;

(g) ~~a complaint which has lead to the protection of vulnerable adults policy or procedures having been activated~~ a complaint which has led to the adult safeguarding procedures or protocol having been activated;

(h) a complaint which is the subject matter of a Child Protection enquiry;

(i) a complaint which has raised an independent inquiry and/or a criminal investigation;

(j) a complaint which has resulted in a referral to a professional regulatory body;

(k) a complaint which activates the Children Order Representation and Complaints Procedure; (l)a complaint the subject matter of which has previously been fully investigated under (i) these Directions; or (ii) former Directions.

(m) a complaint which is being or has been investigated by the ~~NI Commissioner for Complaints~~. Northern Ireland Public Services Ombudsman

(n) a complaint that has been escalated to a Serious Adverse Incident (SAI)."

(2) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (l) (e), investigation shall be commenced, or resumed, where a complainant states in writing that he no longer intends to pursue a remedy by way of legal proceedings.

(3) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (l) (f), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with by disciplinary proceedings.

(4) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with heads (g), (i) or (j) of sub-paragraph (l), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with under the proceedings referred to in those heads.

(4A) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (l)(n), investigation shall be commenced, or resumed in relation to any matter which is not the subject of the Serious Adverse Incident ~~investigation~~.review".

(5) The Chief Executive of the relevant HSC body shall notify the complainant and any person subject to complaint of any decision not to investigate the complaint or to discontinue an investigation of a complaint under sub-paragraph (l) and of any start, or resumption, of an investigation.

(6) The notification to be given under sub-paragraph (5) shall be in writing and shall state the reason for any decision referred to in that sub-paragraph.

(a) 1998 c.29
(b) 2000 c.36

PART 111

THE INITIAL COMPLAINT

Requirement to deal with the complaint

8. Subject to paragraph 7, a complaint shall be dealt with in accordance with the arrangements if it is made—

(a) by a person specified in paragraph 9;

(b) in the manner specified in paragraph 10;

(c) about any matter connected with the provision of care; and

(d) within the period specified in paragraph I l .

Person who may make a complaint

9.—(1)A complaint may be made by — (a) a relevant person; or

(b) a person (in these Directions referred to as a representative) acting on behalf of a relevant person in any case where the relevant person — (i) has died;

(ii) is a child;

(iii) is unable by reason of physical or mental incapacity to make the complaint himself; or

(iv) has requested the person to act on his behalf.

(2) In the case of a relevant person who has died or who is incapable, the representative must be a relative or other person, who, in the opinion of the complaints manager, had or has a sufficient interest in his welfare and is a suitable person to act as representative.

(3) If in any case the complaints manager is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as representative, he must notify that person in

writing, stating his reasons. The complaints manager may then either refuse to deal with the complaint or nominate another person to act with respect to the complaint.

(4) In the case of a child, the representative must be either a parent, or in the absence of both parents, guardian or other adult person who has care of the child, or where the child is in the care of an authority or a voluntary organisation, the representative must be a person authorised by the authority or the voluntary organisation.

(5) In these Directions any reference to a complainant includes a reference to his representative.

Making a complaint

10.—(1) Where a person wishes to make a complaint under these Directions, he may make the complaint to the complaints manager or any other member of the staff of the relevant HSC body.

(2) Any person other than the complaints manager to whom a complaint is made, whether orally, in writing or electronically, shall refer the complaint to the complaints manager.

(3) A complaint may be made orally or in writing, including electronically, and —

(a) where it is made orally, the complaints manager or other member of staff of the relevant HSC body shall make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made, and provide a copy of the written record to the complainant; and

(b) where it is made in writing, the complaints manager shall make a written record of the date on which it was received.

(4) For the purposes of these Directions where the complaint is made in writing it is treated as being made on the date on which it is received by the complaints manager or as the case may be, other member of the staff of the relevant HSC body.

Time limits

11.—(1) Subject to sub-paragraph (2), the period for making a complaint is

(a) six months from the date on which the matter which is the subject of the complaint occurred; or

(b) where the complainant was not aware that there was cause for complaint, within

(i) six months from the date on which the matter which is the subject of the complaint comes to the complainant's notice; or

(ii) twelve months from the date on which the matter which is the subject of the complaint occurred, whichever is the sooner.

(2) Where a complaint is received which was not made during the period specified in subparagraph (l) it shall be referred to the complaints manager and if he is of the opinion that—

(a) having regard to all the circumstances of the case, it would be unreasonable to have expected the complainant to have made the complaint within that period; and

(b) notwithstanding the time that has elapsed since the date on which the matter which is the subject of the complaint occurred, it is still possible to investigate the complaint properly, the complaint shall be treated as though it had been received during the period specified in sub-paragraph (1).

Acknowledgement and record of complaint

12.—(1) The complaints manager shall send to the complainant a written acknowledgement of the complaint within 2 working days of the date on which the complaint was made.

(2) Where a complaint was made orally, the acknowledgment shall be accompanied by the written record mentioned in paragraph 10 (3) (a) with an invitation to the complainant to sign and return it.

(3) The complaints manager shall send a copy of the complaint and its acknowledgement to any person subject to complaint unless he has reasonable grounds to believe that to do so would be detrimental to that person's health or wellbeing.

(4) The acknowledgement sent to the complainant under sub-paragraph (l) must include information about the right to assistance from the Patient and Client Council.

Investigation

13.41) A complaint must be investigated to the extent necessary and in a manner which appears most appropriate to an efficient and effective resolution.

(2) The complaints manager may, in any case where he thinks it would be appropriate to do so and with the agreement of the complainant, make arrangements for independent expert advice, conciliation or other assistance for the purposes of resolving the complaint.

(3) The complaints manager must take such steps as are reasonably practicable to keep the complainant informed about the progress of the investigation.

Response

14.—(1) The complaints manager must ensure a written response is prepared to the complaint which summarises the nature and substance of the complaint, describes the investigation and summarises its conclusions.

(2) The response must be signed off by the Chief Executive of the relevant HSC body. A copy shall be provided to the complainant and any person subject to complaint.

(3) The Chief Executive of the relevant HSC body can delegate responsibility for responding to a complaint, where in the interests of a prompt reply a designated executive director of the relevant HSC body undertakes this task on the Chief Executive's behalf.

(4) The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the complainant must be notified of the delay and the full response issued as soon as reasonably practicable.

(5) The response must notify the complainant of his right to refer the complaint to the Northern Ireland Public Services Ombudsman ~~NI Commissioner for Complaints~~ should he remain dissatisfied with the outcome of the HSC complaints procedure.

(6) Copies of the response mentioned in sub-paragraph (l) must be sent to any other person to whom the complaint was sent under paragraph 12(3).

(7) ~~Responses should not be made electronically~~.

PART IV

MONITORING AND PUBLICITY

Monitoring

15.—(1) For the purposes of—

(a) monitoring the arrangements made for the handling and consideration of complaints;

(b) considering the nature, volume and outcome of complaints; (c) taking remedial action following investigation of complaints; and

(d) organisational learning, the relevant HSC body shall prepare reports at quarterly intervals for consideration by its board.

(2) The reports mentioned in sub-paragraph (l) must— (a) specify the number of complaints received;

(b) identify the subject matter of those complaints;

(c) summarise how they were handled including the outcome of the investigations;

(d) specify the number of complaints that have been referred to the ~~NI Commissioner for Complaints~~ Northern Ireland Public Services Ombudsman ; and

(e) identify any complaints where the recommendations of the NI Commissioner for Complaints were not acted upon, giving the reason why.

(3) For the purposes of ensuring the efficient use of resources HSC bodies will monitor the effectiveness and usage of independent experts, conciliation and lay person assistance.

(4) HSC trusts must provide the Department of Health ~~HSC Board~~ with such information relating to complaints as the HSC Board reasonably requests for the purposes of monitoring and performance management, and only to the extent that it is not in contravention ofthe Data Protection Act 1998.

Learning

16.—(1) All HSC bodies are responsible for ensuring that arrangements are in place for the purposes of organisational and regional learning.

(2) The Department of Health ~~HSC Board~~ is responsible for collating and sharing the learning arising from HSC trust complaints.

Annual Reports

17.—(1) Each HSC body shall publish a report annually on its handling and consideration of complaints under these Directions which shall be sent to—

(a) the Department of Health~~, Social Services and Public Safety~~;

(b) the Patient and Client Council;

(c) the RQIA; and

(d) ~~the NI Commissioner for Complaints~~ Northern Ireland Public Services Ombudsman .

~~(2) HSC trusts' annual reports should also be sent to the HSC Board.~~

Publicity

18.—(1) Each HSC body shall take such steps as are necessary to ensure that—

(a) any person connected with the provision of care by, or on behalf of that body;

(b) staff working for that body;

(c) the Patient and Client Council; are fully informed of the arrangements for dealing with complaints and are informed of the name of the complaints manager and the address at which he can be contacted.

(2) The requirement to provide information specified in sub-paragraph (l) includes a requirement to provide information on the services which the Patient and Client Council offers to persons who wish to make complaints.

Training

19. Each HSC body must ensure that its staff are informed about and appropriately trained in the operation of the complaints arrangements.

PART V

TRANSITIONAL PROVISION AND REVOCATIONS

Transitional provision

20.Where, before 1 st April 2009, a complaint has been made in accordance with any former Directions, it must be investigated, or in an appropriate case continue to be investigated, in accordance with the former Directions as if these Directions had not come into effect.

Revocations

21. The following Directions are revoked—

(a) The Health and Personal Social Services Complaints Procedures Directions (Northern Ireland) 1996;

(b) The Health and Personal Social Services (Special Agencies) Complaints Procedures Directions (Northern Ireland) 1996; and

(c) The Miscellaneous Complaints Procedures Directions (Northern Ireland) 1996.

7.—(1)The Directions to the Health and Social Care Board on Procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers 2009 are revoked.

[redacted] Services and Public Safety on I st April 2009

Personal Information redacted by the USI

A senior officer of the
Department of Health, Social Services and Public Safety