Urology Services Inquiry

Oral Hearing

Day 87 – Wednesday, 21st February 2024

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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CHAIR: Good morning, everyone.

MS. McMAHON BL: The witness this morning is Meadhbha Monaghan, executive officer of the Patient Client Council, and she is represented by Mr. Patel. If I could ask Mr. Patel to formally introduce himself. 10:00

MR. PATEL: Hi, good morning. I'm Priyesh Patel and I'm representing the PCC.

CHAIR: Thank you, Mr. Patel. I think there's going to be a slight pause while we move the screens back, ladies and gentlemen, just in case you are wondering 10:01 what's happening.

MS. McMAHON BL: Ms. Monaghan will affirm.

MS. MEADHBHA MONAGHAN, HAVING AFFIRMED, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:01

1 Q. MS. McMAHON BL: Good morning, Ms. Monaghan. My name is Laura McMahon and I'm junior counsel for the Inquiry. I'll be taking you through the evidence today. We will start with your written evidence you 10:02 have helpfully provided to the Inquiry, a response to the Section 21 notice, Notice 28/2023. If I could ask that to be brought on the screen, please. It is WIT-106633. You'll see your name at the top of that. It is dated 13 December 2023. If we go to WIT-106714, 10:02 you'll see a signature at the bottom of this page with the date 17 January 2024. Can you confirm that that's your signature?

A. I can.

2 Q. Do you wish to adopt this as your evidence?

A. I do.

3 Q. Just before we start, are there any amendments that
you'd wish to make? If there are any, just formally
read them into the record, please. 10:03

A. Yes, thank you. There are four amendments. At
paragraph 35, this paragraph refers to paragraph 43; it
should say 44. At paragraph 61, the last line should
read "This pause also allowed PCC to take stock of the
developments and build on engagement models in 10:03
integrated care system ICS NI programme".

At paragraph 160, it refers to paragraph 197 in the
last line; this should say paragraph 98. Then finally
at paragraph 178, I would ask for a correction to take 10:03
out the lines that say -- or begin with "To the
knowledge of PCC", and to replace it with the
following:

"The RQIA report Review of Advocacy Services for 10:03
Children and Adults in Northern Ireland highlights that
only five of the advocacy services commissioned from
voluntary and community sector organisations are
commissioned as regional services by the HSCB. The PCC
believes that this is still the case". 10:04

4 Q. Thank you. You'll note that we have a transcript live
note. I was told off yesterday and I might be told off
today and you may suffer the same fate, if we both try
to remember that, so that a note can be kept of it.

We'll see how we get on. If I could ask you, just could you move your mic slightly towards you. It's just a bit hard to pick you up.

The context of your evidence, why you have been asked to come along, is because you are Chief Executive of the Patient and Client Council, which is a statutory Arm's Length Body. It is tasked broadly with representing and promoting the development of the public in health and social care. The Panel is interested to hear how the PCC functions, what it does to meet its statutory duties, and put it in the context of some of the issues that the Inquiry has heard about in evidence. 10:04 10:04

10:05

I don't know if you had the opportunity to listen to any of the evidence or read any of the transcripts?

A. Some of it, yes.

5 Q. Would it be fair to say based on the information we have provided as well that you have a fair understanding of the issues before the Inquiry and the matters that they are looking into? 10:05

A. Yes.

6 Q. Now the role in the background of the PCC, you have been in that post relatively recently. Just before we look at that, could you give us a brief synopsis of your career to date and what was your role as chief executive? 10:05

A. Well, I hold degrees. My primary degree is in

Philosophy, a BA Hons from the University of Cambridge.
Also an interdisciplinary Masters in Refugee Enforced
Migration Studies at the University of Oxford. Prior
to joining the PCC in May 2020 as Head of Operations,
my entire career prior to that has been in the third 10:06
sector, the voluntary and community sector, in the UK
and in the US and the south of Ireland, predominantly
in the areas of homelessness and refugee resettlement,
working with people with multi-complex needs. In those
roles, I have had oversight, strategic and operational 10:06
delivery of services that would support people at the
intersection of advocacy, and participation, and health
equity predominantly. My last role prior to coming to
the PCC was as programme manager for homelessness and
refugee services with Extern, an all-Ireland charity, 10:06
where I had responsibility for ten different services,
providing support directly to the public in the North
and in the South.

7 Q. Directly with the Patient and Client Council, what's
your history with them? 10:07

A. I joined the organisation in May 2020 as Head of
Operations; then took up the post of Chief Executive in
May 2023. As chief executive, I would be overall
responsible and accountable for the operational
performance, governance and strategic strategy within 10:07
the organisation. I am accountable for this to the
board or council of the PCC. I'm not a member of the
PCC council or board but I'm responsible to them. As
accounting officer, I am responsible to the Permanent

Secretary in the Department of Health for the good governance and management of public money within the organisation.

8 Q. The Panel will be aware, because we've heard from a couple of arms' lengths bodies at this stage, the 10:08
2009 Act that reformed health and social care was also the origin of the Patient and Client Council at the same time. Now, the structure, as I understand it from your statement, is that the PCC is wholly independent from all the other health and social care bodies. 10:08
Everyone has their own role but there's an expectation of some sort of interlocking activities and that's the juncture that we will try to focus on shortly in your evidence.

10:08

In relation to your engagement with the Department, is your sponsorship branch still the Chief Nursing Officer?

A. It is.

9 Q. Generally with the Department, what's your relationship 10:08
with the Department? How do you engage with them and how would you describe the nature of that engagement?

A. Well, we're responsible through, as you mentioned, the Chief Nursing Officer's department for the governance and operational performance of the organisation, but 10:09
we do have a high degree of operational independence in the organisation for how we deliver on the statutory functions. So, with the rest of the department, our engagement would be aligned to the functions of the

organisation. That can include advising on the best
methods to engage and involve the public in programmes
of work, predominantly with our focus on individual
case work. It would also involve mediating and
providing advocacy and support to members of the public 10:09
who have issues in health and social care, and I think
they would recognise that as a particular mediative
role whenever relationships have broken down.

In our engagement work and seeking to influence 10:09
policies through what we hear from the public directly
in various programmes of engagement, we would engage
with different parts of the Department that have the
policy leads in particular areas such as mental health,
learning disability, care of older people. I would 10:10
describe that relationship as constructive. I think
there is a fundamental constructive tension in the way
the PCC is set up in terms of it being on the one hand
responsible to the public for representing the
interests of the public and promoting their involvement 10:10
but, on the other hand, needing to work within the
system to achieve outcomes for the public on that
basis. So there is a fundamental constructive tension
in how we are set up.

10 Q. So your role in advocacy provides you with an 10:10
opportunity to say things that need to be said but it
may be difficult for others to hear or to respond to,
so you are walking that line of keeping relationships
with all different aspects of your role?

A. I think that would be a fair reflection, but ultimately
the organisation is set up to deliver on behalf of the
public within the system. Our key objective would be
seeking outcomes for the public in those particular
advocacy cases. 10:11

11 Q. In your statement you have mentioned that you have
twice yearly accountability meetings with the
Department. Are they time-tabled every year or is an
expectation you will meet twice yearly? Are they
normally meetings that do go ahead? 10:11

A. There was some disruption to those accountability
meetings during COVID, as there was right across the
board for arm's length bodies. But during my time as
Chief Executive, we have had those twice yearly
accountability meetings. One would be a ground 10:11
clearing meeting directly with the Chief Nursing
Officer, and then once a year with the Permanent
Secretary in the Department of Health.

12 Q. Have you had any of those meetings yet? I don't want
to ask you about meetings you haven't attended but have 10:11
you had them since you took up your role as Chief
Executive?

A. Yes, I have. Both.

13 Q. The nature of engagement in those meetings, is that an
opportunity for you to feedback in a very pragmatic way 10:12
what the difficulties may be for you in fulfilling your
role? What's the appetite for responding to any
concerns you raise at those meetings; what's your
experience been so far?

A. I think it provides an opportunity for us to both speak
to the operational performance of the PCC and what we
are hearing, but also to raise issues around what we
would see as the resourcing of the PCC and the ability
for us to deliver on those financial -- for us to 10:12
deliver on those statutory functions within a very
constrained financial environment. Those are concerns
that we have repeatedly raised. I think it is also an
opportunity for us to reflect some of the challenges in
the work that we are undertaking in the engagement with 10:12
the rest of the system and where we might seek changes
with respect to that. I think in terms of our sponsor
branch, that has been receptive.

14 Q. You've mentioned in your statement that between 2012
and 2013 and 2019 and 2020, the PCC has had significant 10:13
reductions in its budget; rather than just stabilising
in the face of, perhaps, expectation of greater
capacity, you've had a squeeze, as it were, on some of
the monies available. I think that's stabilised more
recently, has it? 10:13

A. It has stabilised more recently. However, I would say
that in real terms, the budget of the PCC currently,
which sit at just under 2 million, represents
a 40% decrease from whenever the organisation was set
up in real terms. Whilst it has somewhat stabilised, 10:13
we are still significantly constrained in terms of the
resource that we have to undertake the statutory
functions. That has obviously led to the need to make
decisions on our part about where we prioritise that

resort in line with what the public asks of the PCC.

15 Q. I think you formalised those concerns in your midyear
assurance statement in 2022 and 2023 and the annual
report of that year, where you have formalised your
concerns about the impact of financial resources on 10:14
your ability to carry out your statutory
responsibilities.

Now, you have secured recurrent funding, 2022-2023. Is
that something that will increase your capacity or just 10:14
allow you to maintain what you are currently doing?

A. It will only allow us to maintain what we are currently
doing. I think the additional recurrent funding that
we were able to maintain allowed us to increase to an
extent the number of frontline advocacy posts that 10:15
we had within the organisation, but it still sits far
below what is required in order for us to deliver on
the core functions of advocacy, engagement and policy
impact.

10:15

We have been proactively working on a strategic outline
case to the Department, which we have recently
submitted last year, which sets out what we would see
as the funding which is required for the PCC over the
next three years in order to maximise the opportunities 10:15
within our statutory legislation.

16 Q. We'll go on and look at the functions of the PCC in
line with its statutory obligations but just as
a general point in light of your comments on funding,

is it your view that the PCC is able to currently fulfil its statutory role according to the legislation?

A. I would say that the PCC meets its statutory functions but, of course, the ability and the extent to which you are able to meet your statutory functions is 10:15 significantly impacted by resource. So, our view would be that in order to represent the public and to fulfil to the maximum possible our functions, particularly within engagement and advocacy, and the analysis of information that we're hearing from the public in order 10:16 to influence policy, it is significantly constrained currently within the resource we have. We are the second smallest ALB. In the overall health budget we have the second smallest budget in total, sitting at just under 2 million. That is significantly 10:16 constraining.

17 Q. If we look at the functions of the PCC given the requirements under the 2009 Reform Act, and if you go to your statement at WIT-106639, paragraph 25.

10:16

"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 2019 Reform Act are set out as 10:17 follows:

Functions of the Patient and Client Council, Article 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 10:17 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, 10:18 commissioning and delivery of health and social care; (e) such other functions as maybe prescribed.

Article 17(2): In exercising its functions under (1)(a), the Patient and Client Council must consult the 10:18 public about matters relating to health and social care and 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 10:18 matter of the consultation".

In general terms, the broad requirement around representation involving the public assisting members of the public as regards complaints - and we'll look at 10:18 complaints separately in a moment - promoting what the bodies do and how they do that for people to understand, and then such other functions as may be prescribed is a very general catch-all. There's also

a requirement to consult the public and report those
consultations back to the Department.

In relation to the last part about the consultation, is
that a process that is derived from the PCC or are you 10:19
asked to undertake consultation? How does the
consultation legal requirement work for the PCC?

A. So in fulfilling our statutory functions, we are
required to consultant and engage the public. All
bodies in health and social care have a statutory 10:19
requirement to engage the public, and the PCC does not
consult on behalf of other bodies. So in interpreting
the role of the PCC, we have developed, since 2020,
a practice model that sets out, within the resource
that we have, structures that we seek to engage the 10:20
public directly through on a number of different
programmes of care, largely determined by what the
public have told us are important to them or which
align to key policy and programme directives at
a departmental level. That would include mental 10:20
health, learning disability, care of older people,
adult protection, SAIs.

18 Q. Could you give us an example of a recent consultation?

A. Yes. So one recent one that we became engaged with was
in relation to the future closure of Muckamore Abbey 10:20
Hospital. At that time - this was January time last
year - the Department had heard very clearly from
families that they wanted independent facilitation of
conversations on the consultation on the future of the

closure. The PCC realised this need from families and
loved ones who had residents in Muckamore, and designed
a tailored programme of engagement to look at
facilitating discussions with those individuals about
the consultation. That involved facilitated 10:21
discussions by PCC staff remotely with family members
of individuals. We then collated the views that
we heard and produced a report that reflected the views
of people on that consultation, and submitted that to
the Department as part of the overall consultation 10:21
process. That's one example, but there are many
others.

19 Q. Just as you've described that, it sounds like you've
provided a link between the voice of people who are
impacted by potential decision-making and the 10:21
Department who are making the decisions with others?

A. Yes.

20 Q. What would your view be on the value of that link as
regards impacting upon or influencing the
decision-making? 10:22

A. I mean, I think that it is invaluable in providing an
opportunity through an independent mechanism to provide
people with the opportunity to share their views on
potential changes. I say through an independent
mechanism because, obviously, there are other 10:22
structures existing within the Trust or through the
Department's own consultations where people have the
opportunity to do so. The challenge in that is that
often there's not the level of diversity within those

engagement structures. We operate at a regional level
within the PCC, so it provides us with the opportunity
to have conversations regionally with the public, but
also to seek to hear representation of a diversity of
views within that space, and also, from an independent 10:22
perspective, provide a safe space for conversations and
views to be heard that aren't tied to the service
provider facilitating those conversations, and
ultimately removes any potential conflicts or anxieties
that people might have in those conversations. I think 10:23
in collating that information, it ensures that there's
that independent link back to the Department that they
can consider that in the round with all of the other
sources of intelligence and engagement that they may
have coming through. 10:23

21 Q. Now, you undertake a role of listening to individuals
affected by, for example, the Muckamore decision-making
process. You listen to them, but does the Department
listen to you? What's your experience of that? Do
they listen to what you have to say? 10:23

A. My experience would be that the Department do take on
board the views of the PCC and they recognise that we
have added value in providing that independent source
of information in diversity of representation, not
least because one of the areas that we have tried to 10:24
maximise is our engagement with the voluntary and
community sector through a network of networks approach
as well, which seeks to take a network approach to
getting information across existing sources of

intelligence and bringing that together, and then
producing that in a report that seeks to influence the
Department's decision-making.

I think examples of where that has changed policy would 10:24
be our care of older people work in 2020 where we set
up an engagement platform working directly with family
members who had relatives in care homes. We brought
them together directly with decision-makers in the
Department of Health, in RQIA, in PHA. Some of the 10:24
tangible outcomes of that work were the implementation
of care partners in the care partner role within care
homes; the pathway for return to normalised visitation
for family members; changes in how vaccination was
being rolled out. I think that's a tangible example of 10:25
where in the PCC have facilitated engagement work
across the third sector and directly with individuals,
and that has brought to bear on decision-making at a
policy level within the Department. Our distance aware
work would be another example of that in terms of the 10:25
impact on people who were shielding during COVID.

22 Q. If we just move down to paragraph 115. These are
further articles on the 2009 Reform Act relevant to the
PCC. The Panel heard evidence yesterday from RQIA and
considered what potential, if I use the term 10:26
enforcement mechanisms very generally, or what
sanctions or what power they had, really, to enable
them to carry out their statutory functions. Under the
Reform Act, Articles 18, 19 and 20 are the relevant

aspects for the PCC. I just want to read paragraphs 115 to 117 of your statement, which is found at WIT-106675.

115 says: 10:26

"Article 18 requires these bodies" - which are the bodies named in the Reform Act - "to cooperate with the PCC in the discharge of its functions. Whilst this article requires these bodies to consult the PCC, this 10:26 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 10:27 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 10:27 staff, and can only be exercised in connection with PCC's functions.

Finally, under Article 18 these bodies must pay due regard to the wishes of the PCC but are essentially 10:27 free to ignore those wishes if they wish".

It would seem that the only teeth in Article 18 is the ability to enter premises controlled by any bodies. It seems an unusual power to give to a patient and client council; I don't think even the RQIA have that particular power and they are charged with inspection. Have you any idea, just in passing, why that's included? Have you ever had to use that? 10:28

A. No, not to my knowledge. But as it says there, that power there also resides with our board as opposed to staff members within the council.

23 Q. The way it is drafted. It is also connected if it is in furtherance of PCC functions, so there's a couple to 10:28 caveats to that. But you have no recollection of that ever having been triggered?

A. Not to my knowledge.

24 Q. Article 18 does seem fairly discretionary in relation to other bodies' engagement with the PCC. The line at 10:28 which they may engage or the extent to which they may engage seems to be a matter for them. They can engage at a low level or high level, dependent on what they think is appropriate. In real terms operationally does that provide any challenge for you in carrying out your 10:28 functions, or is there any frustration perhaps about the discretionary element of that article?

A. I think Article 18 in the legislation significantly caveats the powers of PCC, and there are obvious inherent weaknesses in the way that the legislation 10:29 sets out the powers of the PCC. The duty to cooperate, if it didn't have those caveats, would be significantly stronger and I think we would welcome changes to the legislation that would remove those caveats.

I think in practical terms the PCC seeks to build constructive relationships with other bodies to further our ability to undertake advocacy work and engagement work on behalf of the public. In reality, where 10:29 we experience challenges in terms of progressing some of that advocacy work or seeking information on behalf of public to assist us in that role, we are left to escalate issues or have direct conversations with Trusts where, if those inherent weaknesses in the 10:30 legalisation were removed, it would provide us with stronger powers to, I suppose, support and address some of those challenges more robustly.

25 Q. Article 19 is set out in your Section 21 at paragraph 116. If I just read out what you say about 10:30 that:

"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 10:30 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 10:30 into account".

Again, there is a large amount of discretion placed upon the bodies as to whether -- how they consult or

engage public involvement. As you say in the last sentence, the way in which the Department may consider the views of the PCC is, again, open for them.
I suppose from both legislative and policy reasons, there's an arguable reason why the Department can't be 10:31
mandated to take on board requirements, but do you have any view about the wording of Article 19 and the way in which it either helps or hinders the fulfilment of your statutory duties.

A. I think, again, it reflects the inherent weaknesses in 10:31
the way the PCC is set up in order for us to maximise our ability to deliver on behalf of the public.
I think in reality, both in terms of operationally how Article 18 and 19 come to bear, is that it is reliant on the PCC building constructive relationships and 10:31
having a constructive challenge function, but that is inherently limited by the caveats that are placed in the legislation. What that means is that other bodies are able to set the parameters under which they engage with the PCC and the due regard they give to our views. 10:32
I think we would certainly welcome changes that would strengthen the PCC's ability in these areas. Having to rely on building relationships can be painstaking and time consuming, and for a body that has less than 35 staff in total, that again presents significant 10:32
constraints in terms of our ability to deliver on behalf of the public.

26 Q. Just in relation to Articles 18 and 19, before we look at Article 20, on a day-to-day basis operationally, is

there a sense of frustration that you can't fulfil what
you would like to do because of the constraints of this
legalisation, or does the outworking of that not really
make much of a difference to the PCC? What is the
actual impact? 10:33

A. I think with the development of a new practice model
and the advocacy approach that we are taking, we can
see real benefits for members of the public in terms of
the approach. We have heard directly from the public
that an early resolution approach to us delivering our 10:33
functions not only benefits them directly but also has
benefit for the system. I mean, in the last year
we have managed to resolve 45% of our cases through
early resolution.

10:33

However, again you're constrained by the resource and
the powers. I think what I would say is that you can
see the potential in the organisation in terms of the
functions that we are given on behalf of the public and
the real need within the system both to engage the 10:33
public as assets in those conversations and also to
provide advocacy support to them whenever things go
wrong, but not having the resource to maximise that and
to build on that and the powers that support that
whenever you need to be able to do so is challenging. 10:34

27 Q. Just to finish that Reform Act 2009 provision for the
PCC, in paragraph 117 of your statement you refer to
Article 20. You say:

"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, etcetera, and must pay due regard to the views of the PCC (amongst others)". 10:34

So there is a legislative requirement that in the planning of services, you are involved in that and that the Department must pay due regard to your views. The phrase "due regard" would be one that would be familiar 10:35 to many lawyers, but in operational terms what's your experience as to whether the views of the PCC in relation to the planning of services is fed into that?

A. I think we can speak to programmes where the PCC have proactively got involved, but I think in terms of an 10:35 independent check and balance on the extent to which the consultation schemes and the intent behind them are regularly applied and applied with consistency is potentially lacking and would be something that the PCC would struggle to have comprehensive oversight over, 10:35 again related to some of our statutory -- the constrained resource.

28 Q. Just as a general point just before we move on, you have described some of the issues around the public being engaged and, you know, not engaged fully in some 10:36 processes, not being listened to adequately. Are there some aspects of that replicated in the PCC's relationship with the Department and other arm's length bodies given the strictures or structures of your

legalisation?

A. I think that would be a fair comment. I think the challenge for us is that essentially the way in which the legalisation is caveated means that there is an opportunity there to involve the PCC and to pay due 10:36 regard to our views. However, other bodies are essentially free to ignore it and the PCC doesn't have control over ensuring that we are involved, when we're involved and ensuring that that is done consistently. You can see that reflected at times in areas of work 10:37 where we might expect to be involved or are written into it without knowledge of it. I think that is definitely a challenge.

I think the picture across the system for engagement 10:37 and involvement of the public is confusing. There is quite a lot of resource and structures go into engagement involving the public but I think we would welcome greater clarity on some of those rules and functions and particularly alignment of resource to the 10:37 functions of the PCC with respect to some of that. I think there is opportunity to look at that.

29 Q. We'll look at some specific examples of where PCC may have been readily available or potentially keen to become involved in some of the issues relevant to this 10:37 Inquiry in a moment, which may provide some context for that particular answer. Just in relation to the comment on the functions, if we look at how the PCC carries out its functions. I just want to draw

a couple of examples out of your witness statement.

If we go to WIT-106653 at paragraph 68. This is entitled "Access to PCC Services". You say at paragraph 68: 10:38

"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 to 54. These complaints mostly arise 10:38 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 10:39 services".

I'll just stop there before we move on to the complaints issue. People have access to you directly from the street, as it were. 10:39

A. Yes.

30 Q. They can phone you up, unlike other arm's lengths bodies; they can directly contact you to engage your services, and you then undertake a process of assessment as to the appropriateness of your 10:39 engagement?

A. Yes.

31 Q. I know you said elsewhere if there's legal proceedings ongoing, then the PCC understandably step back from

that. At the point at which there's contact made by
the public, is there a system of assessment that you
decide or your staff decide this is something we're
interested in or is appropriate for us? How does that
happen in real terms? 10:39

A. So it depends on what the point of entry is to the PCC.
If somebody comes in through the phone lines, they
would immediately speak to a receptionist, and we have
developed a model in the last three years where there
are essentially three groupings of staff available on 10:40
any given day, practitioners and senior practitioners,
to respond to a particular query based on the nature of
the issue and the complexity. Whenever somebody phones
through to our phone line, they will be immediately put
through by the receptionist to one of two groups of 10:40
staff dependent on whether or not they are seeking
advice and information, or whether or not their issue
is perhaps they're in immediate distress, perhaps it's
a safeguarding issue, in which case it would
be escalated to our second group of staff, who are our 10:40
senior practitioners who are more used to dealing with
those complex cases. Either way, at any given point on
the phone lines, they will be able to speak immediately
to a member of our practice team.

10:40

If they are already known to the organisation and they
have a case ongoing, then they will be put through
directly to the case workers that is dealing with their
case, or, if they are not available that day, they will

get a message to phone them back. So I suppose the approach we have adopted in changing our model of practice is trying to ensure right person, right time, right information for members of the public. Last year we answered over 4,000 calls through our freephone 10:41 line. We also accept walk-ins to all of the offices. So again, my expectation is that when somebody presents to one of our offices, they will be seen by a member of staff if there's somebody available in the office to see them, otherwise we will seek to respond to them or 10:41 give them an appointment to see a member of staff within the next week or two, based on demand.

Our model of practice in terms of advocacy, we seek, as far as possible, to address issues immediately or 10:41 through early resolution. That model is based on partnership, relationship, understanding what the issue is that the person is coming to us about; what outcome there seeking to achieve; who else is in the picture, I suppose. So, if it is an issue about health and 10:42 social care, are there social workers, does the person have direct engagement with clinicians, what is the outcome we are seeking and how can PCC add value, because sometimes people are coming to us with a range of issues which involved support or engagement from 10:42 a number of different bodies or other support services within the voluntary community sector. So, there would be an assessment undertaken by our team to understand the role of PCC in that space, and then we would look to set out, I suppose, a plan of support around how we begin to address that issue. That, in terms of advocacy, can be right through from advice and information or an issue that might be resolved in a matter of days, or it might be something that 10:42 requires more in-depth case work. Unfortunately that can also extend into the formal complaints process, SAIs, engagement with NIPSO and other bodies as well. So we try to look at that issue in the person that's coming to us holistically and address the issues in 10:43 that space.

It may be also be that somebody is coming through to us where they have advocacy needs but they may also want to be engaged around some of our programmes of work, in 10:43 which case we'll make that linkage to the staff who are facilitating those programmes of engagement. Across the board, we seek to take the information we are hearing through our advocacy case work and the engagement and then ask what is that telling us about 10:43 what we're hearing from the public and how should that influence particular policy programmes or be highlighting issues to the system.

32 Q. That's a very helpful answer, there's a lot of information there. If I could just sum it up: 10:43 Depending on the nature of the query or the contact, you've got multiple different pathways, including pathways out of the organisation to other organisations; pathways into the Trusts; if you need to

make direct contact based on the nature; engagement
with other parts of your own services that may assist,
and ongoing support through case worker utilisation?

A. Yes.

33 Q. So there's a package of measures available to the PCC 10:44
and which part of the menu of that package will be used
depends on the nature of the query?

A. That's correct.

34 Q. One of the things you launched in April 2023 is the
Positive Passporting Initiative. As I understand from 10:44
your statement, that is an attempt to explain PCC's
role, gain a better understanding of partner
organisations, and explore merit of a referral pathway.
I wonder if you could just speak briefly to that?

A. So, the Positive Passporting Initiative really grew 10:44
from our approach in partnership working in
recognising, as I said, that sometimes people come to
us with issues and there are multiple issues behind the
reason they're coming to the PCC. I feel it is
inherent upon us as an organisation to have made 10:45
connections with other organisations so that people are
not falling through cracks in the system and that where
they come to us as a single point of entry, we try to
build relationships with other organisations where it
goes beyond simply sign-posting. 10:45

We had heard from the public that they felt at times
that the system was a bit of a revolving door, so they
perhaps approached one body and were told no, that's

not us, you need to go here, and they were sent on
their merry way. I think the approach around positive
passporting was PCC seeking to build relationships with
other organisations, recognising the wealth of
expertise there is in the third sector and right across 10:45
the system, and assisting people to navigate that and
positively passporting them into those organisations so
it goes beyond mere sign-posting, which has the
potential to lose people but also doesn't recognise the
inherent challenge there is in times when you have 10:46
experienced an issue, about then having to navigate
what is quite a complex and confusing situation.

I mean, my hope is it also can lead to better value for
money and services, because if services are working 10:46
better together, then it should represent
a maximisation of resource in that way. So I think
what we have seen, where we started with that was
seeking to build relationships with frontline
organisations that provide similar type advocacy 10:46
support. So, for example in debt management, we're now
a member of the Helplines NI with other organisations
where people might seek housing support. That has led
to joint case work with a range of organisations,
including COPNI, the Children's Law Centre, the Centre 10:47
For Independent Living, migrant help. We partner with
the Homeless Prevention Forum that represents 13
different organisations that provide floating support.
It has had positive impact so far in terms of

a reciprocal relationship between PCC and other organisations in terms of trying to provide the best outcomes for people who come to PCC or to other organisations regardless of their point of entry.

35 Q. If I just go back to paragraph 68 - it is still on the 10:47
screen - just to read the second part of that sentence where I stopped off. The rest of that paragraph reads:

"The PCC are named within the HSCNI complaints procedure under which all of the HSC Trusts operate, 10:47
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. Under the process, HSC Trusts are expected to advise complainants on the types 10:48
of help available to them, including through the Patient and Client Council".

Then if we just move to WIT-106662, paragraph 92. If we go to paragraph 91, I'll read that for context. It 10:48
says:

"Consistent with the requirements imposed by the statutory duty of quality, the guidance and standards issued by the Department places the responsibility for 10:48
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 complaints process".

Paragraph 92:

10:49

"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 complainants will need or want to 10:49 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 10:49 within the organisation's 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".

10:50

Then for the Panel's note, just in the context of HSC complaints, paragraph 94:

"The Department of Health publishes data on the numbers of HSC complaints each year. The most recent data is 10:50 for the year 2023 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

case work support from the PCC in regard to services
provided by these HSC trusts was 453, or 9.4% of the
total. Case work support refers to circumstances where
we provide advocacy support to individuals and/or
families, including formal HSC complaints and SAIs. The 10:50
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".

10:51

Then you include a table. You have put a caveat in
paragraph 95, just before we go to the table, that
there are differences in demographics between the
Trusts, and there may be differences in the
availability of advocacy services from third sector 10:51
providers between Different Trust areas. You finish by
saying, "It is not possible to say what impact these
differences have on the figures in these tables".

The Panel will see the table at WIT-106664, just the 10:51
next page. These complaints are broken down by Trust.
You'll see that the total number of complaints, Belfast
Trust, sits at 1,633. This is for the year 2022/2023.
The Northern Trust 840, South Eastern Trust 865,
Southern Trust 830, and the Western Trust 658. 10:52

Just in relation to the PCC cases as a percentage of
the total Trust complainants, does that particular
column -- that's not a percentage of the overall

complaints in which PCC were involved, or is that what
that represents, the last column on the right "PCC
cases as a percentage of total Trust complainants".

A. That represents a total of all the advocacy cases that
we have relative to the Trusts' complaints data. 10:52

36 Q. The Belfast Trust is 9.5%, Northern Trust 11.3%,
Southeastern Trust is 11%, Southern Trust is 7.2%,
Western Trust 7.3. As you say, the total involvement
is 9.4%. It strikes me that that figure is very low as
regards engagement within the complaints process given 10:53
the specific reference and expectation, perhaps, that
PCC will form part of that suite of measures that would
support people through that process. What's your view
on that figure, and what can be done about that if you
think it is perhaps something that needs worked on? 10:53

A. I think, as earlier paragraphs in our statement allude
to, it is fundamentally the responsibility of the
Trusts to oversee and run an appropriate complaints
process. When you look at the direction, the 2009
Direction in relation to complaints and then the 10:54
complaints policy, it sets out an expectation that
Trusts will make complainants aware of the support of
PCC but it doesn't set out that they are required to do
so or required to do so exclusively. So, in many of
the documentation relating to Trusts you will find - 10:54
and I believe this is the case in the Southern Trust -
the PCC named amongst a range of organisations that
complainants can go to to seek support. I think we
would certainly welcome clarity within guidelines with

respect to complaints, I suppose, a primacy of the
independent support that PCC can offer, because I think
it speaks to points I make at a later stage around the
independence of support and the expectation from the
public, as they have a growing awareness of their 10:55
rights and expectations around openness and
transparency in the system, that support would be
independent. I think there are challenges, or rather
we can't necessarily be assured that the way the system
of support in terms of commission of advocacy services 10:55
is currently set up to provide that independence.

I think those figures, first and foremost, reflect the
fact that ultimately it sits with the Trusts to ensure
that they are running a complaints process that 10:55
adequately supports complainants through it, but also
that there isn't a requirement to ensure that they
refer to the PCC or make complainants aware of our
services, and we would welcome changes that would
support that. 10:55

37 Q. You've also made some suggestions about where the
complaints overall could be perhaps improved.
Paragraph 130 at WIT-106680. I'll just read
paragraph 130:
10:56

"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". 10:56

We'll look at the SAIs in a moment but just that
sentence, "changes to the system which provide more
independent assurance that HSC Trusts are adhering to
the requirements of the Department's direction on 10:57
complaints and Departmental guidance and standards on
complaints...", is that the process by which complaints
are undertaken, the way in which complaints are dealt
with?

A. Yes. I think what we would welcome is more independent 10:57
assurance, and what we mean by that is there is
currently no requirement, as I understand it, for
a particular body to oversee or scrutinise compliance
of Trusts with the Complaints 2009 Direction. I think
it would be a welcome change, and there is 10:57
possibilities within the system in terms of RQIA and
NIPSO to give them the power to scrutinise compliance
of Trusts from an independent perspective with the
Complaints Direction. In fact, I think the work that
NIPSO is taking forward in terms of the complaints 10:57
standards and enactment of their legalisation in the
2016 potentially provides provision for that, and
I think that would be a welcome change.

I think what we could also see, which would be welcome,
is more independent assurance at a Trust governance
level for boards to be able to independently assure
themselves that the governance system is working in
terms of how they were dealing with complaints. 10:58
I think we have made some suggestions around that in
terms of Trust quality reports and commentary from
external bodies in terms of what they are hearing from
people experiencing complaints processes, which would,
again, provide an independent assessment of how people 10:58
are experiencing complaints processes, and allow
a check and balance on the information that is coming
up through Trust internal systems. I think those are
a number of mechanisms through which that independent
assurance could be sought and could be done through 10:58
changes in guidance or directions as opposed
necessarily through primary legalisation, which
obviously takes time.

38 Q. Are those views on what changes you would welcome based
on the experience of the PCC with people coming through 10:58
the complaints process and you considering, well, that
wasn't done properly or correctly, or the Trusts are
carrying out complaints in an ad hoc way, or there
doesn't seem to be a standardised approach? What's
your view on that? 10:59

A. I think it very much is on the basis of our experience
working with the public directly in relation to their
experience of formal complaints processes. I think
when you look at the 2009 Direction, it is quite

comprehensive in setting out the expectations of
a complaints procedure, but in reality what we are
hearing from people who come to PCC for support is that
there is regional inconsistency in terms of how people
are experiencing the complaints process, the length of 10:59
time that it takes for a complaints process to be
undertaken, the fact that they experience it as
a largely administrative process which often doesn't
address the issues that they have originally raised
a complaint about. I think that's why the PCC has 10:59
sought to adopt a more early resolution approach that
involves conversations and upstream addressing of
issues at an earlier stage.

I think that if you reflect on recommendations that are 11:00
made from other inquiries, this is already picked up.
Aside from the experience the PCC is seeing, I would be
aware of recommendations from the Neurology Inquiry,
for example, that set out recommendations around
looking at the complaints guidance from the Department, 11:00
and looking to have a refocus or ensuring that it
addresses outcomes for people, as opposed to a focus on
compliance with procedure or a process or the
administration of complaints. I think, again, that
independent assurance for Trust boards and for the 11:00
system that people's experience of a process is front
and centre would be really welcome.

39 Q. The Panel heard yesterday from RQIA where they
explained that when they inspect or review, they

usually look at systems application rather than either
the information fed into that system or the outcome at
the end of it. They're looking a disciplinary or a
MHPS procedure, for example, is it in existence, has it
been applied in the way that's expected, rather than 11:01
the quality of the application, perhaps. Like yourself
they're a creature of statute so they are restricted in
what they can do.

Is it the case that you are the other end in many 11:01
respects, where you are looking at the quality of the
outcome of complaints and therefore your particular
views on some changes that you think may be helpful are
based entirely on user experience?

A. They would be predominantly based on user experience of 11:01
what the public are telling us and I think that is
right, given the functions of the PCC set up to
represent the interests of the public and hearing from
them. But I think there is scope for those
recommendations to give consideration to a much wider 11:02
body of evidence that is out there in the system in
terms of compliance with the system and multiple
different sources of intelligence about people's
experience that would give a firm evidence base for
some of those recommendations. I think one of the 11:02
challenges currently is that there isn't good enough
oversight of all of those different sources of
intelligence coming in and then analysis of what that
information is telling us about service improvements

and how we could improve that before issues potentially
become escalated.

40 Q. So the answers are out there as regards all the
different arms' lengths bodies and organisations;
they're a piece of the jigsaw but no one has ownership 11:02
of the picture. Would that be a fair characterisation
of the current position?

A. I think it's fair to say improvements could definitely
be made, yes.

41 Q. In relation to potential ownership of that, who do you 11:03
think that lies with? Where does that rest, or where
could any change that may be needed emanate from?

A. I think there is an inherent responsibility first and
foremost on Trusts themselves who are delivering
services to be assured of the quality of the services 11:03
they are providing and to seek out the intelligence
right across the system that enables them to do so.
These are very large organisations, so I think there's
scope within that.
11:03

I think that there is, at a level within SPPG and the
Department, also scope for that. I think there are
different bodies within the system who have different
responsibilities that could play into that picture.

42 Q. You've identified for your purposes the difference 11:04
between complaints and SAIs as regards the PCC at
WIT-106670 at your Section 21, paragraph 103. You say:

"The complaints system is focused 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. While some SAI
reviews arise out of a complaint made by a service user 11:04
or their family, many SAIs are initiated without a HSC
complaint having been made".

From your statement it's clear that the PCC does try to
support people who are going through the SAI, and 11:05
I think from your earlier evidence it's clear that
those people may contact you individually or be
sign-posted by a member of HSC staff or, indeed,
another organisation or route that brings them to your
door. What way are you able to assist people who are 11:05
going through that process? How onerous - and I use
that term neutrally - is that for you as an
organisation, and do you have the capacity -- sorry,
I'm asking you a couple of questions at once but I'll
try to remember what they are. 11:05

A. If I start with how we support people through that
process. Our work in SAIs is increasing definitely
from about 2020. I think that demonstrated or
represented, I suppose, a change in the people, the
former chief executive and myself, coming from 11:05
a background where we would have supported people
directly in relation to advocacy, so we have seen an
increase in that work. Predominantly we were
experiencing in that time people coming to PCC who have

been through or had had a number of repeatedly poor experiences in the SAI process and were coming to PCC for support at a later point in the process.

PCC are not resourced at all to provide advocacy 11:06 support in SAIs but we saw a need and a demand and a gap there in terms of the support that people were seeking, and sought to try and fulfil that within our advocacy continuum. That has caused significant pressure and I will speak to that in a minute. But 11:06 around that time we looked to put in a dedicated practitioner around SAIs to look at developing the independent advocacy model because that role requires in-depth knowledge of the SAI process. What we would do is meet with families at whatever point they come to 11:07 us in that journey. Ideally it would be before the SAI is initiated, but at times we are also looking at our own case work and working with families in complaints processes and recognising perhaps a matter should have been an SAI, and in that instance we would engage 11:07 directly with Trusts to request a screening or to flag up that it may need to be an SAI.

We would work with families to engage with the panel to set out the terms of reference, and to ensure that 11:07 families are represented in the terms of reference and in the process undertaken to ensure what they want to see as an outcome from the SAI in terms of learning, but also establishing what happened, that they are represented throughout. We would provide advocacy support throughout an SAI to the family members working directly with the panel, with family liaison officers within the Trust, if those were in place; working with the family to set out the questions that may have; to 11:07 have facilitated conversations with panel members, with senior members within the Trust; receiving draft reports. In the work that I have done directly in SAIs, I have engaged directly with a number of panel members throughout the process. Providing constructive 11:08 challenge as well throughout where family members perhaps don't feel - which is a consistent theme - that there is parity of voice in the SAI process for those who have been victims of the SAI, or who have had a loved one or somebody experience the SAI process. 11:08

In our work, I suppose, we seek for that to extend beyond the actual conclusion of the SAI itself. Whenever there is a draft report, unfortunately our experience in a lot of our case work has been that we 11:08 have had experience of cases where the family members have withdrawn from the SAI process partway through because they haven't been satisfied with how the SAI process is being undertaken, or the direction of travel. 11:08

We have worked directly with SPPG and the Trusts to try to resolve some of those issues. Where we haven't been able to seek resolution or, I suppose, agreement

between the family and the panel in terms of the
content of the SAI report, we have sought to work with
families to put together a family statement, and to
work with panels to ensure that family statement is
reflected in the overall SAI report. 11:09

Beyond that process itself, I mean for family members
it doesn't stop at the point where the SAI final report
is produced. Ultimately they are seeking to understand
what went wrong and to ensure that there is 11:09
acknowledgment of that, where appropriate, and that
changes are made in the system to ensure that other
families don't have the same experience. Our
independent advocates would also work with families
beyond the point of the submission of the report to 11:09
engage with Trusts. For example, in the past we had
presentations to Trust Boards; facilitated
conversations directly between family members and chief
executives in the Trusts or senior staff; on some
occasions sought presentations or assurances from the 11:10
Trust six months, or in a time period beyond the SAI,
to feed back to family members about how changes or
recommendations have been implemented.

What I would say is that independent advocacy in SAIs 11:10
require specialist practitioners, it requires dedicated
time, it is painstaking work. You are dealing with not
only the SAI process but also mediating and advocating
with family members and panels, with individuals who

are often experiencing multi levels of trauma and are perhaps still going through grief and bereavement with respect to the issue. So it requires quite a lot of expertise and time.

11:10

As I said, the only way in which PCC has been able to
support families in SAIs over the last three years --
and you can see from the stats I provided, I mean
we dealt with 33 new SAIs last year and the bulk of our
SAIs tend to be at Level 3 of complexity. The only way 11:11
we have been able to do that is by having senior
members of the staff involved in those cases, and that
has included myself as Head of Operations at the time,
the Chief Executive. I still have a number of cases
that I am supporting directly, given the nature of the 11:11
complexity, the sensitivity, the engagement at senior
levels with other bodies, and directly with SPPG in the
Department. So we're not resourced to do that at all,
and I think what we would seek to see is full
implementation of the IHRD recommendation in terms of 11:11
a funded advocacy service in SAIs. Did I cover all
your questions?

43 Q. I think it does, yes, it is very helpful. Just for the
Panel's note, the number of SAIs can be found at
WIT-106701 at paragraph 189. It shows, as you say, an 11:12
upward trend, number of new SAIs 2018/19 was 16,
2019/20 was 26, 2020/2021 31, 2021/2022 the number is
25, 2022/2023 is 33. That's the number engaging with
PCC, obviously, rather than for the SAI process.

A. Yes. Each of those are individual cases but in each case, we are often supporting a number of family members or victims of the SAI within that. I think for the 33 cases we dealt with last year, that represented 63 individuals. Often, given the nature of SAIs, 11:12 you're also dealing with challenges in family relationships, family dynamics, breakdown in relationships during that SAI process where there might be divergent views. So, it is a critical part of that process. 11:13

I think what I have outlined there is predominantly the operational role that we would have in somewhat of the strategic role, but we do engage directly with the Trusts and other bodies about the broad experience that 11:13 we're seeing, and have been doing that repeatedly over the last number of years and also at a policy level because changes to the SAI process are long overdue. I think family members have been calling very much for what they would see as the need for some of that change 11:13 in process, particularly around their involvement, et cetera.

44 Q. I just wanted to deal with those two issues, with the Panel's indulgence, just before we break. You mentioned patient experience, and you have undertaken 11:13 a bit of a filter for the purposes of this Inquiry to assist the Panel in understanding what the families' experience has been and I want to read that in. Just on your last point about the review, the RQIA Review of

Systems and Processes For Learning from Serious Adverse Incidents was published in June 2022, and the Panel heard evidence around that yesterday. Just from the PCC level of involvement, you've included in your papers - we don't need to go to it because I'm just 11:14 going to read the first couple of lines from it - PCC-00839, this is a letter to Peter May dated 21 March 2022, and it is from you and your team. You are writing with reference to that particular review and expressing your views around providing assistance 11:14 and support in relation to the SAI procedure.

First of all, in relation to that review, were you consulted on that review and did you feed into that review before it was published? 11:14

A. The RQIA review, yes. We facilitated -- we fed in directly based on PCC's experience as advocacy providers, but we also facilitated connection between RQIA and a number of key individuals and family members that we were supporting at the time to ensure that 11:15 their experience fed into that review.

45 Q. You say in this letter:

"It is our shared view that any further delay in the commencement of the work on the implementation of a new 11:15 SAI procedure itself compounds harm being caused within our health system, adversely affecting our patients, families, victims and their families, and the wider group of those who use, advocate, support and work in health and social care". Then you say "We wish to help. This is an issue we know the Department is committed to, and so collectively we propose to provide support and assistance to establishing and progressing the coproduction of an involvement charter for the 11:16 investigation of Serious Adverse Incidents and the production and learning that comes from the final SAI report".

Is there any movement in that regard, or what was the 11:16 feedback to this correspondence?

A. We received a response, which I think I've included, that welcomed the support but set out that they didn't want there to be any lack of alignment between the work that we were undertaking and what the Department was 11:16 taking forward. Shortly after that, I think the Department did commence and set up a structure to look at the redesign of the SAI process. We have since established and are taking forward an engagement platform that works directly with family members who 11:16 have had a significant experience of the SAI process but also engagement with a number of other bodies and, I suppose, intersectioning processes such as the Coroner's Court, etcetera, to review and provide proactive feedback on the proposals that the Department 11:17 are producing through those resigned structures. But also to ensure that the experience of family members - and also recommendations that they would have for the system as a whole and not just relating to the patient experience piece - are fed back directly to that process and are heard in that process. It was really a proactive offer of assistance to ensure that that would be as helpful as possible and, I suppose from our perspective, that that experience would be front and centre and a foundation for that work. 11:17

46 Q. Just by way of correction, I think the letter is dated 21 March 2022. Mr. May did reply on 21 April 2023 but actually refers to your letter as being of 2023, so I think there's been a typo in the date of your letter. 11:18 I thought initially it had maybe taken a year to reply but I think just a date has been incorrect. Does that sound right to you?

A. That might be correct. I think so, yes, because the first letter would have been received from our former 11:18 chief executive just prior to her leaving post, I believe.

47 Q. That's Ms McConvey?

A. Yes.

48 Q. Mr. May's reply, just for the Panel's note, can be 11:18 found at PCC-00837. He, in substance, indicates that he doesn't want any duplication to services and that he thinks there may be movement towards the development of a resource that you were anticipating but that it wasn't at that stage, and perhaps wouldn't be led by 11:18 PCC in that regard. He also mentions work progressing on a draft statement of patient and family rights.

Now, is that something that has come to fruition or

where is that, and where do you sit within that?
A. That was a proposed output or an expected output of
work stream 5, I believe, from the IHRD
recommendations. My understanding is that that is
still in draft, and I am not aware of where that is 11:19
sitting currently in terms of its progress to a final
published draft. PCC would have had involvement in
both work stream 5 and 7 in relation to IHRD, but
I think there is clarity required on the IHRD
recommendation. I think the hope, in terms of that 11:19
response, was that that work would be brought in to the
redesign process.
49 Q. Just before we break, I would like to read the
experience list from users of SAI through your
particular organisation and you've collated that. 11:20
WIT-106704, paragraph 201. You say:

"The PCC reached out to families in advance of
completing this Corporate Witness Statement requesting
permission to highlighting their experiences. 11:20
Paragraph 97 details one family's experience over
a five-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 a daughter/sibling 11:20
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".

These are bullet points; I'm just read them.

"No information was provided as to how the Trust/GP
records could be obtained. This would have made the
initial meeting with the chair of the review panel more 11:21
productive. The SAI was deemed Level 2 without any
discussion with the family. The Terms of reference of
the SAI were presented to the family but at an early
stage of the process it was not made clear that these
could be challenged. The family had no independent 11:21
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 11:21
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 the 11:22
PCC at this time was intermittent as the officer worked
part-time and then left on maternity leave. Lack of
confirmation that the draft report would be available
on the date promised. The Trust insisted on meeting
with us to explain the report content, despite the 11:22
family telling them on multiple indications 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 the 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 11:22
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 requests asked.
We were not treated as equals. 11:23

"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 11:23
anything that was unreasonable. Many straightforward
questions remained 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". 11:23

That's a snapshot of experience. When you get
information like that, which would appear on reading to
be value adding for any review process, how do you feed
that back to those that are either doing the review, or 11:23
to the Trusts or the Department?

A. We would feed it back in a number of different ways,
through direct engagement with the panel or the Trust
itself. In 2021, I think, we convened a number of

round tables with the PCC and all the governance leads right across the Trusts to fee back collectively experience such as this, which unfortunately is not unique in what the PCC sees, to the Trust governance leads to set out the new model of practice the PCC were 11:24
undertaking in terms of SAIs and to look to seek collaborative work around addressing some of those issues. We would obviously engage directly with other bodies, including RQIA and NIPSO, within the system to feed this back. 11:24

The recent work that we are undertaking in relation to the redesign work, we have recently written to the Department from the engagement platform members themselves and included a number of vignettes of family 11:24
members' experience setting out this and others in terms of their overarching experience of the process.

50 Q. You also attend the Southern Trust Patient and Client Experience Committee on occasion. Is that another way you can feed this information or is that not 11:25
appropriate for that venue?

A. That committee, which we have had intermittent attendance at, we have in the past presented a report that gives a more regional view of PCC's work right across our advocacy, engagement and policy work. The 11:25
more appropriate venue that we have sought for feeding back this type of experience has been specifically with those governance leads meetings, and, following that round table, we sought to establish quarterly meetings

between the PCC and all the governance leads in the Trusts specifically looking at complex cases in the SAIs. That would be the avenue through which we would fee back that experience more directly in relation to SAIs as opposed to it being within the overall work of 11:25 the PCC.

51 Q. Would it be better if you were able to do it directly at that point? You are in front of the committee, you are in front of members of the Trust Board, would that be an opportunity to say we have a couple of examples 11:25 of people who have gone through, in your own jurisdiction, this is what the practical reality is for them?

A. I think that we reflect some of that experience and, yes, I think that would be an opportunity if we were 11:26 able to consistently attend those committees and had the opportunity and resource to do so.

52 Q. Do you have to be invited?

A. We have to be invited but I think we also need to have the resource to be able to do so consistently. 11:26

53 Q. Do you think if there was a process by which there was a formalisation of contact where they expect feedback and you provide that, that it might be a more direct way to influence change?

A. I think that some of the practical recommendations we 11:26 have made in terms of that independent assurance piece through quality reports and directly to Trust Boards would certainly be an avenue that we would welcome if we were resourced to do so.

54 Q. I don't want to push my luck, I think you have indulged me longer than you might have. If that's suitable, Chair.

CHAIR: We'll take a break now and come back at quarter to 12. 11:26

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

55 Q. MS. McMAHON BL: Just two other brief matters before 11:45 we move on to the issues touching upon the subjects the Inquiry are looking at and the PCC knowledge of those.

You mentioned about the Neurology Inquiry earlier in your evidence, and obviously we have had the 11:45 Hyponatraemia Inquiry prior to that that established the patient advocacy service for SAIs. We have looked at your engagement with Mr. May about your assistance what's the position now; what's the update on that? I know there was a question about -- you've mentioned 11:45 in your statement about it needing to be adequately resourced if it was set up. In relation to that recommendation, what's the position?

A. We haven't had any further clarity from the Department in relation to where that recommendation is sitting or 11:46 taking forward that recommendation.

56 Q. Now, again just in an earlier reference to the RQIA review of the urology SCRR process, where they were asked to look at the process by which they look back

and the analysis of the information was considered, there was recommendation that the Southern Health and Social Care Trust should consider engaging with, for example, the PCC to provide advice and support in the involvement of patients and families as part of the 11:46
both the look back and the SCRR. Was that progressed with the PCC at all?

A. In relation to the recommendation from RQIA, we weren't aware of that recommendation. To my knowledge, the Southern Trust didn't engage with the PCC in respect of 11:47
that. Obviously they had conversations with us, which you might come on to, around the coordination group. To my knowledge there was no linkage with the PCC in respect of that.

57 Q. Given the lookback and the SCRR was specifically 11:47
required to involve engagement with individuals and reach out to people in a cold call sort of way where there was some analysis of their care and treatment being undertaken, might it have been useful for the PCC, given your expertise around advocacy and 11:47
communicating with healthcare users, would there have been some merit in involving you in that process, do you think?

A. Yes, I think that we would welcome involvement in that process. I think that the current lookback guidance 11:47
doesn't make any requirement or mention of the PCC in respect of connecting with us around lookback reviews. We would certainly welcome changes to the lookback guidance that would, at a minimum, give primacy to

engagement with family members and individuals affected at a much earlier stage, and conversations with the PCC to advise on the best methods of how you might go about that. I think that there is a wealth of experience within the third sector around support provision, and 11:48
I suppose the PCC wouldn't seek to replace or displace some of that. I think where we could add value is that independence that I mentioned previously, and also conversations around how that support might be taken forward, who might be most appropriate to do so, 11:48
etcetera. Again, we are constrained by resource but I think our statutory functions do provide the scope for us to engage around that and we would certainly welcome changes to the lookback review that would facilitate that. 11:48

58 Q. You mentioned the SHSCT Urology Coordination Group. Have you had any involvement in that?

A. In seeking to understand the process around that, I engaged with the former chief executive Vivian McConvey and our previous involvement manager because 11:49
whilst I was head of operations during that period of time that they engaged, I didn't have any direct involvement with it. My understanding is --

CHAIR: Not only does the stenographer have to hear what you say, Ms. Monaghan, but I am trying to make 11:49
a note too. If you can, just slow down a little bit. Thank you.

A. Should I start again?

CHAIR: Your previous chief executive and you were Head of Operations at the time.

A. I was Head of Operations at that time but I didn't have any direct involvement in relation to the Southern Trust or the coordination group's connection with the PCC, so I have sought to understand the 11:49 process that was taken.

We didn't have any involvement in the coordination group directly in that we weren't a member of it. My understanding is that there was an open door from the 11:50 PCC to the group and to the Southern Trust to have conversations, and some of those did take place in relation to understanding the process that they were taking forward and the support provision that they had in place to engage with patients and family members 11:50 affected. We undertook a series of conversations to advise around our previous experience in engaging with patient in other inquiries, engaging around the literature that might be used, and to leave open the possibility that the PCC might have a role and 11:50 explore -- I suppose key for us is exploring the added value that PCC brings to any process, and also understanding whether we can do that within the resource that we have. So I know there were a series of conversations during the period of, I think 11:50 December, when the first reach-out came to May of 2021.

59 Q. MS. McMAHON BL: If we could go to PHA-00246. I'm hoping that this is minutes of a meeting of 26 November 2020. PHA-00246. This is the Southern

Urology Coordination Group minutes dated 26 November 2020 at 1530. Names of those present; a few of them would certainly be familiar to the Inquiry and have provided evidence to the Inquiry. If we move down again to 00246, just a couple of pages 11:51
down. Just on down to the bottom, please. PCC representative, you see at the bottom of Box 2.

"It was agreed that Caroline would contact Patient Client Council to invite them to participate in this 11:52
group".

Were you ever formally invited to join the group?

A. To my knowledge we didn't receive an invite to join the group. We had a series of conversations about the 11:52
processes that were undertaken. I would say it is our experience at times that PCC are invited to join groups or are written in as members of groups, sometimes without our knowledge. One of the approaches we have to undertake is to understand why they want PCC to be 11:52
a member of the group, whether it is appropriate for us to be so given our independence and maintaining that independence, but also critically at times whether it is actually a PCC staff member they are seeking or a member of the public directly who could be 11:53
facilitated to engage through PCC. But my understanding is that we were never a member of the urology coordination group, nor did we receive a formal invite to be so.

60 Q. Again, obviously if the group members have met to discuss that, they obviously considered that that may be value adding, but in your understanding there was no correspondence followed through to do that?

A. No. I think there was a series of conversations that 11:53 were had in terms of exploring what the value add might be. I also understand that Vivian, our former chief executive, did also have conversations about whether or not we would require additional resource should we have a greater role. But I understand that there was 11:53 arrangements in place through the Southern Trust to engage with the public. We provided additional advice and they chose to engage Inspire through the Lookback Review to engage patients. So at a point they had noted that there was no engagement required from PCC at 11:54 that time.

61 Q. The nuance of your answer, so I'm fair to the minute and the person tasked with inviting PCC, there seems to be some suggestion in your answer that conversations were engaged with about the potential and the capacity 11:54 and additional funding to facilitate engagement. You won't know the answer to this but, from what you understand, is it possible that PCC were slightly resistant to take an invitation unless they were able to meet the further demands on their services that 11:54 involvement in this group might place?

A. I think the conversation was first and foremost about what additional support PCC could offer to the arrangements that the Trust already had in place, and

then, if there was a role for PCC beyond the advice
we had provided, that we had made clear that we would
perhaps need additional resource. But I don't believe
the conversations ever got to that point because it was
clear from the Trust's end of things that they had 11:54
provision in place.

62 Q. I wouldn't want to characterise it as a failure to
invite, a decision to invite and then be a failure to
do that; it seems there's a more layered answer to
that. I just want to set the record straight on that 11:55
and give you the opportunity to respond.

You have mentioned about looking at documentation.
We can look at an example of that, TRU-325061. It's
a further minute of a meeting. This is 11:55
a DOH/HSCB/SHSCT meeting with PCC to discuss the PCC
role in urology process; again Thursday 20 May 2021 at
one o'clock. In attendance, it is chaired by
Mr. Kavanagh, who we know is a director in the now
SPPG. If we just move down. We have involvement of 11:56
PCC. "Vivian advised" -- is Vivian your predecessor as
chief executive?

A. She is.

63 Q. "Vivian advised that she and Johnny had met to discuss
the update from the meeting on 13 May and she commended 11:56
the Trust for the comprehensive range of processes
already in place, and highlighted the appointment of
the Family Liaison Officer. Vivian added that she had
not seen any evidence of support/action groups. Many

agreed, but highlighted the swell of support for AOB on social media. Vivian noted this may change as evidence starts to come out in the public inquiry. Caroline noted that litigation may also be another contributing factor. Vivian questioned what role or added value PCC 11:57
could bring to the process. Michael highlighted the experience that PCC had gleaned from their involvement in other inquiries, such as the Muckamore Inquiry and Neurology Inquiry. Vivian noted that Muckamore Inquiry had a dedicated PCC staff member and this could 11:57
increase to two members of staff".

Just stopping at that point, is that something that PCC were funded for, that role in particular.

A. We got additional funding to put in place a staff 11:57
member to provide direct advocacy support, and also that assisted us in helping us undertaking the facilitation of the terms of reference for Muckamore.

64 Q. So this is the Structured Clinical Record Review process, SCRR, verses the SAI process was highlighted 11:58
and discussed.

"Patricia advised the Trust as to developing a leaflet and she requested Vivian to review this from a patient perspective. The outcome would be a letter format as 11:58
the template could not be handed over to families".

That seems to be the level of involvement, in my terms, quality assure that leaflet in relation to urology.

Now that you're Chief Executive, do you think - without seeking to criticise anyone but just from your own perspective now you're in post - do you think there was a potential for greater PCC involvement given the people around the table at this meeting, the use of 11:58 their resources? The totality of the involvement - without minimising it at all - seems to be a quality assurance of a front-facing communication for patients. Do you think PCC was underused?

A. Well, my understanding is that prior to this, there was 11:59 one or two other conversations, including in April and May, where PCC provided advice on our experience in the Muckamore and Neurology Inquiries and the role we undertook there, and how we would advise on the best methods to engage and involve the public, providing 11:59 that advice directly to the Southern Trust and also had conversations with them about the mechanisms that they had in place. So I think that support was ongoing, and there was an open door from PCC to the Southern Trust to seek that advice. 11:59

I think the quality assurance and provision of information in respect of the public engagement piece in patient leaflets was just one part of this overall support. I think in any ask that comes to us around 11:59 engagement, we seek to tailor a model specifically to the ask, and sometimes that does require additional resource. We had set out, I think in those conversations, that in other Inquiries we had had to

put in additional resource or received additional
resource to do so. So, my understanding is all of that
was on the table with respect to PCC's offer to the
Southern Trust, but also understanding where that was
situated within the overall arrangements that the Trust 12:00
had in place, and that that continued to be the offer
after this meeting.

65 Q. Do you know if the advice provided by PCC was actually
taken up by the Trust?

A. I don't know whether it was. I know that we did share 12:00
information directly, because this process came after
extensive work that we had done in relation to
Muckamore around both design and engagement process but
also materials to engage with families and the public
around that Inquiry, and we had also already engaged 12:00
with the Southern Trust earlier in October around
advising them on engagement with a range of families in
the nosocomial group SAI they had undertaken. So
we had a range of materials and conversations that we
had already developed -- my apologies, I am not always 12:01
aware of how fast I am speaking.

We had developed a range of those materials that would
have added value and we shared all of that, is my
understanding, with the Trust. 12:01

66 Q. Is there any suggestion that there was some PCC
reluctance to engage with the urology process, given
you had secured funding to engage with the Muckamore
process but not for urology? Was there any conscious

awareness around a reluctance to provide that level of
engagement given you were expected to do it within your
current capacity without having the recompense that you
gained through Muckamore?

A. I don't think there's ever been a reluctance on PCC to 12:02
get engaged on any particular piece of work. I think
that it is realistic and appropriate that we set out
the constraints we are under with respect to resource.
I think the point about that is to say that in relation
to what we were able to achieve in Muckamore, this was 12:02
done at the expense of additional resource being in
place. So I think that conversation was around setting
out this is the buffet of options or the support that
we could provide but that, in order to do so, we may
need additional resource to do so because we have to 12:02
make decisions within where we place our resource. But
I don't believe at any stage there is a reluctance on
the PCC's part to get engaged.

What I would say, as I've set out earlier, there are 12:02
limitations on PCC with respect to us putting ourselves
in a space. The Trusts and the other bodies can decide
the parameters under which they accept that support or
ask us to be involved in any piece of work. The power,
to an extent, lies the other way in terms of us making 12:03
the offer and that being taken up due to the current
limitations in our legalisation.

67 Q. I suppose an example of that tension, with a small t,
is the fact you were formally engaged by the Department

around Muckamore, and providing support and also called
to give evidence, provide a statement to the Inquiry
around the role of the PCC. I'm not saying there's any
conflict in that at all, I'm just highlighting that as
an example of your earlier evidence where you have to 12:03
sometimes have a couple of hats on.

A. Yes, there's definitely that inherent constructive
tension in the PCC's role. I think you also make an
interesting point about in relation to Muckamore and
Neurology, we were directly asked by the Minister and 12:03
the Department to get involved in both of those pieces
of work. My understanding is that that is not the case
in relation to the urology work.

68 Q. Given that and given your experience of those and this
process now, what was the value adding of having PCC in 12:04
the other two? How was that reflected? How did
you see that reflected in the process?

A. I would base that on what we heard from families
directly and my understanding in relation to the work
we undertook to advise on the terms of reference for 12:04
the Muckamore Inquiry, and the extensive process
we undertook facilitating work directly with families
to ensure -- with the primary purpose of ensuring that
their voice and opinions were reflected in those terms
of reference. What we heard when we produced that 12:04
report and shared it directly with the Department and
the chair of that Inquiry was that family members
contacted us to say they felt they could see themselves
in that report. That was a significant risk at that

time for PCC because you are trying to undertake something that you're hoping will meet the expectations and outcomes for family members. I think the value in that was the reflection from family members that they felt that that did reflect the views in what we had 12:05 heard and what they had told us. So I think there is significant value in that.

It speaks to public trust and confidence across the board. I think the piece for me in any Inquiries or 12:05 reviews is they are often coming from a place where public trust and confidence has been affected, and therefore it is critical in setting up any review process that you are doing all you can to ensure that you're rebuilding that public trust and confidence from 12:05 an independent perspective in terms of their engagement in any of those processes.

69 Q. You set out at paragraph 147 - I'll just summarise it - of your statement, the first communication in which you were made aware of the issues in urology, your former 12:06 chief executive, was on 1 December 2020 when Ms. McConvey, then the Chief Executive, received an email from Caroline Cullen, Senior Commissioning Manager of the Southern Health Social Care Trust, who wrote to her on behalf of Mr. Kavanagh, who was then 12:06 the Interim Director of Planning and Commissioning at the HSCB in his then role as chair of the SHSCT Coordination Urology Group. That was a conversation where it was indicated that they would be keen to have

the PCC involved. That was, from your statement, the first point at which PCC was aware of the issues that were ongoing.

You have undertaken, for the purposes of the Inquiry in 12:06
order to answer the Section 21 notice, a review of your
case work to see if there had, in fact, been any
contact with PCC on the issues relevant to the terms of
reference on the Inquiry. I just want to read that
into the record. You find that at WIT-106691, 12:07
paragraph 164. The heading is "Review of PCC Case
Work/Complaints Relevant to the Inquiry".
Paragraph 164:

"To assist the Inquiry, the PCC has reviewed the 12:07
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 12:07
detailed later in this statement. The PCC has
forwarded to the Inquiry the documents which PCC holds
about each of these complaints.

From 2012 PCC implemented a case management system call 12:08
"Alemba" to record case files in relation to the
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

Council whether 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 12:08
complaints relevant to this Inquiry".

That table is at page WIT-106692, for the transcript.
It shows that in the year pre-2009, HSC Councils, the
SHSCT cases, numbered four; in the years 2009 to 2019, 12:09
the PCC, as it was then - it was a different
structure - the number of cases from SHSCT were 26.
From 2019 to the present-day structure of the PCC, the
SHSCT numbered seven. So over that period from
pre-2009 to the present day, the total number of cases 12:09
is 37. Then you provide some detail of that relevant
to our terms of reference.

At paragraph 166, you say:

12:09

"In relation to the four cases from pre-2009, one 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 12:10
staff. From the evidence available in this case files,
no concerns have been identified regarding how the
cases were actioned in line with PCC practice
guidance".

Paragraph 167:

"In relation to the 26 cases from the period 2009 to 2019, eight cases related to patients under the care of Mr. O'Brien or Mr. O'Brien was referenced within the 12:10 cases notes. Six of these eight 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 12:10 client's satisfaction. One 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 12:11 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 the support of PCC, 12:11 with an NHS appointment for surgery received by the patient.

Of the remaining 18 cases which were not under the care of Mr. O'Brien, ten related to waiting times or delays 12:11 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 the PCC practice guidance".

Paragraph 169:

"Of the seven cases identified from 2019 to present, none referred to Mr. O'Brien. Three cases related to waiting times or delays in procedures, two concern support and information provision regarding SAIs. A further case was a generally 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 the PC Practice guidance". 12:12

Paragraph 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 procedure and quality of care were similar to those shared across all programmes of care and Trusts in Northern Ireland".

Paragraph 171: 12:13

"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 12:13 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 12:13 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 12:14 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 they live 12:14 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".

Then the table at the end where, throughout your Section 21, you helpfully included to highlight a summary of points that need to be made or recommendations or suggestions that you have made. 12:15 This page at WIT-106694 says at point 1:

"The majority of the cases in the Southern Trust were discovered due to lookback reviews rather than through patient complaints". Number 2, the PCC was not alerted 12:15 by the Trust at the time when the lookback review was initiated".

So you have provided the materials for those and we have included them in our documents and provided 12:15 them to the Core Participants. They reflect the content of your statement in regards to the issues that were raised and the resolutions that were reached.

Can I take it from the summary in the box that 12:15 I've just read there that your view is that the issues have that arisen and have resulted in the Inquiry, and are under consideration by the Inquiry and they heard evidence on, would not have found a route to the PCC in order for you to highlight those as issues because of 12:15 the way in which they were discovered, namely by lookback exercise, by individuals noticing issues, and not directly through patient complaints or anyone approaching a third party?

A. Yes, I believe so.

70 Q. Now that you have an idea of the nature of the complaints, and the Panel have heard evidence around the extent and duration of some of the issues that have arisen, and given what you know about advocacy 12:16 and reflecting patient experience and trying to fee back what that experience is, is there any system in place now that would allow those issues to bubble up from the Trust and find their way beyond its boundaries so that, if it were needed, there could be a service 12:16 that would advocate for people on those types of issues? They all came from within, and if you look just objectively, there's an existence of a patient service such as yours specifically to address and reflect healthcare experience, there's a myriad of 12:17 examples of a variety of types of experience that people have before the Inquiry; they seem to be more train tracks rather than a combined approach. Is there anything that could be done or changed or added to your service that might allow you to find out about these 12:17 issues before they get to lookback stage?

A. I think what I would say is that there's a number of factors that could be looked at. One is, obviously, people were experiencing these issues. They came primarily to the attention, as you've said, through 12:17 bubbling up through the Trusts. But I think if there was greater access to advocacy more generally, and if there was greater affirmation I suppose at a departmental level and right across the Trust in terms of the value of advocacy as being a fundamental part of governance and assurance so that people feel supported to raise issues and that that can be fed back into the system, that that would certainly assist. I think what we would see as a positive step would, for 12:18 example, be the enactment of advocacy and legislation in Northern Ireland, because it currently doesn't exist. We've already touched on the recommendation from IHRD in terms of a fully funded patient advocacy service. What I think that would do is ensure greater 12:18 parity of access to the public to advocacy services to enable them to have a support to raise issues in a timely way whenever they occur. Because raising issues is something that takes time, it can be quite an arduous process. For me there is a fundamental social 12:19 justice dimension to advocacy support and to ensuring that people are supported to raise issues.

I think the second thing that I would say is there is a clear need for there to be a greater triangulation of 12:19 data from all different sources of intelligence. Again, I think that this was also a recommendation, from my recollection, from the Neurology Inquiry in relation to the Department, RQIA, the Board, the Trust, establishing a system that triangulated data from 12:19 a number of different sources to look at better early identification of issues. There's also commentary in relation to the early alert system in ensuring that that is a clear process and focused on addressing outcomes ultimately for patients.

There is a part about patient experience before the point where it gets to a complaint or advocacy process that is telling the system how people experience issues. If that patient-experienced data is better triangulated, I believe, with information the Trusts see themselves internally within their complaints with issues that are being brought forward with the information that's coming from PCC, I think better triangulation of all of that across the board could give earlier warning signs and potentially opportunities for service improvement in addressing patient safety issues at an earlier stage. 12:20 12:20

71 Q. The Panel have heard evidence that some people did raise issues. I know what you say about people having the voice and the confidence and the opportunity to raise issues. There's also a question, and some witnesses have been asked around how do you create a culture of willingness to listen when people raise issues and also hear what they say and try to address what they're saying. There's that part of the culture as well. 12:20 12:20

Do you feel that PCC has a role in contributing to creating that culture or informing people around how that culture may be created? 12:21

A. I think everybody has a role in that. I think that there is fundamentally an issue that you pick up on in terms of the culture of openness and transparency, and how the system and anyone in the system responds to patient experience, your willingness to hear that and to recognise it as something that is telling you about service improvement. 12:21

72 Q. What did PCC do?

A. I think PCC -- I suppose for me, culture is set from the top. There is a challenge, of course, in how you implement consistency in that culture. I think PCC can and have been consistently feeding back into the system 12:21 about the need for there to be more openness and transparency, and highlighting how the role of advocacy and direct conversations with the public can facilitate that more open culture. That also would be supported by training of staff, and also an approach that enables 12:22 people to feel more empowered at different levels within the system to hear that experience and to take action in response to it.

Like I say, I think culture is set from the top but in 12:22 terms of openness and transparency, you need to have a sense check in terms of how people are experiencing the service and the response that they are getting from staff right across the system, and for people to be trained to respond appropriately. Again there are 12:22 recommendations in terms of IHRD and the Neurology Inquiry that would significantly support that change in culture.

73 Q. If culture is set from the top, what's the quality of

the engagement with PCC and the Trusts? Do they take
PCC seriously as an organisation that may assist them,
both in learning from patients but also contributing to
the culture that you say is needed if these issues are
going to be captured at an earlier stage? 12:23

A. I think that PCC has been on a journey internally and
is now currently on a journey with the Trusts in terms
of resetting some of those relationships. Engagement
with the Trusts for PCC happen at a number of different
levels. At an operational level when issues are 12:23
escalated to heads of service with the Trusts, and also
at an executive team and Board level.

I think the Trusts do value PCC's role in providing
that direct engagement with patients, but also our 12:23
mediative role in assisting them with mediating with
the public whenever things have gone wrong. Over the
last number of months and years, PCC have been on
a journey in engaging directly with the Trusts at an
executive level to bring forward that value add. But 12:23
again, we're a very small organisation; there's 35
individuals in total in the organisation, so that
ultimately will also be constrained by our resource.
Certainly the willingness and appetite is there to do
that. 12:24

74 Q. I just want to summarise some of the -- well, reflect
some of the summary points you've made in your
statement for the assistance of the Panel, given your
position as chief executive and what your feedback is

on the issues we have asked you about. We don't need
to go to these but I'll give the Panel the page in the
witness statement and then the summary point that's
made.
12:24

WIT-106679. The points you make are, number 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 Safety and 12:25
the collapse of the proper procedural requirements.
2. 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, 12:25
it is not always apparent that the process has been
followed".

I think we touched on this earlier in your evidence.
I presume the Trust are the ones responsible for 12:25
training staff on the application of the complaints
process. That's an internal role for them, as you've
said you agree with the fact they are responsible for
that. But the training you would consider, perhaps,
hasn't always been reflective of what the process 12:25
requires.

A. Uh-huh.

75 Q. Then at WIT-106680. We've touched on this before.
This is your point.

"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 of the Complaints Direction standards and guidance". 12:26

The specific concentration on that point is about the Boards would have to report on that rather than that they do that. There's an expectation that the Board would have an idea about the complaints and the way in 12:26 which they are carried out, but you're saying that if they had to report, then there would be a greater, perhaps, oversight and understanding of it, and they would be more involved in it in that respect because they would have to quality assure it. Is that a fair 12:27 summary of the point?

A. Yes, and I think it relates to the duty of quality and other points we've made about potential independence assurance that they could seek with regard to that.

76 Q. Then at WIT-106688, for the Panel's note, at 12:27 paragraph 154 you say:

"A proactive measure would be to include within the Department's guidance on governance a requirement for the PCC to provide direct feedback, for example on an 12:27 annual basis, To Trust boards based on the experience of service users gathered from the PCC's roles in SAIs and complaints etcetera. 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". 12:28

So again, that's asking for a more formalised way for
you to feed your intelligence gathered from carrying
out your statutory role back to the Department. Does
that need to be on a footing within the guidance? Is 12:28
that suggestion based on the fact that that's the way
it would be heard if it was part of the guidance? Is
it based on experience of it perhaps not being heard?

A. I think it's based on the fact that there is currently
no requirement. I think, reflecting the fact that the 12:28
Trust have to produce a quality report, it would
introduce a requirement for there to be an independent
assurance within those reports. I suppose it provides
an evidence base for potentially information that we're
already feeding back but also would need to be linked 12:29
to the requirement to take account of that, which we've
touched on earlier, is an inherent weakness currently
in terms of that. So one of the other things we asked
about is removing some of those caveats in our own
legalisation. 12:29

77 Q. Then at WIT-106688, the summary point is:

"Training should be provided to Board members on good
practice in monitoring complaints, SAI, and incidents

and listening to service users".

Again, is that a suggestion from you based on the quality that you see emanating from the Trusts, or simply because you think it might reflect better practice to train Board members? Is it a bit of both? 12:29

A. I think it is probably both. I think that is in line with recommendations that were made around IHRD. But our experience also has been over the last number of years, we have designed input directly to SAI training that the Leadership Centre has put in place for chairs and members of SAI panels. I think we have heard that has been very helpful and that that has centred specifically on family members going through the SAI process and what they would wish to see. I believe that was the first set of training that was done around SAIs and we've inputted into that on a number of occasions. That recommendation reflects the benefit we would see in that also being given to Board members, given their role in oversight at a Trust level around SAIs and complaints. 12:30 12:30 12:30

78 Q. Then at WIT-106691, the point there is:

"More robust independent monitoring of Trust responses to SAIs and complaints is required". 12:30

Again, that seems like a quality assurance issue. Who do you think should be responsible for that monitoring?

A. I think that probably RQIA, the SPPG and potentially

NIPSO in respect of complaints have a role potentially
in scope to play in that. Again, I think that reflects
other recommendations from inquiries.

79 Q. At WIT-106708 you've summarised the points you wanted
to make in your Section 21 and it reflects what you 12:31
have written previously so I'll just read the summary
table in. Point 1:

"Recognising the critical nature and urgency for review
and change" -- sorry, if I just go to this for the ease 12:31
of the stenographer. WIT-106708. Just from that
table, point 1:

"Recognising the critical nature and urgency for review
and change within the SAI process, the PCC has 12:32
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 12:32
unable to secure the additional funding to enable
a service to meet the demand and complexity of this
work.
3. In contrast to the Complaints Direction, the PCC's
role is not clearly defined or set out in the HSCB's 12:32
SAI guidance".

Just stopping there, you have a formalised role in the
direction around complaints. Do you think the same

sort of involvement in the SAI, where you're sign-posted and there's an expectation of your involvement, would be value adding?

A. I think it would be value adding and I think it is an IHRD recommendation in respect of the patient advocacy service. But I also think placing the SAI procedure on a statutory footing through direction similar to the complaints guidance would be of significant advantage. 12:33

80 Q. Point 4:

12:33

"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. 12:33

6. Increased advocacy support should be independently commissioned to support families through the SAI process as stated in recommendation 37 of the Hyponatremia Inquiry report. 12:33

7. Advocacy providers require to be commissioned in a manner that ensures that they can be true to the principles of independent advocacy".

12:34

Just on that last point, what is the rationale behind that?

A. I think we set out the principles of independent advocacy in terms of psychological, structural and

financial independence. Obviously PCC, being set up
under the Reform Act, has all three of those. That
point speaks to the fact that there is a wide range of
advocacy services commissioned by the Trusts in varying
different forms. I think there is an expectation from 12:34
the public that those services would be provided and
commissioned independently from the commissioner and
service provider. I think there is a challenge
currently in being assured that the current structure
delivers that. So in order to ensure that 12:35
independence, we are suggesting that services should be
commissioned independently of the Trusts to facilitate
that financial, psychological and structural
independence on behalf of advocacy providers.
12:35

There is precedence for this within the five services
the RQIA review picks up in terms of SPPG's
commissioning role. We would see value in that being
the case across the board.

81 Q. Just a couple of mop-up points just for the transcript. 12:35

Was the PCC aware that there was a Maintaining High
Professional Standards process undertaken in relation
to Mr. O'Brien? Is that something you would know about
or be involved with? 12:35

A. No.

82 Q. You were never provided with a copy of that?

A. Sorry, say again.

83 Q. Were you ever provided with a copy of the determination

in MHPS?

A. No, not to my knowledge.

84 Q. You were never aware of any grievance lodged after that?

A. No. 12:36

85 Q. You have no knowledge of any of that.

Are you able to confirm, in a position to confirm, that from 2019 to date whether the PCC has received any complaints from patients about the medical treatment 12:36 they received from Mr. O'Brien, or can the Inquiry take that what you have provided to us is the totality of what you have?

A. That would be the totality.

86 Q. I think I have highlighted everything in the statement 12:36 that might assist the Panel. Obviously all of your statement is in as evidence but just at this point there is an opportunity if there's anything you would like to add or to say before the Panel ask you their questions. 12:37

A. I think I've touched on most of it in terms of some of the opportunities we see for changes, particularly around the role of advocacy in Northern Ireland in improving health services. As I say, I see that as having a fundamental social justice dimension to it. 12:37

I think that extends to the role of engagement of the public that we very much see as assets in their health and social care. I think, further to that, we would also welcome greater alignment of that engagement system and the resource, particularly with respect to the PHA and other bodies, to the role of PCC. I think that would deliver better for the public overall. But I'm content. 12:37

MS. McMAHON BL: Thank you. I have no further questions. The Panel will have some further questions for you.

CHAIR: Thank you, Ms. McMahon, thank you, Ms. Monaghan. 12:38

Mr. Hanbury, do you have some questions?

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 12:38

87 Q. MR. HANBURY: Thank you very much for your evidence. I just have a couple of things. Looking at the complaint, it is interesting to see your analysis, and I was interested to see the over 4,000 complaints, over 12:38 9% came to you. Is another spin on that that roughly 90% are being satisfactorily sorted out by the Trust?

A. I would say that another spin on that would be that 90% of them haven't come to us. I don't know whether you could extend that to being satisfactorily resolved 12:38 because complainants come to PCC for support, and I don't think that you could say that the fact that people didn't come to us is a reflection on the satisfaction of the resolution of complaints. Does that answer your question?

88 Q. Yes, I think so. Thank you. You made a comment about, and we've also noticed how long the SAI reports took. Did you collect data on the length of time complaints took from a family making a complaint or a patient 12:39 making a complaint to resolution?

A. Last year, I think, in our outcome report we looked at the -- we had set an output with respect to the length of time it took to resolve a complaint for PCC. The challenge in that for us was that often the resolution 12:39 of a complaint is very much dependent on the response of the Trust and therefore we didn't continue to look at that sort of data because we were finding that we had little control to an extent over the length of time that was taking. I suppose what that reflects is 12:39 that we would find that complaints often take a lot longer than what is maybe expected within the Complaints Direction. But that would be anecdotal, I couldn't speak to the evidence at this stage with respect to that. 12:40

89 Q. Okay, thank you. Moving on to the SAIs, you said an interesting thing, that some families engage with you initially and then pull out or fade away. What's your thoughts about that? Why does that happen?

A. Just to clarify, that point was in relation to families 12:40 engaging with the SAI process and then deciding at a point in that process to disengage from the process rather than from PCC support. That, in our experience, has been because families have been dissatisfied with

the SAI process and feel a loss of confidence in the
process addressing the issue that is subject of the
SAI, or how the process is being undertaken, or the
outcomes they are seeing. Often it is also the case -
in case work I've been involved in - that families feel 12:40
that there isn't parity of voice or they're
experiencing a necessary weight being given to that
within the SAI process. Often you are talking about
family members who have been pushing and have been
engaged in trying to understand what went wrong, to 12:41
seek acknowledgment of that and to also seek
recommendations around what would change that
fundamentally to ensure that other family members don't
have the same experience. It's an incredibly arduous
process that places a huge burden on family members. 12:41

What I have seen is the tenacity required can often be
too much for family members. They are dealing with
a lot of other things going on as well and there's
a repeat trauma associated with consistently revisiting 12:41
that issue. So we have found that the process itself
can be retraumatising for people and, as a result, some
family members have lost confidence in the process and
have disengaged. That is generally with the process as
opposed to than PCC support. 12:42

90 Q. That is more a reflection of how Trusts are engaging or
not with the families, you're saying?

A. Yes, how they are experiencing the process of the SAI
review, yes.

91 Q. Okay, thank you. One other thing on the SAIs, you helpfully did a table about the number of SAIs per year that came to you between 2019 and 2023. I was interested that it's roughly 50% of the ones coming in in the last year but only about 5% five years ago. Do 12:42
you have an explanation for that? There might be many reasons for it.

A. In terms of the reason why we're seeing the uptake?

92 Q. Level 3 rather than Level 2 or below?

A. I suppose that perhaps reflects often PCC in terms of 12:42
the cases that we are becoming engaged with; family members are coming to us where there is a significant level of complexity or sensitivity in relation to the event. So, Level 3 cases are often where people have suffered significant harm or have died, and that 12:43
reflects the level of support that families are requiring within that and coming to PCC for that support. We're increasingly seeing that reflected in terms of the levels.

93 Q. That presumably will involve you in more input for a 12:43
more complicated case is an indication?

A. Yes.

94 Q. Thank you. The last general thing is on SCRR's lookback. I was interested that you haven't heard much from people who have identified by the SCRR and the 12:43
Lookback Review, which is surprising in a way. Do you think that means that the Trust has handled those patients better?

A. My understanding is that the Trust put in place Inspire to support patients, so perhaps more my expectation is that they weren't referring to PCC for that support, they were referring to Inspire. I couldn't comment on the quality of the support that people were experiencing through that process. 12:44

95 Q. I guess, lastly, the Trust are thinking about going back to 2010 for the lookbacks and maybe some more SCRR process, and also involving private patients. Do you see much in the way of private patients, and do you think you might see an uptake on a sort of second phase 12:44 of lookback?

A. We do see people coming to the PCC for support where they have been seen privately. There is a significant gap, I would say, currently in the guidance and process around how you manage complaints arising from the 12:44 private sector, and also the interaction of those processes and where the intelligence from those processes might go into the system. Currently PCC's role with respect to complaints is limited in relation to the private sector unless the provision of treatment 12:44 through the private sector has been commissioned by one of the HSCs. We wouldn't generally get involved or have a role in private sector complaints unless the original referral has originated from the HSC.

12:45

I think one of the interesting recommendations again from Neurology was looking at the issues in data and intelligence coming through from the private sector and how that might influence at an earlier stage response

to issues. There was a recommendation around,
I believe, a database of clinicians practising
privately to keep a record of their private patients
and the diagnosis and treatments, and they had to
provide that as part of lookback reviews. I think that 12:45
would be very welcome if implemented, because I think
increasingly the way treatment is going is that people
are increasingly turning to the private sector, and
I think there is a significant risk with respect to
patient safety if there isn't consideration given to 12:45
how that intelligence is sought, understood and
triangulated with HSC and the rest of the intelligence.
Also from the patient perspective and where the PCC is
coming from, how the public are adequately supported
when issues in the private sector go wrong, and where 12:46
they turn to for support with respect to that and what
the procedures and guidance are governing it.

MR. HANBURY: Thank you very much. I have no further
questions.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart? 12:46

96 Q. DR. SWART: The complaints process, first of all. You
had a sort of statement that you didn't think the Trust
staff were always adequately trained in the procedures.
What did you see as the biggest deficit in their
understanding? 12:46

A. I think our comment is based on the experience we see
from members of the public coming to us for support and
their experience of the complaints process. I think
timeliness of response, understanding of the

expectation of responding to complainants and what they are trying to seek from that process. Understanding from people's experience in the process. Often what we see is trying to -- a focus less on the outcomes and how people experience a complaints process as opposed 12:47 to the administration of a complaint. I think greater training and awareness around the impact of why somebody is coming to complain, what patient experience might at an earlier stage feed in to an awareness would really assist, as opposed to an administrative response 12:47 to complaints, which is about following a process and maybe losing the person in the middle of that.

97 Q. So you have the information from the patients and families, not from the Trust staff, just to get that clear? 12:47

A. That would be the case. Or our experience of then supporting patients and engaging directly with the Trust where, at times, our staff would report finding regional inconsistency with respect to the response they are getting from Trust staff, their 12:47 understanding of the complaints process, the expectation, the role of PCC, etcetera. So it would be twofold, directly from patients and our experience of the staff.

98 Q. As far as I can see, most of the oversight of 12:48 complaints really does focus on the time scales more than anything else, not particularly customer satisfaction, shall I say, or outcome?

A. Yes.

99 Q. What thought have you put into actually working with complaints departments directly? My personal experience is if you contact families right at the beginning and ask them what they really want from the complaint and agree all of that, you get a much better 12:48
result. But I don't see that happening here in Southern Health Care Trust, and anyway I don't know about that. But is that not a role for the PCC in terms of actually working -- a training role with complaints departments. I know you talked about boards 12:48
but the people who really make this happen are the senior people in the complaints team and the governance team. If they can set that process to mandate talking to people early on, it makes a big difference, in my view. Have you had those discussions at all? 12:49

A. Yes, and I would absolutely agree with your point. I suppose that is why, in 2021, the PCC convened a round table of all of the governance leads and complaints staff at a senior level within each of the Trusts to set out the experience we were hearing, but 12:49
also to set out the change practice models the PCC were engaging in, and made an offer after that for short, medium and long-term outcomes we would like to see, and sought quarterly governance meetings with each of the Trusts to directly have that relationship. 12:49

100 Q. I don't think that's happening, is it?

A. The uptake on the part of the Trusts has been better in some areas than others and there is only one that is consistently engaging with us on that.

101 Q. Because really you don't want duplication, you don't want the PCC to be doing all of this. There's a role for the Trust, isn't there, and it is being really clear what they should do themselves always as a matter of course and in what circumstances your advocacy is 12:49
required, accepting it will be required; in a number of complex cases people have ongoing issues and so on. Do you think that's clear to everyone, that sort of balance of the relative responsibilities and the principles of family engagement? 12:50

A. No, and I think more work needs to be done on that for sure. I think again it speaks to the piece about openness, transparency and culture and setting the expectation in terms of how you manage complaints from the top but consistently throughout. Also empowering 12:50
the staff to feel comfortable to pick up the phone and have that conversation at an earlier stage as opposed to administratively following a process that is set in place.

12:50

We have tried to engage around those conversations but I think more needs to be done internally to the Trusts to recognise a switch in approach to how they respond to complaints and patient feedback.

102 Q. I think we have seen the same thing with serious 12:50
incidents. I think certainly there was very good family involvement at Southern Health Care Trust for one group of serious incidents but I think that was a relatively new concept at that time; I'm sure it's

embedded now. But the way safety culture would take that is get the families in very early, work with the staff on the ground and with the families together to demystify that and not formalise so much. Again, though, that has to happen in the Trust. It could all 12:51 be done with the PCC in another room.

How do you see that alignment working in the future because it seems to me we could have risk of duplication, we could have risk of differing methods of 12:51 oversight. How do you see that, and do you think the right conversations are happening in that regard?

A. I think that a lot of work needs to be done to take on board and, I suppose, absorb the need for family engagement in that that needs to be integrated right 12:51 throughout any complaints or SAI process, ensuring that there is a culture around that, that you are training staff, that there's a recognition that that could be the switch that could make the difference in terms of patient outcomes and, yes, that that fundamentally lies 12:52 with the Trust and the service provider with respect to the quality of services they are providing, including the complaints response and SAI response. And that other independent sources outside of that are in addition to as opposed to the fundamental provider of 12:52 that service.

103 Q. Say if you take SAI review that's going on at the moment, is your voice being heard sufficiently loudly? Is there more that needs to be done? How proactive are

the PCC being in terms of saying not give us more work necessarily but please, please think more about the patient and family voice. Is that happening?

A. I think that there needs -- I think there is a tendency to compartmentalise patient and family engagement as 12:52 one part of a process as opposed to something that is the foundation for the process. I would say in the current redesign process, that also needs to be given further thought and advocacy being a fundamental part of that also. I think the PCC have been very proactive 12:53 over the last number of years, and you can see that particularly through our establishment of the SAI engagement platform to try and ensure from an independent perspective that that is very strongly heard. We have written directly to the Department on 12:53 a number of occasions with respect to that, and most recently from the engagement platform members themselves, setting out the principles they would expect to see and the fact that patient engagement is the fundamental foundation for that. I think more 12:53 needs to be done in terms of absorbing that.

104 Q. If you look at lookback reviews specifically, in this particular inquiry most of these families would not have been aware that there was anything amiss. We saw it even in a big group of serious incidents that the 12:53 families, when they were brought into the meeting, were a bit shocked about various things. The experience of families in lookback review is really rather different from a normal complaint or a normal SAI, I think. Has

specific consideration been given to developing a way
of handling that, bearing in mind it's a different
group of people with different understandings, often
different -- patients often older. What discussions
have happened? I know the Trusts have engaged with 12:54
Inspire or whatever to do it, I don't know exactly what
they have done. But lookback reviews are a feature of
modern medicine and it is a particular challenge in
terms of the best way to engage people without
upsetting everybody more, frankly? 12:54

A. To my knowledge, no conversations have been had with
the PCC with respect to that and the current lookback
guidance doesn't reference us, and I'm not aware of
other conversations that are ongoing outside of that.
I think that your points are very well made. What we 12:55
have said is we would like to see consideration about
the engagement involvement of those affected by a
Lookback Review being front and centre at the very
outset, and giving considering to a special staff or
a model that would be adapted for Lookback Reviews to 12:55
ensure that that is done to a high standard. I think
it is interconnected with other considerations around
the primacy of advocacy, independence of that support,
commissioning, provision of advice around how you might
go about the best methods to engage, and also what the 12:55
appropriate services are to do so. I think much more
thought needs to be given.

I just wanted to touch on your earlier point around the
centrality of patient engagement. I think one of the
things is absorbing the fact that people's experience
is the first line of defence in addressing issues in
giving clarity to service improvement in early 12:56
resolution of issues. I think there needs to be
broader consideration given to a patient safety
framework and not compartmentalising Lookback Reviews
or SAIs or complaints within that, but thinking about
more holistically a patient safety framework for 12:56
services where all the intelligence is brought together
and where patient experience and engagement is
fundamental to that framework, and I think that
requires a shift in thinking right across the board.

105 Q. I think when you look at it from the outside, have you 12:56
done any specific work as a council in terms of the
impact of this on patients' lives, and the distress
caused, quite apart from actual harm, the actual
patient experience of being on these waiting lists?

A. We produced a report in 2018 that set out the 12:56
experience of patients at that time. We haven't done
any specific work in relation to that since then,
although we have engaged with Versus Arthritis and
a number of other organisations to look at the
experience, and I know they have been doing work around 12:57
Waiting Well, etcetera.

106 Q. But the waiting times are much longer now?

A. Yes.

107 Q. I would imagine there's a huge amount of information

out there about what has actually happened?

A. Yes. We haven't done any work to date on that. I mean, I think one of the challenges of PCC's statutory functions is it is looking at research into the best methods of engaging people. We have tried to 12:57 look at adapting, you know, where we engage people on specific pieces of work to take their lived experience. That is specifically constrained by the experience we have to look across the breadth of HSC -- health and social care services across the board. That's 12:57 a challenge for us --

108 Q. It goes along with the patient being on a list, often not knowing what's happening, often not had a copy of their initial letter saying what was going to happen. There's a big issue there around failure to capture 12:58 that patient voice. I would have thought the Patient Client Council would be a useful place to bring that information together.

A. Well, the interesting thing about is that the patient client experience programmes of work don't actually sit 12:58 within the PCC, they sit within the PHA, and I think there is significant resource there in Care Opinion and 10,000 Voices that do really good work, but the challenge at the minute is that they are not aligned to the functions of the PCC currently. 12:58

109 Q. Should they be?

A. I think greater alignment would certainly be -- would make sense to me.

110 Q. Thank you.

111 Q. CHAIR: I think most of the questions I was going to
ask you have been asked. One thing, you talked about
the lack of resource, and obviously that is an issue
across the piste in the health setting at the moment.
Assuming that you have to work within the resource that 12:59
you have at the minute, what one change -- you've
talked about the recommendations of the Neurology
Inquiry and the recommendations of the Hyponatraemia
Inquiry. What one recommendation do you feel would
make a difference to patients in Northern Ireland that 12:59
this Inquiry could make that is different to those that
have already been made? Is there one?

A. I mean, I suppose I've touched on the statutory footing
of advocacy in Northern Ireland in general, and that
isn't touched upon in other recommendations from the 12:59
inquiries. I mean, IHRD talks about having a fully
funded patient advocacy service, but until you have
a statutory right to advocacy, as there is in Scotland
and in other places, in Northern Ireland I think that
there will always be a challenge. Therefore, what 13:00
I would see as a fundamental change could be both that
legislative standing for advocacy. But changes in the
interim to guidance and direction that demonstrated an
affirmative commitment from the Department and the
health Trusts to the role advocacy plays in being 13:00
a fundamental part of governance and assurance in terms
of the quality of services that patients get, and
supporting patients to engage around that, I think
would make a difference, not just within the health

sphere but right across the board in terms of third sector organisations and the experience of the public generally when they have issues that they need to address right across public services. I think that could be a fundamental change. 13:00

CHAIR: Thank you very much.

I think that's it, Ms. McMahon, unless there are any other questions?

MS. McMAHON BL: No, thank you. 13:00

CHAIR: Thank you for coming and speaking to us, Ms. Monaghan.

That is us until ten o'clock tomorrow morning, ladies and gentlemen. See you then. 13:01

THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 22ND FEBRUARY 2024