



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.

Gwen Malone Stenography Services

Ms. Meadhbha Monaghan,

Examined by Ms. McMahon BL
Questioned by the Inquiry Panel

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1 CHAIR: Good morning, everyone.

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

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

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

12 MS. McMAHON BL: Ms. Monaghan will affirm.

13

14 MS. MEADHBHA MONAGHAN, HAVING AFFIRMED, WAS EXAMINED BY

15 MS. McMAHON AS FOLLOWS: 10:01

16

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

29 A. I can.

1 2 Q. Do you wish to adopt this as your evidence?

2 A. I do.

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

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

12
13 At paragraph 160, it refers to paragraph 197 in the
14 last line; this should say paragraph 98. Then finally
15 at paragraph 178, I would ask for a correction to take 10:03
16 out the lines that say -- or begin with "To the
17 knowledge of PCC", and to replace it with the
18 following:

19
20 "The RQIA report Review of Advocacy Services for 10:03
21 Children and Adults in Northern Ireland highlights that
22 only five of the advocacy services commissioned from
23 voluntary and community sector organisations are
24 commissioned as regional services by the HSCB. The PCC
25 believes that this is still the case". 10:04

26 4 Q. Thank you. You'll note that we have a transcript live
27 note. I was told off yesterday and I might be told off
28 today and you may suffer the same fate, if we both try
29 to remember that, so that a note can be kept of it.

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

4
5 The context of your evidence, why you have been asked 10:04
6 to come along, is because you are Chief Executive of
7 the Patient and Client Council, which is a statutory
8 Arm's Length Body. It is tasked broadly with
9 representing and promoting the development of the
10 public in health and social care. The Panel is 10:04
11 interested to hear how the PCC functions, what it does
12 to meet its statutory duties, and put it in the context
13 of some of the issues that the Inquiry has heard about
14 in evidence.

15
16 I don't know if you had the opportunity to listen to 10:05
17 any of the evidence or read any of the transcripts?

18 A. Some of it, yes.

19 5 Q. Would it be fair to say based on the information we 10:05
20 have provided as well that you have a fair
21 understanding of the issues before the Inquiry and the
22 matters that they are looking into?

23 A. Yes.

24 6 Q. Now the role in the background of the PCC, you have 10:05
25 been in that post relatively recently. Just before
26 we look at that, could you give us a brief synopsis of
27 your career to date and what was your role as chief
28 executive?

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

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

19 7 Q. Directly with the Patient and Client Council, what's
 20 your history with them? 10:07

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

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

4 8 Q. The Panel will be aware, because we've heard from
5 a couple of arms' lengths bodies at this stage, the 10:08
6 2009 Act that reformed health and social care was also
7 the origin of the Patient and Client Council at the
8 same time. Now, the structure, as I understand it from
9 your statement, is that the PCC is wholly independent
10 from all the other health and social care bodies. 10:08
11 Everyone has their own role but there's an expectation
12 of some sort of interlocking activities and that's the
13 juncture that we will try to focus on shortly in your
14 evidence.

15
16 In relation to your engagement with the Department, is
17 your sponsorship branch still the Chief Nursing
18 Officer? 10:08

19 A. It is.

20 9 Q. Generally with the Department, what's your relationship 10:08
21 with the Department? How do you engage with them and
22 how would you describe the nature of that engagement?

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

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

9
 10 In our engagement work and seeking to influence 10:09
 11 policies through what we hear from the public directly
 12 in various programmes of engagement, we would engage
 13 with different parts of the Department that have the
 14 policy leads in particular areas such as mental health,
 15 learning disability, care of older people. I would 10:10
 16 describe that relationship as constructive. I think
 17 there is a fundamental constructive tension in the way
 18 the PCC is set up in terms of it being on the one hand
 19 responsible to the public for representing the
 20 interests of the public and promoting their involvement 10:10
 21 but, on the other hand, needing to work within the
 22 system to achieve outcomes for the public on that
 23 basis. So there is a fundamental constructive tension
 24 in how we are set up.

25 10 Q. So your role in advocacy provides you with an 10:10
 26 opportunity to say things that need to be said but it
 27 may be difficult for others to hear or to respond to,
 28 so you are walking that line of keeping relationships
 29 with all different aspects of your role?

- 1 A. I think that would be a fair reflection, but ultimately
2 the organisation is set up to deliver on behalf of the
3 public within the system. Our key objective would be
4 seeking outcomes for the public in those particular
5 advocacy cases. 10:11
- 6 11 Q. In your statement you have mentioned that you have
7 twice yearly accountability meetings with the
8 Department. Are they time-tabled every year or is an
9 expectation you will meet twice yearly? Are they
10 normally meetings that do go ahead? 10:11
- 11 A. There was some disruption to those accountability
12 meetings during COVID, as there was right across the
13 board for arm's length bodies. But during my time as
14 Chief Executive, we have had those twice yearly
15 accountability meetings. One would be a ground 10:11
16 clearing meeting directly with the Chief Nursing
17 Officer, and then once a year with the Permanent
18 Secretary in the Department of Health.
- 19 12 Q. Have you had any of those meetings yet? I don't want
20 to ask you about meetings you haven't attended but have 10:11
21 you had them since you took up your role as Chief
22 Executive?
- 23 A. Yes, I have. Both.
- 24 13 Q. The nature of engagement in those meetings, is that an
25 opportunity for you to feedback in a very pragmatic way 10:12
26 what the difficulties may be for you in fulfilling your
27 role? what's the appetite for responding to any
28 concerns you raise at those meetings; what's your
29 experience been so far?

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

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

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

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

2 15 Q. I think you formalised those concerns in your midyear
3 assurance statement in 2022 and 2023 and the annual
4 report of that year, where you have formalised your
5 concerns about the impact of financial resources on
6 your ability to carry out your statutory
7 responsibilities.

10:14

8

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

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

10:15

20

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

10:15

10:15

27 16 Q. We'll go on and look at the functions of the PCC in
28 line with its statutory obligations but just as
29 a general point in light of your comments on funding,

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

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

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

20 10:16
21 "The PCC is a regional body, which means that its remit
22 with regard to its statutory functions is Northern
23 Ireland wide. The PCC has local offices in Belfast,
24 Lurgan, Omagh and Ballymena, and its statutory
25 functions under the 2019 Reform Act are set out as 10:17
26 follows:

27
28 Functions of the Patient and Client Council,
29 Article 17(1): The Patient and Client Council has the

1 following functions as respects the provision of health
2 and social care in Northern Ireland, (a) representing
3 the interests of the public; (b) promoting involvement
4 of the public; (c) providing assistance by way of
5 representation or otherwise to individuals making or 10:17
6 intending to make a complaint relating to health and
7 social care for which a body to which this section
8 applies is responsible; (d) promoting the provision by
9 bodies to which this section applies of advice and
10 information to the public about the design, 10:18
11 commissioning and delivery of health and social care;
12 (e) such other functions as maybe prescribed.

13
14 Article 17(2): In exercising its functions under
15 (1)(a), the Patient and Client Council must consult the 10:18
16 public about matters relating to health and social care
17 and report the views of those consulted to the
18 Department (where it appears to the council appropriate
19 to do so) and to any other body to which this section
20 applies appearing to have an interest in the subject 10:18
21 matter of the consultation".

22
23 In general terms, the broad requirement around
24 representation involving the public assisting members
25 of the public as regards complaints - and we'll look at 10:18
26 complaints separately in a moment - promoting what the
27 bodies do and how they do that for people to
28 understand, and then such other functions as may be
29 prescribed is a very general catch-all. There's also

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

3
 4 In relation to the last part about the consultation, is
 5 that a process that is derived from the PCC or are you 10:19
 6 asked to undertake consultation? How does the
 7 consultation legal requirement work for the PCC?

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

23 18 Q. Could you give us an example of a recent consultation?

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

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

13 19 Q. Just as you've described that, it sounds like you've
 14 provided a link between the voice of people who are
 15 impacted by potential decision-making and the 10:21
 16 Department who are making the decisions with others?

17 A. Yes.

18 20 Q. What would your view be on the value of that link as
 19 regards impacting upon or influencing the
 20 decision-making? 10:22

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

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

16 21 Q. Now, you undertake a role of listening to individuals
 17 affected by, for example, the Muckamore decision-making
 18 process. You listen to them, but does the Department
 19 listen to you? What's your experience of that? Do
 20 they listen to what you have to say? 10:23

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

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

4
 5 I think examples of where that has changed policy would 10:24
 6 be our care of older people work in 2020 where we set
 7 up an engagement platform working directly with family
 8 members who had relatives in care homes. We brought
 9 them together directly with decision-makers in the
 10 Department of Health, in RQIA, in PHA. Some of the 10:24
 11 tangible outcomes of that work were the implementation
 12 of care partners in the care partner role within care
 13 homes; the pathway for return to normalised visitation
 14 for family members; changes in how vaccination was
 15 being rolled out. I think that's a tangible example of 10:25
 16 where in the PCC have facilitated engagement work
 17 across the third sector and directly with individuals,
 18 and that has brought to bear on decision-making at a
 19 policy level within the Department. Our distance aware
 20 work would be another example of that in terms of the 10:25
 21 impact on people who were shielding during COVID.

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

1 aspects for the PCC. I just want to read paragraphs
2 115 to 117 of your statement, which is found at
3 WIT-106675.

4
5 115 says:

10:26

6
7 "Article 18 requires these bodies" - which are the
8 bodies named in the Reform Act - "to cooperate with the
9 PCC in the discharge of its functions. Whilst this
10 article requires these bodies to consult the PCC, this 10:26
11 is only in respect of matters and on such occasions as
12 these bodies consider appropriate. Similarly, whilst
13 the PCC can essentially require these bodies to provide
14 the PCC with information which the PCC requires in line
15 with the PCC's functions, the information provided is 10:27
16 subject to whatever conditions the providing body
17 decides upon. This article also gives the PCC Council
18 a power of entry to premises controlled by any of these
19 bodies. However, this power applies to members of the
20 council, i.e. the PCC board, and does not extend to PCC 10:27
21 staff, and can only be exercised in connection with
22 PCC's functions.

23
24 Finally, under Article 18 these bodies must pay due
25 regard to the wishes of the PCC but are essentially 10:27
26 free to ignore those wishes if they wish".

27
28 It would seem that the only teeth in Article 18 is the
29 ability to enter premises controlled by any bodies. It

- 1 seems an unusual power to give to a patient and client
 2 council; I don't think even the RQIA have that
 3 particular power and they are charged with inspection.
 4 Have you any idea, just in passing, why that's
 5 included? Have you ever had to use that? 10:28
- 6 A. No, not to my knowledge. But as it says there, that
 7 power there also resides with our board as opposed to
 8 staff members within the council.
- 9 23 Q. The way it is drafted. It is also connected if it is
 10 in furtherance of PCC functions, so there's a couple to 10:28
 11 caveats to that. But you have no recollection of that
 12 ever having been triggered?
- 13 A. Not to my knowledge.
- 14 24 Q. Article 18 does seem fairly discretionary in relation 10:28
 15 to other bodies' engagement with the PCC. The line at
 16 which they may engage or the extent to which they may
 17 engage seems to be a matter for them. They can engage
 18 at a low level or high level, dependent on what they
 19 think is appropriate. In real terms operationally does
 20 that provide any challenge for you in carrying out your 10:28
 21 functions, or is there any frustration perhaps about
 22 the discretionary element of that article?
- 23 A. I think Article 18 in the legislation significantly
 24 caveats the powers of PCC, and there are obvious
 25 inherent weaknesses in the way that the legislation 10:29
 26 sets out the powers of the PCC. The duty to cooperate,
 27 if it didn't have those caveats, would be significantly
 28 stronger and I think we would welcome changes to the
 29 legislation that would remove those caveats.

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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 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 legislation were removed, it would provide us with stronger powers to, I suppose, support and address some of those challenges more robustly.

10:29

10:30

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

10:30

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

10:30

10:30

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

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

10 A. I think, again, it reflects the inherent weaknesses in 10:31
 11 the way the PCC is set up in order for us to maximise
 12 our ability to deliver on behalf of the public.

13 I think in reality, both in terms of operationally how
 14 Article 18 and 19 come to bear, is that it is reliant
 15 on the PCC building constructive relationships and 10:31
 16 having a constructive challenge function, but that is
 17 inherently limited by the caveats that are placed in
 18 the legislation. What that means is that other bodies
 19 are able to set the parameters under which they engage
 20 with the PCC and the due regard they give to our views. 10:32

21 I think we would certainly welcome changes that would
 22 strengthen the PCC's ability in these areas. Having to
 23 rely on building relationships can be painstaking and
 24 time consuming, and for a body that has less than 35
 25 staff in total, that again presents significant 10:32
 26 constraints in terms of our ability to deliver on
 27 behalf of the public.

28 26 Q. Just in relation to Articles 18 and 19, before we look
 29 at Article 20, on a day-to-day basis operationally, is

1 there a sense of frustration that you can't fulfil what
 2 you would like to do because of the constraints of this
 3 legislation, or does the outworking of that not really
 4 make much of a difference to the PCC? What is the
 5 actual impact?

10:33

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

10:33

15
 16 However, again you're constrained by the resource and
 17 the powers. I think what I would say is that you can
 18 see the potential in the organisation in terms of the
 19 functions that we are given on behalf of the public and
 20 the real need within the system both to engage the
 21 public as assets in those conversations and also to
 22 provide advocacy support to them whenever things go
 23 wrong, but not having the resource to maximise that and
 24 to build on that and the powers that support that
 25 whenever you need to be able to do so is challenging.

10:33

10:33

26 27 Q. Just to finish that Reform Act 2009 provision for the
 27 PCC, in paragraph 117 of your statement you refer to
 28 Article 20. You say:

10:34

1 "Article 20 requires that the consultation scheme must
2 make it clear how it will involve and consult the PCC
3 (amongst others) in regard to planning services,
4 etcetera, and must pay due regard to the views of the
5 PCC (amongst others)".

10:34

6
7 So there is a legislative requirement that in the
8 planning of services, you are involved in that and that
9 the Department must pay due regard to your views. The
10 phrase "due regard" would be one that would be familiar
11 to many lawyers, but in operational terms what's your
12 experience as to whether the views of the PCC in
13 relation to the planning of services is fed into that?

10:35

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

10:35

10:35

23 28 Q. Just as a general point just before we move on, you
24 have described some of the issues around the public
25 being engaged and, you know, not engaged fully in some
26 processes, not being listened to adequately. Are there
27 some aspects of that replicated in the PCC's
28 relationship with the Department and other arm's length
29 bodies given the strictures or structures of your

10:36

1 legislation?

2 A. I think that would be a fair comment. I think the

3 challenge for us is that essentially the way in which

4 the legislation is caveated means that there is an

5 opportunity there to involve the PCC and to pay due 10:36

6 regard to our views. However, other bodies are

7 essentially free to ignore it and the PCC doesn't have

8 control over ensuring that we are involved, when we're

9 involved and ensuring that that is done consistently.

10 You can see that reflected at times in areas of work 10:37

11 where we might expect to be involved or are written

12 into it without knowledge of it. I think that is

13 definitely a challenge.

14

15 I think the picture across the system for engagement 10:37

16 and involvement of the public is confusing. There is

17 quite a lot of resource and structures go into

18 engagement involving the public but I think we would

19 welcome greater clarity on some of those rules and

20 functions and particularly alignment of resource to the 10:37

21 functions of the PCC with respect to some of that.

22 I think there is opportunity to look at that.

23 29 Q. We'll look at some specific examples of where PCC may

24 have been readily available or potentially keen to

25 become involved in some of the issues relevant to this 10:37

26 Inquiry in a moment, which may provide some context for

27 that particular answer. Just in relation to the

28 comment on the functions, if we look at how the PCC

29 carries out its functions. I just want to draw

1 a couple of examples out of your witness statement.

2

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

10:38

6

7 "The PCC provides an advocacy and support service to
8 members of the public who wish to make a complaint
9 about health and social care services, as set out above
10 in paragraphs 46 to 54. These complaints mostly arise
11 through direct contact being made by an individual or
12 their representative with the PCC. In some cases the
13 individual will have been referred to the PCC by
14 a member of HSC staff, a third sector organisation, or
15 by word of mouth from someone who has experienced PCC's
16 services".

10:38

10:39

17

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

10:39

21 A. Yes.

22 30 Q. They can phone you up, unlike other arm's lengths
23 bodies; they can directly contact you to engage your
24 services, and you then undertake a process of
25 assessment as to the appropriateness of your
26 engagement?

10:39

27 A. Yes.

28 31 Q. I know you said elsewhere if there's legal proceedings
29 ongoing, then the PCC understandably step back from

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

10:39

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

10:40

10:40

10:40

25
 26 If they are already known to the organisation and they
 27 have a case ongoing, then they will be put through
 28 directly to the case workers that is dealing with their
 29 case, or, if they are not available that day, they will

10:40

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

13
14 Our model of practice in terms of advocacy, we seek, as
15 far as possible, to address issues immediately or 10:41
16 through early resolution. That model is based on
17 partnership, relationship, understanding what the issue
18 is that the person is coming to us about; what outcome
19 there seeking to achieve; who else is in the picture,
20 I suppose. So, if it is an issue about health and 10:42
21 social care, are there social workers, does the person
22 have direct engagement with clinicians, what is the
23 outcome we are seeking and how can PCC add value,
24 because sometimes people are coming to us with a range
25 of issues which involved support or engagement from 10:42
26 a number of different bodies or other support services
27 within the voluntary community sector. So, there would
28 be an assessment undertaken by our team to understand
29 the role of PCC in that space, and then we would look

1 to set out, I suppose, a plan of support around how
2 we begin to address that issue. That, in terms of
3 advocacy, can be right through from advice and
4 information or an issue that might be resolved in
5 a matter of days, or it might be something that 10:42
6 requires more in-depth case work. Unfortunately that
7 can also extend into the formal complaints process,
8 SAIs, engagement with NIPSO and other bodies as well.
9 So we try to look at that issue in the person that's
10 coming to us holistically and address the issues in 10:43
11 that space.

12
13 It may be also be that somebody is coming through to us
14 where they have advocacy needs but they may also want
15 to be engaged around some of our programmes of work, in 10:43
16 which case we'll make that linkage to the staff who are
17 facilitating those programmes of engagement. Across
18 the board, we seek to take the information we are
19 hearing through our advocacy case work and the
20 engagement and then ask what is that telling us about 10:43
21 what we're hearing from the public and how should that
22 influence particular policy programmes or be
23 highlighting issues to the system.

24 32 Q. That's a very helpful answer, there's a lot of
25 information there. If I could just sum it up: 10:43
26 Depending on the nature of the query or the contact,
27 you've got multiple different pathways, including
28 pathways out of the organisation to other
29 organisations; pathways into the Trusts; if you need to

1 make direct contact based on the nature; engagement
 2 with other parts of your own services that may assist,
 3 and ongoing support through case worker utilisation?
 4 A. Yes.
 5 33 Q. So there's a package of measures available to the PCC 10:44
 6 and which part of the menu of that package will be used
 7 depends on the nature of the query?
 8 A. That's correct.
 9 34 Q. One of the things you launched in April 2023 is the 10:44
 10 Positive Passporting Initiative. As I understand from
 11 your statement, that is an attempt to explain PCC's
 12 role, gain a better understanding of partner
 13 organisations, and explore merit of a referral pathway.
 14 I wonder if you could just speak briefly to that?
 15 A. So, the Positive Passporting Initiative really grew 10:44
 16 from our approach in partnership working in
 17 recognising, as I said, that sometimes people come to
 18 us with issues and there are multiple issues behind the
 19 reason they're coming to the PCC. I feel it is
 20 inherent upon us as an organisation to have made 10:45
 21 connections with other organisations so that people are
 22 not falling through cracks in the system and that where
 23 they come to us as a single point of entry, we try to
 24 build relationships with other organisations where it
 25 goes beyond simply sign-posting. 10:45
 26
 27 we had heard from the public that they felt at times
 28 that the system was a bit of a revolving door, so they
 29 perhaps approached one body and were told no, that's

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

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

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

5 35 Q. If I just go back to paragraph 68 - it is still on the 10:47
6 screen - just to read the second part of that sentence
7 where I stopped off. The rest of that paragraph reads:

8
9 "The PCC are named within the HSCNI complaints
10 procedure under which all of the HSC Trusts operate, 10:47
11 and often within complaints literature shared by each
12 of the HSC Trusts who signpost complainants to PCC for
13 independent support. The HSC complaints process is
14 described in more detail below. Under the process, HSC
15 Trusts are expected to advise complainants on the types 10:48
16 of help available to them, including through the
17 Patient and Client Council".

18
19 Then if we just move to WIT-106662, paragraph 92. If
20 we go to paragraph 91, I'll read that for context. It 10:48
21 says:

22
23 "Consistent with the requirements imposed by the
24 statutory duty of quality, the guidance and standards
25 issued by the Department places the responsibility for 10:48
26 establishing and operating this complaints procedure on
27 the organisations providing the service. In the case
28 of HSC Trusts, the Chief Executive is accountable for
29 the handling of consideration of complaints. It is the

1 responsibility of the organisation providing the
2 service to ensure that all of their staff are familiar
3 with the complaints process".

4 Paragraph 92:

5
6 "The Department guidance and standards place the onus
7 on the organisation providing services to provide
8 support to the complainant during the complaints
9 process. It is not expected within the complaints
10 process that all complainants will need or want to
11 enlist the support of the PCC to fairly resolve their
12 complaint. If that was to happen, it would most likely
13 indicate one or more of a failure to operate an
14 effective complaints procedure, a significant failure
15 of internal control divergences and risk management
16 within the organisation's system of governance,
17 a failure to comply with the Department's direction and
18 guidance on complaints, a failure to meet the
19 requirements of the statutory duty of quality".

10:49

10:49

10:49

20
21 Then for the Panel's note, just in the context of HSC
22 complaints, paragraph 94:

23
24 "The Department of Health publishes data on the numbers
25 of HSC complaints each year. The most recent data is
26 for the year 2023 and, excluding the NI Ambulance
27 Service, shows that the total number of complainants
28 who raised complaints with HSC Trusts was 4,826. In
29 the same period the number of complainants who sought

10:50

10:50

1 case work support from the PCC in regard to services
2 provided by these HSC trusts was 453, or 9.4% of the
3 total. Case work support refers to circumstances where
4 we provide advocacy support to individuals and/or
5 families, including formal HSC complaints and SAIs. The 10:50
6 PCC is not in a position to comment on whether or not
7 all of these contacts are recorded by Trusts on their
8 systems as complaints. In 2022/23 the PCC provided
9 a further 837 people with advice and information".

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

19
20 The panel will see the table at WIT-106664, just the 10:51
21 next page. These complaints are broken down by Trust.
22 You'll see that the total number of complaints, Belfast
23 Trust, sits at 1,633. This is for the year 2022/2023.
24 The Northern Trust 840, South Eastern Trust 865,
25 Southern Trust 830, and the Western Trust 658. 10:52

26
27 Just in relation to the PCC cases as a percentage of
28 the total Trust complainants, does that particular
29 column -- that's not a percentage of the overall

1 complaints in which PCC were involved, or is that what
 2 that represents, the last column on the right "PCC
 3 cases as a percentage of total Trust complainants".
 4 A. That represents a total of all the advocacy cases that
 5 we have relative to the Trusts' complaints data. 10:52
 6 36 Q. The Belfast Trust is 9.5%, Northern Trust 11.3%,
 7 Southeastern Trust is 11%, Southern Trust is 7.2%,
 8 Western Trust 7.3. As you say, the total involvement
 9 is 9.4%. It strikes me that that figure is very low as
 10 regards engagement within the complaints process given 10:53
 11 the specific reference and expectation, perhaps, that
 12 PCC will form part of that suite of measures that would
 13 support people through that process. What's your view
 14 on that figure, and what can be done about that if you
 15 think it is perhaps something that needs worked on? 10:53
 16 A. I think, as earlier paragraphs in our statement allude
 17 to, it is fundamentally the responsibility of the
 18 Trusts to oversee and run an appropriate complaints
 19 process. When you look at the direction, the 2009
 20 Direction in relation to complaints and then the 10:54
 21 complaints policy, it sets out an expectation that
 22 Trusts will make complainants aware of the support of
 23 PCC but it doesn't set out that they are required to do
 24 so or required to do so exclusively. So, in many of
 25 the documentation relating to Trusts you will find - 10:54
 26 and I believe this is the case in the Southern Trust -
 27 the PCC named amongst a range of organisations that
 28 complainants can go to to seek support. I think we
 29 would certainly welcome clarity within guidelines with

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

12
13 I think those figures, first and foremost, reflect the
14 fact that ultimately it sits with the Trusts to ensure
15 that they are running a complaints process that 10:55
16 adequately supports complainants through it, but also
17 that there isn't a requirement to ensure that they
18 refer to the PCC or make complainants aware of our
19 services, and we would welcome changes that would
20 support that. 10:55

21 37 Q. You've also made some suggestions about where the
22 complaints overall could be perhaps improved.
23 Paragraph 130 at WIT-106680. I'll just read
24 paragraph 130:

25 10:56
26 "The current complaint system places the onus on the
27 service provider to address and resolve fairly the
28 complaint. The PCC believes that this is the correct
29 approach. The PCC would welcome changes to the system

1 which provide more independent assurance that HSC
2 Trusts are adhering to the requirements of the
3 Department's direction on complaints and Departmental
4 guidance and standards on complaints, as well as SPPG
5 guidance on SAIs".

10:56

6
7 we'll look at the SAIs in a moment but just that
8 sentence, "changes to the system which provide more
9 independent assurance that HSC Trusts are adhering to
10 the requirements of the Department's direction on
11 complaints and Departmental guidance and standards on
12 complaints...", is that the process by which complaints
13 are undertaken, the way in which complaints are dealt
14 with?

10:57

- 15 A. Yes. I think what we would welcome is more independent
16 assurance, and what we mean by that is there is
17 currently no requirement, as I understand it, for
18 a particular body to oversee or scrutinise compliance
19 of Trusts with the Complaints 2009 Direction. I think
20 it would be a welcome change, and there is
21 possibilities within the system in terms of RQIA and
22 NIPSO to give them the power to scrutinise compliance
23 of Trusts from an independent perspective with the
24 Complaints Direction. In fact, I think the work that
25 NIPSO is taking forward in terms of the complaints
26 standards and enactment of their legislation in the
27 2016 potentially provides provision for that, and
28 I think that would be a welcome change.

10:57

10:57

10:57

1 I think what we could also see, which would be welcome,
 2 is more independent assurance at a Trust governance
 3 level for boards to be able to independently assure
 4 themselves that the governance system is working in
 5 terms of how they were dealing with complaints. 10:58

6 I think we have made some suggestions around that in
 7 terms of Trust quality reports and commentary from
 8 external bodies in terms of what they are hearing from
 9 people experiencing complaints processes, which would,
 10 again, provide an independent assessment of how people 10:58
 11 are experiencing complaints processes, and allow
 12 a check and balance on the information that is coming
 13 up through Trust internal systems. I think those are
 14 a number of mechanisms through which that independent
 15 assurance could be sought and could be done through 10:58
 16 changes in guidance or directions as opposed
 17 necessarily through primary legislation, which
 18 obviously takes time.

19 38 Q. Are those views on what changes you would welcome based
 20 on the experience of the PCC with people coming through 10:58
 21 the complaints process and you considering, well, that
 22 wasn't done properly or correctly, or the Trusts are
 23 carrying out complaints in an ad hoc way, or there
 24 doesn't seem to be a standardised approach? What's
 25 your view on that? 10:59

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

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

14
 15 I think that if you reflect on recommendations that are 11:00
 16 made from other inquiries, this is already picked up.
 17 Aside from the experience the PCC is seeing, I would be
 18 aware of recommendations from the Neurology Inquiry,
 19 for example, that set out recommendations around
 20 looking at the complaints guidance from the Department, 11:00
 21 and looking to have a refocus or ensuring that it
 22 addresses outcomes for people, as opposed to a focus on
 23 compliance with procedure or a process or the
 24 administration of complaints. I think, again, that
 25 independent assurance for Trust boards and for the 11:00
 26 system that people's experience of a process is front
 27 and centre would be really welcome.

28 39 Q. The Panel heard yesterday from RQIA where they
 29 explained that when they inspect or review, they

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

9
 10 Is it the case that you are the other end in many 11:01
 11 respects, where you are looking at the quality of the
 12 outcome of complaints and therefore your particular
 13 views on some changes that you think may be helpful are
 14 based entirely on user experience?

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

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

3 40 Q. So the answers are out there as regards all the
 4 different arms' lengths bodies and organisations;
 5 they're a piece of the jigsaw but no one has ownership 11:02
 6 of the picture. Would that be a fair characterisation
 7 of the current position?

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

10 41 Q. In relation to potential ownership of that, who do you 11:03
 11 think that lies with? Where does that rest, or where
 12 could any change that may be needed emanate from?

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

20 11:03

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

25 42 Q. You've identified for your purposes the difference 11:04
 26 between complaints and SAIs as regards the PCC at
 27 WIT-106670 at your Section 21, paragraph 103. You say:
 28
 29 "The complaints system is focused on seeking

1 a resolution to complaints raised by individuals and
 2 their families. The SAI review process is different in
 3 that it is a system mechanism designed to identify
 4 learning when something has gone wrong. While some SAI
 5 reviews arise out of a complaint made by a service user 11:04
 6 or their family, many SAIs are initiated without a HSC
 7 complaint having been made".

8
 9 From your statement it's clear that the PCC does try to
 10 support people who are going through the SAI, and 11:05
 11 I think from your earlier evidence it's clear that
 12 those people may contact you individually or be
 13 sign-posted by a member of HSC staff or, indeed,
 14 another organisation or route that brings them to your
 15 door. What way are you able to assist people who are 11:05
 16 going through that process? How onerous - and I use
 17 that term neutrally - is that for you as an
 18 organisation, and do you have the capacity -- sorry,
 19 I'm asking you a couple of questions at once but I'll
 20 try to remember what they are. 11:05

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

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

4
 5 PCC are not resourced at all to provide advocacy 11:06
 6 support in SAIs but we saw a need and a demand and
 7 a gap there in terms of the support that people were
 8 seeking, and sought to try and fulfil that within our
 9 advocacy continuum. That has caused significant
 10 pressure and I will speak to that in a minute. But 11:06
 11 around that time we looked to put in a dedicated
 12 practitioner around SAIs to look at developing the
 13 independent advocacy model because that role requires
 14 in-depth knowledge of the SAI process. What we would
 15 do is meet with families at whatever point they come to 11:07
 16 us in that journey. Ideally it would be before the SAI
 17 is initiated, but at times we are also looking at our
 18 own case work and working with families in complaints
 19 processes and recognising perhaps a matter should have
 20 been an SAI, and in that instance we would engage 11:07
 21 directly with Trusts to request a screening or to flag
 22 up that it may need to be an SAI.

23
 24 We would work with families to engage with the panel to
 25 set out the terms of reference, and to ensure that 11:07
 26 families are represented in the terms of reference and
 27 in the process undertaken to ensure what they want to
 28 see as an outcome from the SAI in terms of learning,
 29 but also establishing what happened, that they are

1 represented throughout. we would provide advocacy
2 support throughout an SAI to the family members working
3 directly with the panel, with family liaison officers
4 within the Trust, if those were in place; working with
5 the family to set out the questions that may have; to 11:07
6 have facilitated conversations with panel members, with
7 senior members within the Trust; receiving draft
8 reports. In the work that I have done directly in
9 SAIs, I have engaged directly with a number of panel
10 members throughout the process. Providing constructive 11:08
11 challenge as well throughout where family members
12 perhaps don't feel - which is a consistent theme - that
13 there is parity of voice in the SAI process for those
14 who have been victims of the SAI, or who have had
15 a loved one or somebody experience the SAI process. 11:08
16

17 In our work, I suppose, we seek for that to extend
18 beyond the actual conclusion of the SAI itself.
19 Whenever there is a draft report, unfortunately our
20 experience in a lot of our case work has been that we 11:08
21 have had experience of cases where the family members
22 have withdrawn from the SAI process partway through
23 because they haven't been satisfied with how the SAI
24 process is being undertaken, or the direction of
25 travel. 11:08
26

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

1 between the family and the panel in terms of the
2 content of the SAI report, we have sought to work with
3 families to put together a family statement, and to
4 work with panels to ensure that family statement is
5 reflected in the overall SAI report.

11:09

6
7 Beyond that process itself, I mean for family members
8 it doesn't stop at the point where the SAI final report
9 is produced. Ultimately they are seeking to understand
10 what went wrong and to ensure that there is

11:09

11 acknowledgment of that, where appropriate, and that
12 changes are made in the system to ensure that other
13 families don't have the same experience. Our
14 independent advocates would also work with families
15 beyond the point of the submission of the report to
16 engage with Trusts. For example, in the past we had
17 presentations to Trust Boards; facilitated
18 conversations directly between family members and chief
19 executives in the Trusts or senior staff; on some
20 occasions sought presentations or assurances from the
21 Trust six months, or in a time period beyond the SAI,
22 to feed back to family members about how changes or
23 recommendations have been implemented.

11:09

11:10

24
25 what I would say is that independent advocacy in SAIs
26 require specialist practitioners, it requires dedicated
27 time, it is painstaking work. You are dealing with not
28 only the SAI process but also mediating and advocating
29 with family members and panels, with individuals who

11:10

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

5
 6 As I said, the only way in which PCC has been able to
 7 support families in SAIs over the last three years --
 8 and you can see from the stats I provided, I mean
 9 we dealt with 33 new SAIs last year and the bulk of our
 10 SAIs tend to be at Level 3 of complexity. The only way 11:10
 11 we have been able to do that is by having senior
 12 members of the staff involved in those cases, and that
 13 has included myself as Head of Operations at the time,
 14 the Chief Executive. I still have a number of cases
 15 that I am supporting directly, given the nature of the 11:11
 16 complexity, the sensitivity, the engagement at senior
 17 levels with other bodies, and directly with SPPG in the
 18 Department. So we're not resourced to do that at all,
 19 and I think what we would seek to see is full
 20 implementation of the IHRD recommendation in terms of 11:11
 21 a funded advocacy service in SAIs. Did I cover all
 22 your questions?

23 43 Q. I think it does, yes, it is very helpful. Just for the
 24 Panel's note, the number of SAIs can be found at
 25 WIT-106701 at paragraph 189. It shows, as you say, an 11:12
 26 upward trend, number of new SAIs 2018/19 was 16,
 27 2019/20 was 26, 2020/2021 31, 2021/2022 the number is
 28 25, 2022/2023 is 33. That's the number engaging with
 29 PCC, obviously, rather than for the SAI process.

1 A. Yes. Each of those are individual cases but in each
 2 case, we are often supporting a number of family
 3 members or victims of the SAI within that. I think for
 4 the 33 cases we dealt with last year, that represented
 5 63 individuals. Often, given the nature of SAIs, 11:12
 6 you're also dealing with challenges in family
 7 relationships, family dynamics, breakdown in
 8 relationships during that SAI process where there might
 9 be divergent views. So, it is a critical part of that
 10 process. 11:13

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

23 44 Q. I just wanted to deal with those two issues, with the
 24 Panel's indulgence, just before we break. You
 25 mentioned patient experience, and you have undertaken 11:13
 26 a bit of a filter for the purposes of this Inquiry to
 27 assist the Panel in understanding what the families'
 28 experience has been and I want to read that in. Just
 29 on your last point about the review, the RQIA Review of

1 Systems and Processes For Learning from Serious Adverse
 2 Incidents was published in June 2022, and the Panel
 3 heard evidence around that yesterday. Just from the
 4 PCC level of involvement, you've included in your
 5 papers - we don't need to go to it because I'm just 11:14
 6 going to read the first couple of lines from it -
 7 PCC-00839, this is a letter to Peter May dated
 8 21 March 2022, and it is from you and your team. You
 9 are writing with reference to that particular review
 10 and expressing your views around providing assistance 11:14
 11 and support in relation to the SAI procedure.

12
 13 First of all, in relation to that review, were you
 14 consulted on that review and did you feed into that
 15 review before it was published? 11:14

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

22 45 Q. You say in this letter:

23
 24 "It is our shared view that any further delay in the
 25 commencement of the work on the implementation of a new 11:15
 26 SAI procedure itself compounds harm being caused within
 27 our health system, adversely affecting our patients,
 28 families, victims and their families, and the wider
 29 group of those who use, advocate, support and work in

1 health and social care". Then you say "We wish to
2 help. This is an issue we know the Department is
3 committed to, and so collectively we propose to provide
4 support and assistance to establishing and progressing
5 the coproduction of an involvement charter for the 11:16
6 investigation of Serious Adverse Incidents and the
7 production and learning that comes from the final SAI
8 report".

9
10 Is there any movement in that regard, or what was the 11:16
11 feedback to this correspondence?

- 12 A. We received a response, which I think I've included,
13 that welcomed the support but set out that they didn't
14 want there to be any lack of alignment between the work
15 that we were undertaking and what the Department was 11:16
16 taking forward. Shortly after that, I think the
17 Department did commence and set up a structure to look
18 at the redesign of the SAI process. We have since
19 established and are taking forward an engagement
20 platform that works directly with family members who 11:16
21 have had a significant experience of the SAI process
22 but also engagement with a number of other bodies and,
23 I suppose, intersectioning processes such as the
24 Coroner's Court, etcetera, to review and provide
25 proactive feedback on the proposals that the Department 11:17
26 are producing through those resigned structures. But
27 also to ensure that the experience of family members -
28 and also recommendations that they would have for the
29 system as a whole and not just relating to the patient

1 experience piece - are fed back directly to that
 2 process and are heard in that process. It was really
 3 a proactive offer of assistance to ensure that that
 4 would be as helpful as possible and, I suppose from our
 5 perspective, that that experience would be front and 11:17
 6 centre and a foundation for that work.

7 46 Q. Just by way of correction, I think the letter is dated
 8 21 March 2022. Mr. May did reply on 21 April 2023 but
 9 actually refers to your letter as being of 2023, so
 10 I think there's been a typo in the date of your letter. 11:18
 11 I thought initially it had maybe taken a year to reply
 12 but I think just a date has been incorrect. Does that
 13 sound right to you?

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

18 47 Q. That's Ms McConvey?

19 A. Yes.

20 48 Q. Mr. May's reply, just for the Panel's note, can be 11:18
 21 found at PCC-00837. He, in substance, indicates that
 22 he doesn't want any duplication to services and that he
 23 thinks there may be movement towards the development of
 24 a resource that you were anticipating but that it
 25 wasn't at that stage, and perhaps wouldn't be led by 11:18
 26 PCC in that regard. He also mentions work progressing
 27 on a draft statement of patient and family rights.

28
 29 Now, is that something that has come to fruition or

1 where is that, and where do you sit within that?

2 A. That was a proposed output or an expected output of

3 work stream 5, I believe, from the IHRD

4 recommendations. My understanding is that that is

5 still in draft, and I am not aware of where that is 11:19

6 sitting currently in terms of its progress to a final

7 published draft. PCC would have had involvement in

8 both work stream 5 and 7 in relation to IHRD, but

9 I think there is clarity required on the IHRD

10 recommendation. I think the hope, in terms of that 11:19

11 response, was that that work would be brought in to the

12 redesign process.

13 49 Q. Just before we break, I would like to read the

14 experience list from users of SAI through your

15 particular organisation and you've collated that. 11:20

16 WIT-106704, paragraph 201. You say:

17

18 "The PCC reached out to families in advance of

19 completing this Corporate Witness Statement requesting

20 permission to highlighting their experiences. 11:20

21 Paragraph 97 details one family's experience over

22 a five-year period, with the PCC assisting them to

23 engage across the system, including the SHSCT. The

24 second family experienced a Level 2 SAI review which

25 was conducted following the death of a daughter/sibling 11:20

26 by suicide while under the care of the Southern Trust.

27 The following sets out their experience on being

28 advised that an SAI was to take place".

29

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

2

3 "No information was provided as to how the Trust/GP
4 records could be obtained. This would have made the
5 initial meeting with the chair of the review panel more 11:21
6 productive. The SAI was deemed Level 2 without any
7 discussion with the family. The Terms of reference of
8 the SAI were presented to the family but at an early
9 stage of the process it was not made clear that these
10 could be challenged. The family had no independent 11:21
11 advice. Initial contact person within the governance
12 office was absent for a prolonged period of time and
13 the family were not provided with a suitably senior
14 alternative in his absence. The family had requested a
15 meeting with the lead professional prior to issue of 11:21
16 the draft SAI report; this request was never passed to
17 him by the governance office. There was a lack of
18 regular updates, thus had to constantly seek
19 information. Family input was not considered to be an
20 integral part of the review process. Support from the 11:22
21 PCC at this time was intermittent as the officer worked
22 part-time and then left on maternity leave. Lack of
23 confirmation that the draft report would be available
24 on the date promised. The Trust insisted on meeting
25 with us to explain the report content, despite the 11:22
26 family telling them on multiple indications that we
27 would take the report, read it, respond and then ask
28 for a meeting. A series of meetings with the
29 Southern Trust facilitated by the PCC eventually took

1 place virtually, including a meeting with the new chair
2 of the SAI panel. Following the finalisation of the
3 SAI, the family were offered an opportunity to escalate
4 our concerns with the office of the Public Service
5 Ombudsman. The ombudsman accepted our case for 11:22
6 investigation. The SAI process certainly caused
7 further harm to my family, not the investigation itself
8 but the lack of engagement and communication, lack of
9 openness and willingness to answer all requests asked.
10 We were not treated as equals. 11:23

11
12 "On reading the RQIA review of the systems and
13 processes for Learning From SAIs (June 2022) it is
14 obvious that what we were asking for from the Trust
15 should have been delivered. We were not asking for 11:23
16 anything that was unreasonable. Many straightforward
17 questions remained unanswered in the final SAI report.
18 The family requested that their response to the draft
19 report be included as an appendix to the final report,
20 this did not occur". 11:23

21
22 That's a snapshot of experience. When you get
23 information like that, which would appear on reading to
24 be value adding for any review process, how do you feed
25 that back to those that are either doing the review, or 11:23
26 to the Trusts or the Department?

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

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

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

18 50 Q. You also attend the Southern Trust Patient and Client
 19 Experience Committee on occasion. Is that another way
 20 you can feed this information or is that not 11:25
 21 appropriate for that venue?

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

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

7 51 Q. would it be better if you were able to do it directly
8 at that point? You are in front of the committee, you
9 are in front of members of the Trust Board, would that
10 be an opportunity to say we have a couple of examples 11:25
11 of people who have gone through, in your own
12 jurisdiction, this is what the practical reality is for
13 them?

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

18 52 Q. Do you have to be invited?

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

21 53 Q. Do you think if there was a process by which there was
22 a formalisation of contact where they expect feedback
23 and you provide that, that it might be a more direct
24 way to influence change?

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

1 54 Q. I don't want to push my luck, I think you have indulged
 2 me longer than you might have. If that's suitable,
 3 Chair.

4 CHAIR: we'll take a break now and come back at quarter
 5 to 12.

11:26

6
 7
 8

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

9 CHAIR: Thank you, everyone.

10 55 Q. MS. McMAHON BL: Just two other brief matters before
 11 we move on to the issues touching upon the subjects the
 12 Inquiry are looking at and the PCC knowledge of those.

11:45

13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23

You mentioned about the Neurology Inquiry earlier in
 your evidence, and obviously we have had the
 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
 in your statement about it needing to be adequately
 resourced if it was set up. In relation to that
 recommendation, what's the position?

11:45

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

11:46

27 56 Q. Now, again just in an earlier reference to the RQIA
 28 review of the urology SCRR process, where they were
 29 asked to look at the process by which they look back

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

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

15 57 Q. Given the lookback and the SCRR was specifically 11:47
 16 required to involve engagement with individuals and
 17 reach out to people in a cold call sort of way where
 18 there was some analysis of their care and treatment
 19 being undertaken, might it have been useful for the
 20 PCC, given your expertise around advocacy and 11:47
 21 communicating with healthcare users, would there have
 22 been some merit in involving you in that process, do
 23 you think?

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

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

16 58 Q. You mentioned the SHSCT Urology Coordination Group.
 17 Have you had any involvement in that?

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

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

28 A. Should I start again?

29 CHAIR: Your previous chief executive and you were Head

1 of Operations at the time.

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

11:49

7
 8 We didn't have any involvement in the coordination
 9 group directly in that we weren't a member of it. My
 10 understanding is that there was an open door from the
 11 PCC to the group and to the Southern Trust to have
 12 conversations, and some of those did take place in
 13 relation to understanding the process that they were
 14 taking forward and the support provision that they had
 15 in place to engage with patients and family members
 16 affected. We undertook a series of conversations to
 17 advise around our previous experience in engaging with
 18 patient in other inquiries, engaging around the
 19 literature that might be used, and to leave open the
 20 possibility that the PCC might have a role and
 21 explore -- I suppose key for us is exploring the added
 22 value that PCC brings to any process, and also
 23 understanding whether we can do that within the
 24 resource that we have. So I know there were a series
 25 of conversations during the period of, I think
 26 December, when the first reach-out came to May of 2021.

11:50

11:50

11:50

11:50

27 59 Q. MS. McMAHON BL: If we could go to PHA-00246. I'm
 28 hoping that this is minutes of a meeting of
 29 26 November 2020. PHA-00246. This is the Southern

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

8
9 "It was agreed that Caroline would contact Patient
10 Client Council to invite them to participate in this 11:52
11 group".

12
13 Were you ever formally invited to join the group?
14 A. To my knowledge we didn't receive an invite to join the
15 group. We had a series of conversations about the 11:52
16 processes that were undertaken. I would say it is our
17 experience at times that PCC are invited to join groups
18 or are written in as members of groups, sometimes
19 without our knowledge. One of the approaches we have
20 to undertake is to understand why they want PCC to be 11:52
21 a member of the group, whether it is appropriate for us
22 to be so given our independence and maintaining that
23 independence, but also critically at times whether it
24 is actually a PCC staff member they are seeking or
25 a member of the public directly who could be 11:53
26 facilitated to engage through PCC. But my
27 understanding is that we were never a member of the
28 urology coordination group, nor did we receive a formal
29 invite to be so.

- 1 60 Q. Again, obviously if the group members have met to
 2 discuss that, they obviously considered that that may
 3 be value adding, but in your understanding there was no
 4 correspondence followed through to do that?
- 5 A. No. I think there was a series of conversations that 11:53
 6 were had in terms of exploring what the value add might
 7 be. I also understand that Vivian, our former chief
 8 executive, did also have conversations about whether or
 9 not we would require additional resource should we have
 10 a greater role. But I understand that there was 11:53
 11 arrangements in place through the Southern Trust to
 12 engage with the public. We provided additional advice
 13 and they chose to engage Inspire through the Lookback
 14 Review to engage patients. So at a point they had
 15 noted that there was no engagement required from PCC at 11:54
 16 that time.
- 17 61 Q. The nuance of your answer, so I'm fair to the minute
 18 and the person tasked with inviting PCC, there seems to
 19 be some suggestion in your answer that conversations
 20 were engaged with about the potential and the capacity 11:54
 21 and additional funding to facilitate engagement. You
 22 won't know the answer to this but, from what
 23 you understand, is it possible that PCC were slightly
 24 resistant to take an invitation unless they were able
 25 to meet the further demands on their services that 11:54
 26 involvement in this group might place?
- 27 A. I think the conversation was first and foremost about
 28 what additional support PCC could offer to the
 29 arrangements that the Trust already had in place, and

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

7 62 Q. I wouldn't want to characterise it as a failure to
8 invite, a decision to invite and then be a failure to
9 do that; it seems there's a more layered answer to
10 that. I just want to set the record straight on that 11:55
11 and give you the opportunity to respond.

12
13 You have mentioned about looking at documentation.
14 We can look at an example of that, TRU-325061. It's
15 a further minute of a meeting. This is 11:55
16 a DOH/HSCB/SHSCT meeting with PCC to discuss the PCC
17 role in urology process; again Thursday 20 May 2021 at
18 one o'clock. In attendance, it is chaired by
19 Mr. Kavanagh, who we know is a director in the now
20 SPPG. If we just move down. We have involvement of 11:56
21 PCC. "Vivian advised" -- is Vivian your predecessor as
22 chief executive?

23 A. She is.

24 63 Q. "Vivian advised that she and Johnny had met to discuss
25 the update from the meeting on 13 May and she commended 11:56
26 the Trust for the comprehensive range of processes
27 already in place, and highlighted the appointment of
28 the Family Liaison Officer. Vivian added that she had
29 not seen any evidence of support/action groups. Many

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

12
13 Just stopping at that point, is that something that PCC
14 were funded for, that role in particular.

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

19 64 Q. So this is the Structured Clinical Record Review
20 process, SCRR, verses the SAI process was highlighted 11:58
21 and discussed.

22
23 "Patricia advised the Trust as to developing a leaflet
24 and she requested Vivian to review this from a patient
25 perspective. The outcome would be a letter format as 11:58
26 the template could not be handed over to families".

27
28 That seems to be the level of involvement, in my terms,
29 quality assure that leaflet in relation to urology.

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

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

21
 22 I think the quality assurance and provision of
 23 information in respect of the public engagement piece
 24 in patient leaflets was just one part of this overall
 25 support. I think in any ask that comes to us around 11:59
 26 engagement, we seek to tailor a model specifically to
 27 the ask, and sometimes that does require additional
 28 resource. We had set out, I think in those
 29 conversations, that in other Inquiries we had had to

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

8 65 Q. Do you know if the advice provided by PCC was actually
 9 taken up by the Trust?

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

22
 23 We had developed a range of those materials that would
 24 have added value and we shared all of that, is my
 25 understanding, with the Trust. 12:01

26 66 Q. Is there any suggestion that there was some PCC
 27 reluctance to engage with the urology process, given
 28 you had secured funding to engage with the Muckamore
 29 process but not for urology? was there any conscious

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

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

19
 20 what I would say, as I've set out earlier, there are 12:02
 21 limitations on PCC with respect to us putting ourselves
 22 in a space. The Trusts and the other bodies can decide
 23 the parameters under which they accept that support or
 24 ask us to be involved in any piece of work. The power,
 25 to an extent, lies the other way in terms of us making 12:03
 26 the offer and that being taken up due to the current
 27 limitations in our legislation.

28 67 Q. I suppose an example of that tension, with a small t,
 29 is the fact you were formally engaged by the Department

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

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

14 68 Q. Given that and given your experience of those and this
 15 process now, what was the value adding of having PCC in 12:04
 16 the other two? How was that reflected? How did
 17 you see that reflected in the process?

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

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

8
 9 It speaks to public trust and confidence across the
 10 board. I think the piece for me in any Inquiries or 12:05
 11 reviews is they are often coming from a place where
 12 public trust and confidence has been affected, and
 13 therefore it is critical in setting up any review
 14 process that you are doing all you can to ensure that
 15 you're rebuilding that public trust and confidence from 12:05
 16 an independent perspective in terms of their engagement
 17 in any of those processes.

18 69 Q. You set out at paragraph 147 - I'll just summarise it -
 19 of your statement, the first communication in which you
 20 were made aware of the issues in urology, your former 12:06
 21 chief executive, was on 1 December 2020 when
 22 Ms. McConvey, then the Chief Executive, received an
 23 email from Caroline Cullen, Senior Commissioning
 24 Manager of the Southern Health Social Care Trust, who
 25 wrote to her on behalf of Mr. Kavanagh, who was then 12:06
 26 the Interim Director of Planning and Commissioning at
 27 the HSCB in his then role as chair of the SHSCT
 28 Coordination Urology Group. That was a conversation
 29 where it was indicated that they would be keen to have

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

4
5 You have undertaken, for the purposes of the Inquiry in 12:06
6 order to answer the Section 21 notice, a review of your
7 case work to see if there had, in fact, been any
8 contact with PCC on the issues relevant to the terms of
9 reference on the Inquiry. I just want to read that
10 into the record. You find that at WIT-106691, 12:07
11 paragraph 164. The heading is "Review of PCC Case
12 Work/Complaints Relevant to the Inquiry".

13 Paragraph 164:

14
15 "To assist the Inquiry, the PCC has reviewed the 12:07
16 records PCC holds and identified any complaints
17 relevant to the Urology Services Inquiry. The case
18 evidence will be provided in three sections, pre-2009,
19 2009 to 2019 and 2019 to 2024, reflecting periods of
20 change in the PCC's operations and practice model 12:07
21 detailed later in this statement. The PCC has
22 forwarded to the Inquiry the documents which PCC holds
23 about each of these complaints.

24
25 From 2012 PCC implemented a case management system call 12:08
26 "Alemba" to record case files in relation to the
27 complaints referred to the organisation. The PCC is
28 also in possession of a number of hard copy case files
29 transferred from the Legacy Health and Social Services

1 Council whether PCC was set up in 2009 or that were
2 dealt with by PCC from 2009 until the Alamba case
3 management system was introduced in 2012. All case
4 file record sources, either Alamba or hard copy, were
5 reviewed. The table below sets out the number of 12:08
6 complaints relevant to this Inquiry".

7
8 That table is at page WIT-106692, for the transcript.
9 It shows that in the year pre-2009, HSC Councils, the
10 SHSCT cases, numbered four; in the years 2009 to 2019, 12:09
11 the PCC, as it was then - it was a different
12 structure - the number of cases from SHSCT were 26.
13 From 2019 to the present-day structure of the PCC, the
14 SHSCT numbered seven. So over that period from
15 pre-2009 to the present day, the total number of cases 12:09
16 is 37. Then you provide some detail of that relevant
17 to our terms of reference.

18
19 At paragraph 166, you say:

20 12:09
21 "In relation to the four cases from pre-2009, one case,
22 dating back to 2001, related to a patient under the
23 care of Mr. O'Brien. However, the quality of
24 Mr. O'Brien's care was not the subject of the case,
25 which focused on waiting times and the attitude of 12:10
26 staff. From the evidence available in this case files,
27 no concerns have been identified regarding how the
28 cases were actioned in line with PCC practice
29 guidance".

1 Paragraph 167:

2
3 "In relation to the 26 cases from the period 2009 to
4 2019, eight cases related to patients under the care of
5 Mr. O'Brien or Mr. O'Brien was referenced within the 12:10
6 cases notes. Six of these eight cases related to
7 waiting times or a delay in follow-up procedures. From
8 a review of the case documentation recorded at the
9 time, the PCC worked with the Trust and the
10 patients/clients, and the issues were resolved to the 12:10
11 client's satisfaction. One case related to concerns
12 about out- and in-patient care at Craigavon Area
13 Hospital. This case was investigated by the Trust, who
14 concluded the treatment was appropriate. The client
15 subsequently elected to take legal action, and the case 12:11
16 was closed by the PCC, which is a pre-legal service.
17 The remaining case related to a patient who, through
18 a private appointment with Mr. O'Brien, was advised
19 he would be placed on the NHS list, but this did not
20 occur. The case was resolved, with the support of PCC, 12:11
21 with an NHS appointment for surgery received by the
22 patient.

23
24 Of the remaining 18 cases which were not under the care
25 of Mr. O'Brien, ten related to waiting times or delays 12:11
26 in procedures, with the remaining covering issues
27 concerning diagnosis, vaginal mesh and care quality.
28 From the evidence available in the case files, no
29 concerns have been identified regarding how the cases

1 were actioned in line with the PCC practice guidance".

2
3 **Paragraph 169:**

4
5 "Of the seven cases identified from 2019 to present, 12:12
6 none referred to Mr. O'Brien. Three cases related to
7 waiting times or delays in procedures, two concern
8 support and information provision regarding SAI s.
9 A further case was a generally query from a third party
10 concerning the Urology Inquiry. Advice was provided 12:12
11 regarding PCC services and support. However, no direct
12 support from PCC was sought by the third party or
13 a member of the public. The final case related to
14 a patient who wished to complain about care and
15 treatment during a day procedure. The patient did not 12:12
16 follow up on initial contact, or respond to PCC, and
17 the case was closed. From the evidence available in
18 the case files, no concerns have been identified
19 regarding how the cases were actioned in line with the
20 PC Practice guidance". 12:12

21
22 **Paragraph 170:**

23
24 "In conclusion, from our analysis of the limited number
25 of cases relating to Urology Services which span over 12:13
26 a 20-year period in the SHSCT area, it would be
27 difficult if not impossible to have identified systemic
28 issues in general, and specifically to the Urology
29 Services Inquiry's terms of reference. The concerns

1 raised regarding waiting times, delays in procedure and
2 quality of care were similar to those shared across all
3 programmes of care and Trusts in Northern Ireland".
4

5 **Paragraph 171:**

12:13

6
7 "On the basis of the evidence available to the PCC,
8 only a small number of complainants have approached the
9 PCC seeking assistance in raising a complaint about
10 Urology Services in the Southern Trust. The nature of
11 most of these complaints is typical of complaints about
12 other services, particularly in relation to waiting
13 lists and waiting times, for example. On the basis of
14 the evidence provided to the Inquiry, the majority of
15 the concerns about urology and Mr. O'Brien were

12:13

12:13

16 identified by management and through reviews of cases
17 by the Trust through lookback exercise and clinical
18 records reviews. These cases would not have come to
19 the notice of the PCC in our role under the complaints
20 procedure, and the Southern Trust engaged Inspire
21 rather than the PCC to support service users through
22 the lookback exercises. Inspire is an all-Ireland
23 charity and social enterprise providing services to
24 people living with mental ill-health, intellectual
25 disability, autism, and addictions to ensure they live
26 with dignity and realise their full potential.

12:14

12:14

27 Department of Health guidance on lookbacks does not
28 require HSC Trusts to engage with PCC as part of these
29 lookbacks".

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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. This page at WIT-106694 says at point 1:

12:15

"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 by the Trust at the time when the lookback review was initiated".

12:15

So you have provided the materials for those and we have included them in our documents and provided 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.

12:15

Can I take it from the summary in the box that 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 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?

12:15

12:15

1 A. Yes, I believe so.

2 70 Q. Now that you have an idea of the nature of the
 3 complaints, and the Panel have heard evidence around
 4 the extent and duration of some of the issues that have
 5 arisen, and given what you know about advocacy 12:16
 6 and reflecting patient experience and trying to fee
 7 back what that experience is, is there any system in
 8 place now that would allow those issues to bubble up
 9 from the Trust and find their way beyond its boundaries
 10 so that, if it were needed, there could be a service 12:16
 11 that would advocate for people on those types of
 12 issues? They all came from within, and if you look
 13 just objectively, there's an existence of a patient
 14 service such as yours specifically to address and
 15 reflect healthcare experience, there's a myriad of 12:17
 16 examples of a variety of types of experience that
 17 people have before the Inquiry; they seem to be more
 18 train tracks rather than a combined approach. Is there
 19 anything that could be done or changed or added to your
 20 service that might allow you to find out about these 12:17
 21 issues before they get to lookback stage?

22 A. I think what I would say is that there's a number of
 23 factors that could be looked at. One is, obviously,
 24 people were experiencing these issues. They came
 25 primarily to the attention, as you've said, through 12:17
 26 bubbling up through the Trusts. But I think if there
 27 was greater access to advocacy more generally, and if
 28 there was greater affirmation I suppose at
 29 a departmental level and right across the Trust in

1 terms of the value of advocacy as being a fundamental
2 part of governance and assurance so that people feel
3 supported to raise issues and that that can be fed back
4 into the system, that that would certainly assist.
5 I think what we would see as a positive step would, for 12:18
6 example, be the enactment of advocacy and legislation
7 in Northern Ireland, because it currently doesn't
8 exist. We've already touched on the recommendation
9 from IHRD in terms of a fully funded patient advocacy
10 service. What I think that would do is ensure greater 12:18
11 parity of access to the public to advocacy services to
12 enable them to have a support to raise issues in
13 a timely way whenever they occur. Because raising
14 issues is something that takes time, it can be quite an
15 arduous process. For me there is a fundamental social 12:19
16 justice dimension to advocacy support and to ensuring
17 that people are supported to raise issues.

18
19 I think the second thing that I would say is there is
20 a clear need for there to be a greater triangulation of 12:19
21 data from all different sources of intelligence.
22 Again, I think that this was also a recommendation,
23 from my recollection, from the Neurology Inquiry in
24 relation to the Department, RQIA, the Board, the Trust,
25 establishing a system that triangulated data from 12:19
26 a number of different sources to look at better early
27 identification of issues. There's also commentary in
28 relation to the early alert system in ensuring that
29 that is a clear process and focused on addressing

1 outcomes ultimately for patients.

2

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

15 71 Q. The Panel have heard evidence that some people did 12:20
 16 raise issues. I know what you say about people having
 17 the voice and the confidence and the opportunity to
 18 raise issues. There's also a question, and some
 19 witnesses have been asked around how do you create
 20 a culture of willingness to listen when people raise 12:20
 21 issues and also hear what they say and try to address
 22 what they're saying. There's that part of the culture
 23 as well.

24

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

28 A. I think everybody has a role in that. I think that
 29 there is fundamentally an issue that you pick up on in

1 terms of the culture of openness and transparency, and
 2 how the system and anyone in the system responds to
 3 patient experience, your willingness to hear that and
 4 to recognise it as something that is telling you about
 5 service improvement.

12:21

6 72 Q. What did PCC do?

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

12:21

12:22

19
 20 Like I say, I think culture is set from the top but in
 21 terms of openness and transparency, you need to have
 22 a sense check in terms of how people are experiencing
 23 the service and the response that they are getting from
 24 staff right across the system, and for people to be
 25 trained to respond appropriately. Again there are
 26 recommendations in terms of IHRD and the Neurology
 27 Inquiry that would significantly support that change in
 28 culture.

12:22

12:22

29 73 Q. If culture is set from the top, what's the quality of

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

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

13
 14 I think the Trusts do value PCC's role in providing
 15 that direct engagement with patients, but also our 12:23
 16 mediative role in assisting them with mediating with
 17 the public whenever things have gone wrong. Over the
 18 last number of months and years, PCC have been on
 19 a journey in engaging directly with the Trusts at an
 20 executive level to bring forward that value add. But 12:23
 21 again, we're a very small organisation; there's 35
 22 individuals in total in the organisation, so that
 23 ultimately will also be constrained by our resource.
 24 Certainly the willingness and appetite is there to do
 25 that. 12:24

26 74 Q. I just want to summarise some of the -- well, reflect
 27 some of the summary points you've made in your
 28 statement for the assistance of the Panel, given your
 29 position as chief executive and what your feedback is

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

5
 6 WIT-106679. The points you make are, number 1:

7
 8 "It is not always evident that HSC Trust staff have
 9 been trained on the appropriate complaints process and
 10 this potentially increases risk to Patient Safety and
 11 the collapse of the proper procedural requirements.

12 2. PCC considers that a greater knowledge of the PCC
 13 and the complaints process will reduce confusion and
 14 inconsistency in complaints.

15 3. Although a HSCNI standardised process is set out,
 16 it is not always apparent that the process has been
 17 followed".

18
 19 I think we touched on this earlier in your evidence.
 20 I presume the Trust are the ones responsible for
 21 training staff on the application of the complaints
 22 process. That's an internal role for them, as you've
 23 said you agree with the fact they are responsible for
 24 that. But the training you would consider, perhaps,
 25 hasn't always been reflective of what the process
 26 requires.

27 A. Uh-huh.

28 75 Q. Then at WIT-106680. We've touched on this before.
 29 This is your point.

1 "The PCC would welcome an amendment to the Departmental
2 direction and update to the guidance to require Trust
3 Boards to report on how they have met the specific
4 requirements of the Complaints Direction standards and
5 guidance".

12:26

6
7 The specific concentration on that point is about the
8 Boards would have to report on that rather than that
9 they do that. There's an expectation that the Board
10 would have an idea about the complaints and the way in
11 which they are carried out, but you're saying that if
12 they had to report, then there would be a greater,
13 perhaps, oversight and understanding of it, and they
14 would be more involved in it in that respect because
15 they would have to quality assure it. Is that a fair
16 summary of the point?

12:26

12:27

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

20 76 Q. Then at WIT-106688, for the Panel's note, at
21 paragraph 154 you say:

12:27

22
23 "A proactive measure would be to include within the
24 Department's guidance on governance a requirement for
25 the PCC to provide direct feedback, for example on an
26 annual basis, To Trust boards based on the experience
27 of service users gathered from the PCC's roles in SAIs
28 and complaints etcetera. Whilst this might be a useful
29 addition to Trust governance arrangements, the PCC does

12:27

1 not currently have the resources or budget to provide
 2 such a service. However, the ability for the PCC to
 3 meet this requirement could only be achieved through
 4 the provision of a dedicated resource to provide an
 5 independent review of the Trust quality reports".

12:28

6
 7 So again, that's asking for a more formalised way for
 8 you to feed your intelligence gathered from carrying
 9 out your statutory role back to the Department. Does
 10 that need to be on a footing within the guidance? Is
 11 that suggestion based on the fact that that's the way
 12 it would be heard if it was part of the guidance? Is
 13 it based on experience of it perhaps not being heard?

12:28

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

12:28

12:29

12:29

26 77 Q. Then at WIT-106688, the summary point is:

27
 28 "Training should be provided to Board members on good
 29 practice in monitoring complaints, SAI, and incidents

1 and listening to service users".

2

3 Again, is that a suggestion from you based on the
4 quality that you see emanating from the Trusts, or
5 simply because you think it might reflect better

12:29

6 practice to train Board members? Is it a bit of both?

7 A. I think it is probably both. I think that is in line
8 with recommendations that were made around IHRD. But
9 our experience also has been over the last number of

10 years, we have designed input directly to SAI training

12:30

11 that the Leadership Centre has put in place for chairs
12 and members of SAI panels. I think we have heard that

13 has been very helpful and that that has centred
14 specifically on family members going through the SAI

15 process and what they would wish to see. I believe

12:30

16 that was the first set of training that was done around
17 SAIs and we've inputted into that on a number of

18 occasions. That recommendation reflects the benefit we
19 would see in that also being given to Board members,

20 given their role in oversight at a Trust level around

12:30

21 SAIs and complaints.

22 78 Q. Then at WIT-106691, the point there is:

23

24 "More robust independent monitoring of Trust responses
25 to SAIs and complaints is required".

12:30

26

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

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

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

4 79 Q. At WIT-106708 you've summarised the points you wanted
 5 to make in your Section 21 and it reflects what you 12:31
 6 have written previously so I'll just read the summary
 7 table in. Point 1:

8
 9 "Recognising the critical nature and urgency for review
 10 and change" -- sorry, if I just go to this for the ease 12:31
 11 of the stenographer. WIT-106708. Just from that
 12 table, point 1:

13
 14 "Recognising the critical nature and urgency for review
 15 and change within the SAI process, the PCC has 12:32
 16 established a bespoke engagement platform with
 17 membership drawn from families with extensive
 18 experience of the SAI process.

19 2. From 2020 PCC has been developing an SAI advocacy
 20 support model for families. Thus far, PCC have been 12:32
 21 unable to secure the additional funding to enable
 22 a service to meet the demand and complexity of this
 23 work.

24 3. In contrast to the Complaints Direction, the PCC's
 25 role is not clearly defined or set out in the HSCB's 12:32
 26 SAI guidance".

27
 28 Just stopping there, you have a formalised role in the
 29 direction around complaints. Do you think the same

1 sort of involvement in the SAI, where you're
 2 sign-posted and there's an expectation of your
 3 involvement, would be value adding?
 4 A. I think it would be value adding and I think it is an
 5 IHRD recommendation in respect of the patient advocacy 12:33
 6 service. But I also think placing the SAI procedure on
 7 a statutory footing through direction similar to the
 8 complaints guidance would be of significant advantage.
 9 80 Q. Point 4:
 10
 11 "Trust reports need to use clear and unambiguous 12:33
 12 language and to be completely forthright in describing
 13 service failures.
 14 5. From serious incident to SAI review and
 15 implementation of recommendations and service change 12:33
 16 can be an extensive amount of time. In the interim
 17 Patient Safety can be at risk.
 18 6. Increased advocacy support should be independently
 19 commissioned to support families through the SAI
 20 process as stated in recommendation 37 of the 12:33
 21 Hyponatremia Inquiry report.
 22 7. Advocacy providers require to be commissioned in
 23 a manner that ensures that they can be true to the
 24 principles of independent advocacy".
 25
 26 Just on that last point, what is the rationale behind 12:34
 27 that?
 28 A. I think we set out the principles of independent
 29 advocacy in terms of psychological, structural and

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

15 12:35
16 There is precedence for this within the five services
17 the RQIA review picks up in terms of SPPG's
18 commissioning role. We would see value in that being
19 the case across the board.

20 81 Q. Just a couple of mop-up points just for the transcript. 12:35
21

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

26 A. No.

27 82 Q. You were never provided with a copy of that?

28 A. Sorry, say again.

29 83 Q. Were you ever provided with a copy of the determination

1 in MHPS?

2 A. No, not to my knowledge.

3 84 Q. You were never aware of any grievance lodged after
4 that?

5 A. No.

12:36

6 85 Q. You have no knowledge of any of that.

7

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

14 A. That would be the totality.

15 86 Q. I think I have highlighted everything in the statement 12:36
16 that might assist the Panel. Obviously all of your
17 statement is in as evidence but just at this point
18 there is an opportunity if there's anything you would
19 like to add or to say before the Panel ask you their
20 questions. 12:37

21 A. I think I've touched on most of it in terms of some of
22 the opportunities we see for changes, particularly
23 around the role of advocacy in Northern Ireland in
24 improving health services. As I say, I see that as
25 having a fundamental social justice dimension to it. 12:37
26

27 I think that extends to the role of engagement of the
28 public that we very much see as assets in their health
29 and social care. I think, further to that, we would

1 also welcome greater alignment of that engagement
 2 system and the resource, particularly with respect to
 3 the PHA and other bodies, to the role of PCC. I think
 4 that would deliver better for the public overall. But
 5 I'm content.

12:37

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

9 CHAIR: Thank you, Ms. McMahon, thank you,
 10 Ms. Monaghan.

12:38

11
 12 Mr. Hanbury, do you have some questions?

13
 14 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
 15 FOLLOWS:

12:38

16
 17 87 Q. MR. HANBURY: Thank you very much for your evidence. I
 18 just have a couple of things. Looking at the
 19 complaint, it is interesting to see your analysis, and
 20 I was interested to see the over 4,000 complaints, over
 21 9% came to you. Is another spin on that that roughly
 22 90% are being satisfactorily sorted out by the Trust?

12:38

23 A. I would say that another spin on that would be that 90%
 24 of them haven't come to us. I don't know whether you
 25 could extend that to being satisfactorily resolved
 26 because complainants come to PCC for support, and
 27 I don't think that you could say that the fact that
 28 people didn't come to us is a reflection on the
 29 satisfaction of the resolution of complaints. Does

12:38

1 that answer your question?

2 88 Q. Yes, I think so. Thank you. You made a comment about,
3 and we've also noticed how long the SAI reports took.
4 Did you collect data on the length of time complaints
5 took from a family making a complaint or a patient 12:39
6 making a complaint to resolution?

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

21 89 Q. Okay, thank you. Moving on to the SAIs, you said an
22 interesting thing, that some families engage with you
23 initially and then pull out or fade away. What's your
24 thoughts about that? Why does that happen?

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

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

16
 17 what I have seen is the tenacity required can often be
 18 too much for family members. They are dealing with
 19 a lot of other things going on as well and there's
 20 a repeat trauma associated with consistently revisiting 12:41
 21 that issue. So we have found that the process itself
 22 can be retraumatizing for people and, as a result, some
 23 family members have lost confidence in the process and
 24 have disengaged. That is generally with the process as
 25 opposed to than PCC support. 12:42

26 90 Q. That is more a reflection of how Trusts are engaging or
 27 not with the families, you're saying?

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

- 1 91 Q. Okay, thank you. One other thing on the SAIs, you
 2 helpfully did a table about the number of SAIs per year
 3 that came to you between 2019 and 2023. I was
 4 interested that it's roughly 50% of the ones coming in
 5 in the last year but only about 5% five years ago. Do 12:42
 6 you have an explanation for that? There might be many
 7 reasons for it.
- 8 A. In terms of the reason why we're seeing the uptake?
- 9 92 Q. Level 3 rather than Level 2 or below?
- 10 A. I suppose that perhaps reflects often PCC in terms of 12:42
 11 the cases that we are becoming engaged with; family
 12 members are coming to us where there is a significant
 13 level of complexity or sensitivity in relation to the
 14 event. So, Level 3 cases are often where people have
 15 suffered significant harm or have died, and that 12:43
 16 reflects the level of support that families are
 17 requiring within that and coming to PCC for that
 18 support. We're increasingly seeing that reflected in
 19 terms of the levels.
- 20 93 Q. That presumably will involve you in more input for a 12:43
 21 more complicated case is an indication?
- 22 A. Yes.
- 23 94 Q. Thank you. The last general thing is on SCRR's
 24 lookback. I was interested that you haven't heard much
 25 from people who have identified by the SCRR and the 12:43
 26 Lookback Review, which is surprising in a way. Do you
 27 think that means that the Trust has handled those
 28 patients better?
- 29 A. My understanding is that the Trust put in place Inspire

1 to support patients, so perhaps more my expectation is
 2 that they weren't referring to PCC for that support,
 3 they were referring to Inspire. I couldn't comment on
 4 the quality of the support that people were
 5 experiencing through that process.

12:44

6 95 Q. I guess, lastly, the Trust are thinking about going
 7 back to 2010 for the lookbacks and maybe some more SCRR
 8 process, and also involving private patients. Do you
 9 see much in the way of private patients, and do you
 10 think you might see an uptake on a sort of second phase
 11 of lookback?

12:44

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

12:44

12:45

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

1 to issues. There was a recommendation around,
 2 I believe, a database of clinicians practising
 3 privately to keep a record of their private patients
 4 and the diagnosis and treatments, and they had to
 5 provide that as part of lookback reviews. I think that 12:45
 6 would be very welcome if implemented, because I think
 7 increasingly the way treatment is going is that people
 8 are increasingly turning to the private sector, and
 9 I think there is a significant risk with respect to
 10 patient safety if there isn't consideration given to 12:45
 11 how that intelligence is sought, understood and
 12 triangulated with HSC and the rest of the intelligence.
 13 Also from the patient perspective and where the PCC is
 14 coming from, how the public are adequately supported
 15 when issues in the private sector go wrong, and where 12:46
 16 they turn to for support with respect to that and what
 17 the procedures and guidance are governing it.
 18 MR. HANBURY: Thank you very much. I have no further
 19 questions.
 20 CHAIR: Thank you, Mr. Hanbury. Dr. Swart? 12:46
 21 96 Q. DR. SWART: The complaints process, first of all. You
 22 had a sort of statement that you didn't think the Trust
 23 staff were always adequately trained in the procedures.
 24 What did you see as the biggest deficit in their
 25 understanding? 12:46
 26 A. I think our comment is based on the experience we see
 27 from members of the public coming to us for support and
 28 their experience of the complaints process. I think
 29 timeliness of response, understanding of the

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

13 97 Q. So you have the information from the patients and
 14 families, not from the Trust staff, just to get that
 15 clear? 12:47

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

25 98 Q. As far as I can see, most of the oversight of 12:48
 26 complaints really does focus on the time scales more
 27 than anything else, not particularly customer
 28 satisfaction, shall I say, or outcome?

29 A. Yes.

- 1 99 Q. what thought have you put into actually working with
 2 complaints departments directly? My personal
 3 experience is if you contact families right at the
 4 beginning and ask them what they really want from the
 5 complaint and agree all of that, you get a much better 12:48
 6 result. But I don't see that happening here in
 7 Southern Health Care Trust, and anyway I don't know
 8 about that. But is that not a role for the PCC in
 9 terms of actually working -- a training role with
 10 complaints departments. I know you talked about boards 12:48
 11 but the people who really make this happen are the
 12 senior people in the complaints team and the governance
 13 team. If they can set that process to mandate talking
 14 to people early on, it makes a big difference, in my
 15 view. Have you had those discussions at all? 12:49
- 16 A. Yes, and I would absolutely agree with your point.
 17 I suppose that is why, in 2021, the PCC convened
 18 a round table of all of the governance leads and
 19 complaints staff at a senior level within each of the
 20 Trusts to set out the experience we were hearing, but 12:49
 21 also to set out the change practice models the PCC were
 22 engaging in, and made an offer after that for short,
 23 medium and long-term outcomes we would like to see, and
 24 sought quarterly governance meetings with each of the
 25 Trusts to directly have that relationship. 12:49
- 26 100 Q. I don't think that's happening, is it?
- 27 A. The uptake on the part of the Trusts has been better in
 28 some areas than others and there is only one that is
 29 consistently engaging with us on that.

- 1 101 Q. Because really you don't want duplication, you don't
 2 want the PCC to be doing all of this. There's a role
 3 for the Trust, isn't there, and it is being really
 4 clear what they should do themselves always as a matter
 5 of course and in what circumstances your advocacy is 12:49
 6 required, accepting it will be required; in a number of
 7 complex cases people have ongoing issues and so on. Do
 8 you think that's clear to everyone, that sort of
 9 balance of the relative responsibilities and the
 10 principles of family engagement? 12:50
- 11 A. No, and I think more work needs to be done on that for
 12 sure. I think again it speaks to the piece about
 13 openness, transparency and culture and setting the
 14 expectation in terms of how you manage complaints from
 15 the top but consistently throughout. Also empowering 12:50
 16 the staff to feel comfortable to pick up the phone and
 17 have that conversation at an earlier stage as opposed
 18 to administratively following a process that is set in
 19 place.
 20 12:50
- 21 We have tried to engage around those conversations but
 22 I think more needs to be done internally to the Trusts
 23 to recognise a switch in approach to how they respond
 24 to complaints and patient feedback.
- 25 102 Q. I think we have seen the same thing with serious 12:50
 26 incidents. I think certainly there was very good
 27 family involvement at Southern Health Care Trust for
 28 one group of serious incidents but I think that was a
 29 relatively new concept at that time; I'm sure it's

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

7
 8 How do you see that alignment working in the future
 9 because it seems to me we could have risk of
 10 duplication, we could have risk of differing methods of 12:51
 11 oversight. How do you see that, and do you think the
 12 right conversations are happening in that regard?

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

27 103 Q. Say if you take SAI review that's going on at the
 28 moment, is your voice being heard sufficiently loudly?
 29 Is there more that needs to be done? How proactive are

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

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

22 104 Q. If you look at lookback reviews specifically, in this
 23 particular inquiry most of these families would not
 24 have been aware that there was anything amiss. We saw
 25 it even in a big group of serious incidents that the 12:53
 26 families, when they were brought into the meeting, were
 27 a bit shocked about various things. The experience of
 28 families in lookback review is really rather different
 29 from a normal complaint or a normal SAI, I think. Has

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

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

28
 29

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

15 105 Q. I think when you look at it from the outside, have you 12:56
 16 done any specific work as a council in terms of the
 17 impact of this on patients' lives, and the distress
 18 caused, quite apart from actual harm, the actual
 19 patient experience of being on these waiting lists?

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

27 106 Q. But the waiting times are much longer now?

28 A. Yes.

29 107 Q. I would imagine there's a huge amount of information

- 1 out there about what has actually happened?
- 2 A. Yes. We haven't done any work to date on that.
- 3 I mean, I think one of the challenges of PCC's
- 4 statutory functions is it is looking at research into
- 5 the best methods of engaging people. We have tried to 12:57
- 6 look at adapting, you know, where we engage people on
- 7 specific pieces of work to take their lived experience.
- 8 That is specifically constrained by the experience
- 9 we have to look across the breadth of HSC -- health and
- 10 social care services across the board. That's 12:57
- 11 a challenge for us --
- 12 108 Q. It goes along with the patient being on a list, often
- 13 not knowing what's happening, often not had a copy of
- 14 their initial letter saying what was going to happen.
- 15 There's a big issue there around failure to capture 12:58
- 16 that patient voice. I would have thought the Patient
- 17 Client Council would be a useful place to bring that
- 18 information together.
- 19 A. Well, the interesting thing about is that the patient
- 20 client experience programmes of work don't actually sit 12:58
- 21 within the PCC, they sit within the PHA, and I think
- 22 there is significant resource there in Care Opinion and
- 23 10,000 voices that do really good work, but the
- 24 challenge at the minute is that they are not aligned to
- 25 the functions of the PCC currently. 12:58
- 26 109 Q. Should they be?
- 27 A. I think greater alignment would certainly be -- would
- 28 make sense to me.
- 29 110 Q. Thank you.

- 1 111 Q. CHAIR: I think most of the questions I was going to
2 ask you have been asked. One thing, you talked about
3 the lack of resource, and obviously that is an issue
4 across the piste in the health setting at the moment.
5 Assuming that you have to work within the resource that 12:59
6 you have at the minute, what one change -- you've
7 talked about the recommendations of the Neurology
8 Inquiry and the recommendations of the Hyponatraemia
9 Inquiry. What one recommendation do you feel would
10 make a difference to patients in Northern Ireland that 12:59
11 this Inquiry could make that is different to those that
12 have already been made? Is there one?
- 13 A. I mean, I suppose I've touched on the statutory footing
14 of advocacy in Northern Ireland in general, and that
15 isn't touched upon in other recommendations from the 12:59
16 inquiries. I mean, IHRD talks about having a fully
17 funded patient advocacy service, but until you have
18 a statutory right to advocacy, as there is in Scotland
19 and in other places, in Northern Ireland I think that
20 there will always be a challenge. Therefore, what 13:00
21 I would see as a fundamental change could be both that
22 legislative standing for advocacy. But changes in the
23 interim to guidance and direction that demonstrated an
24 affirmative commitment from the Department and the
25 health Trusts to the role advocacy plays in being 13:00
26 a fundamental part of governance and assurance in terms
27 of the quality of services that patients get, and
28 supporting patients to engage around that, I think
29 would make a difference, not just within the health

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

6 CHAIR: Thank you very much.

7
8 I think that's it, Ms. McMahon, unless there are any
9 other questions?

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

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

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

16
17 THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 22ND
18 FEBRUARY 2024

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