PCC
PATIENT & CLIENT COUNCIL

Serious Adverse Incidents Procedure

An Overview Report

August 2024

Your Voice,
Our Journey

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Introduction

1. The purpose of this report is to provide an overview of the Patient and Client Council's (PCC) assessment of the current state of the Serious Adverse Incident (SAI) Review system in Northern Ireland. The information contained in this report is based on PCC's engagement with those affected by SAIs, and our broader organisational experience, including that developed in providing independent advocacy support in SAIs. It reflects evidence PCC has provided in recent Inquiries.

2. The PCC supports and provides services to the public of Northern Ireland. Amongst those we provide support and services to are those who are patients, carers, advocates, communities, service users, family members, victims and those affected by serious adverse incidents. These terms are not mutually exclusive and more than one of these terms can apply in individual cases. How we describe those we support and provide services to has the potential to unintentionally cause upset, which is why, in providing support and services to individuals or groups of individuals, the PCC is sensitive towards, and cognisant of the terminology which those individuals, or groups of individuals, prefer in describing themselves. In the context of this report we use the generic term 'service users and families' to describe those individuals and groups of individuals who we support through, or who have been affected by, the Serious Adverse Incident process. The current SAI guidance refers to "Service Users/Family/Carers", so when referring to the guidance in this paper we use that terminology, acknowledging, however, that this terminology needs to be reviewed.

3. The stated purpose of the SAI Review system[1] is to *"ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation."* There is a general perception that the SAI review system is in

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[1] Health and Social Care Board - Procedure for the Reporting and Follow up of Serious Adverse Incidents – November 2016.

place only to review incidents involving harm or potential harm to patients and/or other users of Health and Social Care (HSC) services. However, the system can also be applied to review other types of incident including for example IT system failures or failures in the HSC estate. The PCC's role means that the PCC is primarily focussed on those SAIs which do involve harm or potential harm to service users, carers and families.

4. The SAI Review system was first established in Northern Ireland in 2004 predating the creation of the PCC (April 2009) by five years. The requirements on involving service users/family/carers are set out in section 5.4 of the guidance and an accompanying addendum[2].

5. The main body of the current, November 2016, SAI Review guidance envisages a very limited role for the PCC in the process which is described in sections 1.5 and 1.8 of the guidance. For patients and service users with learning disabilities the PCC is described as one of the options for providing advocacy support (1.5). When patients or families are dissatisfied with the information provided to them as part of the SAI review the PCC is listed as an option to help identify the issues and seek a mutually agreeable solution. However, addendum 1 to the guidance included additional information for service users/carers/families that "*The Patient and Client Council offers independent, confidential advice and support to people who have a concern about a HSC service. This may include help with writing letter, making a telephone call or supporting you at meetings, or if you are unhappy with recommendations/outcomes of the review."*

6. Between 2004 and 2016 the SAI review system was revised on a number of occasions. The current system was scrutinised by the Inquiry into Hyponatraemia Related Deaths (IHRD) which published its reports in January 2019. The final report included multiple specific recommendations on changes to the SAI Review systems as well as recommendations on Candour/Openness, Death Certification, Bereavement, Litigation, Inquests and Post Mortems, which are also directly relevant to the SAI review system (A full list of recommendations

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[2] addendum 1 – A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.

from relevant reports concerning SAIs can be found at **Appendix 3**). The PCC position is that the IHRD report and its recommendations should lead to a sea-change in how the SAI review system operates particularly from the perspective of service users and families.

7. Implementation of these recommendations was interrupted by the COVID pandemic, and the Department of Health can provide its latest update on progress with regards implementation. It is a fact that five years after the publication of the IHRD report the extant guidance for the operation of the SAI Review system is the November 2016 guidance. The Department has established a group to review the SAI process, the PCC has separately established an engagement platform involving representatives of several families with direct experience of the SAI review process to feed their experiences into the review group. The PCC's own experience is that the service users and families, which the PCC is currently supporting and has recently supported through the SAI Review process, continue to suffer very negative experiences which could be avoided if the IHRD recommendations were implemented in full.

Role of the PCC

8. The PCC is a statutory corporate body established in 2009 to ***provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues within Northern Ireland***[3] through:

    - Representing the interests of the public;
    - Promoting the involvement of the public;
    - Assisting people making, or intending to make, a complaint;
    - Promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of services; and
    - Undertaking research into the best methods and practices for consulting and engaging the public[4]

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[3] DHSSPS Framework Document – September 2011, Department of Health

[4] Health and Social Care (Reform) Act (Northern Ireland) 2009

9. Health and Social Care (HSC) bodies have a duty to co-operate with the PCC in the exercise of its functions (**Appendix 1**). The PCC, along with the RQIA, has a role in providing independent assurance to the Department of Health[5]. The PCC's relationship with other HSC bodies is characterised, on the one hand, by its independence from these bodies in representing the interests and promoting the involvement of the public and, on the other hand, the need to engage with these same bodies in a constructive manner to ensure that it is able to efficiently and effectively discharge its functions on behalf of the public.

10. The PCC is a small Arm's-Length Body with an annual budget of £2.1m. £1.8m is recurrent funds, £0.3m is non-recurrent funds relating to inquiry related work. PCC employs 34 members of staff, excluding Council members. With a budget of £1.8m – equivalent to less than £1 for each member of the public in Northern Ireland – it is a challenge to fulfil the statutory functions outlined above, across engagement and support, across the breadth of health and social care services. As such the PCC has to prioritise within this resource where it focuses its efforts to best support the population of Northern Ireland; combining delivering a service to individuals with trying to make a strategic impact; informing Department policy, as well as Department and HSC decisions on HSC structures and decisions on how, when and where services are delivered.

11. To be effective, it is essential that the PCC not only speaks and acts with authority as an independent voice for service users, carers, and families but that it is perceived and trusted by the public to be independent from those who provide services and those who commission services. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the services provided by HSC Trusts.

12. That independence also underpins the assurance required by the Minister and the Department of Health. The PCC's approach today is that it will contribute to and seek to influence policy and service developments by the Department and HSC bodies. The PCC will do so by attending and contributing to groups and

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[5] DHSSPS Framework Document – September 2011, Department of Health

meetings established to take forward such work; by engaging with service users, carers, families and members of the general public to seek their views; and by submitting evidence. The ***PCC does not join such groups as a member***, where membership includes having a decision-making role or function in relation to the planning, commissioning and delivery of health and social care services and is not party to decisions made by such groups reserving the right to highlight any concerns regarding decisions made. The PCC believes that it has to remain separate from and independent of the HSC system if it is to then represent the interests of service users and families etc. who may be adversely affected by services and policies developed by such Departmental or HSC groups or bodies.

13. The PCC has developed a ***Statement of Strategic Intent 2022-2025,*** setting out the strategic direction of the organisation over the next three years. The Statement of Strategic Intent (SSI) summarises the vision, values and purpose of the PCC, along with an improved way of working. Looking ahead, we are ambitious to continue to develop this **different way of working**, providing a more comprehensive range of engagement and advocacy opportunities to fulfil our statutory functions, meeting the needs of patients, service users, and families, supporting improvement in HSC service delivery and transformation by bringing the voices of people into crucial discussions. Further detail of the PCC Practice Model is set out in **Appendix 2**.

14. The SSI describes what PCC want to see and achieve for people in the future, our purpose and role in achieving that, our values and ways of working and the difference we want to make. In the long term we hope to see two big differences:

Strategic Objective One: Through our engagement and impact work, *the public voice is influential regionally and locally in the design, planning, commissioning and delivery of health and social care.*
Strategic Objective Two: Through our work in advocacy, engagement and impact, *the health and social care system responds regularly to people with openness, honesty and compassion to address difficulties or failures in standards of care.*

When things go wrong in the HSC

15. The PCC provides an advocacy and support service to members of the public who wish to make a ***complaint about health and social care services*** as set out in the legislation, ‘Functions of the Patient and Client Council’:

> ***17***—*(1) The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland —*
> *(c)providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;*

16. It is acknowledged within the November 2016 SAI Review guidance that on occasions a SAI Review can be initiated following on from a complaint made by a service user, carer or family. In some respects, these instances represent a failure in the adverse incident reporting system and the operation of the SAI process. Ideally adverse incidents and Serious Adverse Incidents will be proactively reported by HSC staff and the SAI review process will be initiated without the need for the process to be ‘kick-started’ by a HSC complaint being made.

17. In the November 2016 guidance a “Serious Adverse Incident (SAI)” is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage. ***The SAI process*** is governed by the guidance issued by the HSCB/SPPG. The process is not underpinned by legislation or a Department Direction. The November 2016 guidance updated the Regional SAI procedure to guide SAI review panels in relation to providing patients and families with an opportunity to contribute to the SAI review. The guidance outlined that:

    - The level of involvement depended on the nature of the SAI and the patient and family’s willingness to be involved.
    - Teams involved in the review of SAIs should ensure sensitivity to the needs of the patient and family/carer involved.

- Teams should agree on appropriate communication arrangements with the patient and family/carer involved.

18. The complaints system is focussed on ***seeking a resolution to complaints*** raised by individuals and their families. The SAI review process is different in that it is a system mechanism designed ***to identify learning*** when something has gone wrong. Whilst some SAI reviews arise out of a complaint made by a patient, service user, carer or their family, the vast majority of SAIs should be initiated in response to reporting by HSC staff without a HSC complaint having being made, that is if the system is working as intended.

19. The PCC are named within the ***HSCNI Complaints Procedure*** under which all of the HSC Trusts operate, and often within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support. Under the complaints procedure, HSC Trusts are expected to advise complainants on the types of help available to them including through the Patient and Client Council (PCC). In some cases, the individual will have been referred to the PCC by a member of HSC staff, a third sector organisation or by word of mouth from someone who has experienced PCC's services.

20. PCC would highlight that although the SAI guidance issued by the HSCB (now SPPG) refers to the PCC, the PCC role is not specified in the same way it is in the Complaints Direction issued by the Department of Health. Thus, service users and families who engage with the SAI process do not report a level of awareness of the PCC or having been given contact information about the PCC.

21. We have learnt through our engagement activity that the PCC needs to increase the general public's awareness of the PCC and this is something we have been actively progressing. Contact with an advocacy support service should start at the point when things go wrong. Those closest to the person should be encouraged to promote the PCC and/or other advocacy services enabling a more pro-active approach, which hopefully will reduce confusion and inconsistency in supporting families at a time of immense distress.

PCC Advocacy Service – SAIs

22. It is essential to understand the starting point for the PCC when engaging with those who request advocacy support in relation to their SAI. The majority of the public who seek support from the PCC have experienced significant harm including, potentially, the loss of a loved one resulting from the service received from statutory providers. Those to whom we provide support have described their negative and distressing engagement experience with health and social care services when trying to find a resolution and understand what went wrong. Many have stated that the SAI process exacerbated the distress, causing significant further harm with the result of a loss of confidence and trust in health and social care. Ultimately this comes down to ***'how'*** service users and families were treated as they attempted to find out what went wrong.

23. It is our experience that the typical motivation of service users and families is one of ensuring learning and protecting / safeguarding others from future poor practice. Whilst this may not be true for all service users and families engaged in the SAI process, it is for the majority of those who have availed of the PCC advocacy service.

24. To this end many service users and families see the starting point for any SAI Review as the need ***to establish the facts of what happened***. The extent to which facts are established in a way which is comprehensive, unambiguous and accessible to service users can vary significantly and may be affected by the fact that the SAI review process is not intended to assign blame to individuals. Service users and families struggle with the idea that professional failings by individuals are not addressed within the SAI Review process. HSC staff participating in SAI Reviews are often 'supported' by their union/professional representative body and there needs to be clarity about how this aligns with individual's professional responsibilities for candour and the specific focus on learning within the SAI process. The tension between identifying system learning and addressing the role of individuals in a SAI, which may require individual staff to receive training or in some instances referral to a professional body needs to be explicitly resolved. Whilst the SAI process itself may not be the vehicle for

addressing individual failings, from the perspective of the public, the guidance does need to explain how those issues should be addressed and there needs to be clarity about what those affected by a SAI are entitled to know about what action has been taken in respect of individuals.

25. It is acknowledged within the Department led review of SAIs that issues may arise during the course of a SAI review which may need to be dealt with outside of the SAI process. This includes, for example, where an event leads to concerns about an individual’s conduct or performance or there is reason to think criminal activity may have taken place. The PCC reflection on this, based on the experience of PCC staff and those whom PCC staff have supported through the SAI process, is that a SAI review is not necessarily appropriate where the circumstances underpinning an incident involves failures to follow existing standards and guidance by individuals or failures by organisations to implement learning from previous SAI reviews, Public Inquiries etc.

26. In the case of individual staff, the way forward would often require additional or refresher training, the development of a new process or the development of new guidance for staff. It could also include, in some cases, instigating a disciplinary process and/or where the criteria are met, referral to a professional regulatory body. Applying the same logic, in instances where a SAI arises from a failure to implement recommendations from previous SAIs, Public Inquiries etc. these issues should be considered in the context of the organisation’s internal governance structures and addressed as part of accountability arrangements.

27. There is a need to describe within the SAI Review process guidance, how and when and by whom these other processes would be instigated and the thresholds underpinning any such decisions. Any such guidance needs to reflect the potentially competing needs of patients, families and carers for openness and transparency whilst also protecting the rights of individual staff. This is not an easy issue to resolve.

28. The following diagram describes the journey which many service users and family members may/do experience during the SAI process.

29. The IHRD report and its recommendations recognised the need for service users, and families to have access to independent advocacy support. PCC's experience is that the way the SAI Review process is currently operating and is currently resourced, means that there is often a need to provide advocacy support to families engaged in SAIs for up to five years. There is often a complexity to the support required, during and post the actual SAI review, with a single SAI potentially requiring support to multiple family members, not all of whom may have the same perspectives on the actual incident or on the SAI Review itself.

30. In cases where a SAI has been initiated in response to serious incidents which may have caused death or serious harm to a service user or people affected by a serious adverse incident[6], the timeframes taken to complete this SAI can be particularly extended. Concerns have been raised in relation to this being an indication of the weakness of the current system. Families are acutely aware that learning needs to be disseminated quickly and effectively to safeguard current and future patients. Some of these SAIs where the PCC are supporting service users and families were originally complaints which have been escalated to be

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[6] This includes victims and their families.

SAIs. Others are cases which were notified and reviewed as SAIs without a complaint being made or in place of a complaint.

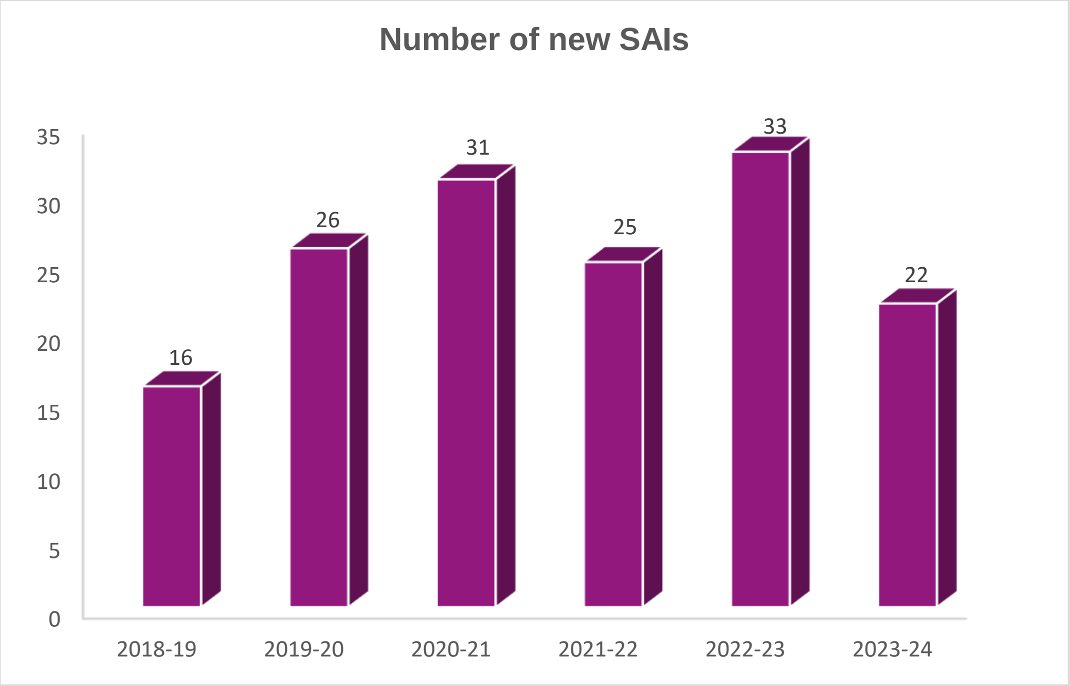
31. The demand for independent advocacy support from the PCC in Serious Adverse Incidents has increased year on year. Although the PCC has a broad range of functions in relation to HSC, competing functions need to be balanced against an increasingly constrained budget. It is also a fact that in some instances service users and families require some form of specialised support where the expertise resides, for example, in some voluntary sector organisations. The PCC does its best to passport those requiring this specialist support to these organisations when this is required. Some of this is achieved through the PCC's positive passporting initiative. It would, however, be better if PCC was in a position to commission this support so that the service user, carer or family receive a seamless and completely joined up service.

32. Thus far PCC have been ***unable to secure the additional funding*** to enable a service to meet the demand and complexity of advocacy work in SAIs or to meet the recommendations of the Inquiry into Hyponatraemia-related deaths (IHRD). Within its existing resources PCC has effectively prioritised resources to support a number of families through the SAI process. This is unsatisfactory in relation to the PCC's statutory role which also encompasses involvement and engagement functions and has been highlighted to the Department through its sponsorship arrangements.

Increasing demand for Support in the SAI Process

33. The demand for independent advocacy support from the PCC in Serious Adverse Incidents has grown and remained strong in 2023-24. The nature of support to families navigating the SAI process is such that one case can involve support to multiple members of a family. The 22 new SAIs in 2023-24, represented 45 individuals seeking support from the PCC. However, these figures account for SAI cases which were opened as a new SAI between 1st April 2023 and 31st March 2024. As of 31st March 2024, the PCC had 47 open SAI cases that PCC were supporting.

Figure 1: Number of new SAI cases PCC supported between 2018-19 & 2022-23



Service Development and Learning

34. From 2019, the PCC has been on a significant journey of change and development in its advocacy service supporting service users and families engaged in SAIs. This is a continual ongoing process as PCC gather, understand and integrate the learning from our engagement with families, practice, reviews, inquiries and research. Central to this change has been the development of advocacy support. PCC know that effective advocacy clearly plays an important role in addressing imbalances in power, and in helping to support service users, their families and carers. We have learnt that advocacy support can be provided through a range of models, that is independent advocacy, peer advocacy, self-advocacy and family advocates.

35. From 2018 the PCC has been actively involved in the Inquiry into Hyponatraemia-Related deaths (IHRD) and the related 96 recommendations from Justice O'Hara's inquiry. The Hyponatraemia Implementation Programme comprised nine workstreams. The *Serious Adverse Incident Workstream* (Workstream 5) was tasked with taking forward ten recommendations. The *User*

Experience and Advocacy Workstream (Workstream 7) considered a Recommendation that "*A fully funded Patient Advocacy Service should be established, independent of individual Trusts to assist families in the process. It should be allowed funded access to independent expert advice in complex cases."* The workstream considered how advocacy might be provided across all health and social care services. There are other IHRD recommendations on Candour/Openness, Death Certification, Bereavement, Litigation, Inquests and Post Mortems which are also directly relevant to the SAI review system.

36. The Patient and Client Council (PCC) facilitated and supported families to inform the IHRD workstreams through describing their experience, aspirations and vision for change. Reports were submitted to the Chair and members of IHRD Workstreams to inform their work going forward particularly in relation to:
    - The Statement of Patient and Family Rights.
    - The development of an advocacy service for families

37. The PCC Report, "*A Thematic Review of Complaints Support Services Cases 2014-2018*", was published in October 2019. The data sourced from the PCC Complaints Service database, presented:

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

38. A workshop facilitated by PCC in late 2019 engaged with service users and families with experience of the SAI Review Process and of the PCC in its role of providing support to such service users and families. The following findings were presented to the Chair and members of Workstream 5:

- Families should be informed of their rights proactively by the responsible HSC Trust

- Families should be signposted to an independent source of support – whether a link person, advocate or independent review panel

An Advocacy Service Which is Fit for Purpose

39. The PCC recognises that an advocacy service which is fit for purpose in the Health and Social Care system requires that all those who may be affected by the operation of the service need to have ownership of the service and to recognize the contribution which advocacy can make to better quality and safer services for all.

40. In the context of Serious Adverse Incidents, the PCC believes that the ***Advocacy Service*** which is consistent with the recommendations of **the Hyponatraemia Inquiry Report,** published in January 2018**,** should first and foremost, attend to the needs of families engaged in Serious Adverse Incident reviews through ensuring:

    - Recognition, understanding and response to the emotional needs of families (for example when people are bereaved)
    - Accompanying families through the review and being by their side throughout (including, for example, reading through SAI reports with families when they receive them)
    - Provide expert advice and information about the Serious Adverse Incident review process to enable families to understand what is going on and to enable families to make decisions and to ask questions

41. The Advocacy Service should be empowered to ***safeguard families' interests*** through:

    - Ensuring on behalf of the families that the review process is conducted in accordance with written standards and procedures including that the rights of families are championed and upheld;

- Having sufficient authority to hold HSC Trusts to account and to ensure families are kept informed and that their concerns / questions are answered; and
- Having sufficient expertise and authority to challenge HSC Trusts where necessary.

42. Independence is an important factor – both in terms of advocacy provision and also in terms of the independence of panels undertaking reviews.

43. The successful promotion of engagement with advocacy services to service users, families and those affected by patient safety incidents[7], is to a ***large degree determined by the DOH and HSC system's commitment to an investment in advocacy***. Listening and hearing people's experience is the first line of defence when safeguarding vulnerable people. Access to advocacy plays a fundamental role in governance and assurance. Trusts as the first point of contact when things go wrong, and a complaint or SAI has been enacted, need to inform and ***direct the public to the support available from PCC.***

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

45. The PCC have developed an advocacy model that is provided across a continuum (**Appendix 2 – PCC Practice Model**). This ranges from; advice and information over the phone or via email, to signposting and 'supportive passporting' to appropriate services to meet immediate need, to individual and group advocacy casework, through to advocacy in formal processes including formal complaints, SAIs and Inquiries.

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[7] This includes victims and their families.

46. The PCC has recently responded to a Department of Health initial consultation on the outcome of an Independent Review of Children's Social Care Services[8]. The final review report includes two recommendations for the development of Independent Advocacy Services. The PCC response[9] included the following which we believe should underpin the provision of advocacy services within the Health and Social Care system by the PCC or any other provider including in relation to both SAI reviews and Inquiries:

- Advocacy services should be commissioned as regional services;
- Advocacy services should be commissioned independently of HSC Trusts; Commissioning and delivery of advocacy services should be independent of the HSC Trusts enabling advocacy providers to assert structural, financial and psychological independence, which is at the core of the effectiveness and efficacy of advocacy. This in particular is of relevance to the third sector providers. The Scottish Independent Advocacy Alliance (SIAA) /www.siaa.org.uk funded by the Scottish government, aims to ensure that independent advocacy is available to anyone in Scotland. (See **Appendix 4**) A similar body does not exist in NI. The principles and standards adopted by the SIAA ensure that advocacy is of the highest possible standard. The SIAA define '***Independent advocacy'*** as being structurally, financially and psychologically separate from service providers and other services, which means it is a separate organisation in its own right, has its own funding and is true to the principles of independent advocacy
- Advocacy services should be commissioned on the basis of agreed standards which include addressing the role of these advocacy services in dealing with complaints and concerns raised by clients, responding to safeguarding issues and systems of regulation of services and the workforce.

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[8] Jones, R. (2023) *'The Report of the Independent Review of Northern Ireland's Children's Social Care Services'* The NI Review of Children's Social Care Services.pdf (cscsreviewni.net)

[9] PCC (2023) *'PCC Consultation Response – Department of Heath Children's Social Care Services CSCS Review'* PCC Consultation Response - DoH CSCS Review

- The service specification with providers commissioned to provide advocacy services should specify how these service providers relate to the Patient and Client Council in the discharge of its statutory roles (where the PCC is not the provider or commissioner of the service).

- The same specification should specify a minimum data set to be collected by the service provider both for the purposes of monitoring the providers performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts.

- Access to these advocacy services should be client led and not solely dependent on a referral by HSC Trust.

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

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

    - understanding the role of advocacy in safeguarding vulnerable people, the different advocacy models, be that independent advocacy, peer advocacy self-advocacy and family advocates;

- understand how advocacy can be integrated into the different decision-making fora in the patient's journey whilst in their care, particularly when things go wrong;
- Voice and Choice. Service Users and families require clear information about how to make a complaint, who is there to support them, including an introduction to the PCC. Where there are a range of advocacy services the public must be given space and time to choose how and which service they wish to avail of;
- Trust staff taking the lead in complaints / SAIs and advocacy providers require an understanding of each other's role, the legislation, policy and guidance thus ensuring that service users and families are fully informed and guided through the complaints / SAI process.

49. Training should also be provided to Trust Board members on good practice in monitoring complaints, SAIs and incidents and listening to service users and families.

50. The PCC also believes that the development of advocacy services should be supported and nurtured through a regional network that would enhance communication, training and development.

51. It is important that there is openness and transparency within the HSC as to how the HSC responds to complaints. The PCC would welcome an amendment to the Departmental Direction and update to the Department's Guidance which underpins the complaints system to require Trust Boards to report on how they have met the specific requirements in the Complaints Direction, Standards and Guidance. The PCC believes that there would be considerable value in the Department issuing an equivalent (to the complaints Direction) Direction to underpin the SAI system and requiring, as part of the Direction, that Trusts also report on how they have met the requirements of the SAI guidance and the Direction itself.

Connecting into the system

52. Over the last three years the PCC has been continually engaging with the Department of Health, HSCB / SPPG and the PHA to share knowledge and learning and to promote advocacy as an essential service within a modern Health and Social Care system. This engagement has included:

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

SAI Redesign Development Group

53. The Department has established a Redesign Group to review the current SAI system. The group includes three service users recruited by the Department. The PCC does attend meetings of the Redesign Group and contributes evidence and advice but is not a member where membership is understood as having a decision-making role, as set out in paragraph 12.

54. The PCC has, separate from the Department structure, designed and established a SAI Engagement Platform with a small number of families who have had extensive experience of the SAI processes. An Engagement Platform is a space to bring together a group of people, with a common theme or interest and lived experience, to work together and make change in health

and social care. The SAI Engagement Platform was set up to provide a lived experience perspective on the Department of Health's SAI Redesign Programme. The Platform has met to discuss their individual and collective experiences of the current SAI process and consider the papers produced to date by the Redesign Development Group (RDG), which were shared with them, in confidence, by the PCC and with the agreement of the Department of Health.

55. The members of the engagement platform wrote to the DoH Redesign Development Group (RDG) in February 2024, setting out their initial reflections and baseline expectations of any new policy, procedure and practices relating to serious safety incidents. They stated that when harm or death occurs through the actions or omissions on the part of the HSC Service, service users, families, victims, the general public and HSC staff should expect, as a minimum, a policy, procedure and practice that:

- Delivers a robust investigation, to a consistent standard, which establishes what happened;
- Is independent, and is seen to be independent, of the Trust/s involved in the incident;
- Is based on best practice in the UK, Ireland and Internationally;
- Respects, involves and values patients, families and victims throughout the entire process, from establishing the Terms of Reference, to verifying that any learnings have been implemented;
- Has appropriate and robust governance and oversight to ensure independence and quality;
- Makes recommendations to, where possible, prevent the incident happening again;
- Ensures recommendations are acted upon locally and regionally, and provides independent verification that new processes/procedures have been implemented, are in use and understood by staff on the ground, who have received appropriate training;

- Based on the establishment of what happened, is capable of holding people to account for their actions or omissions, where appropriate. This should include referrals to external organisations such as regulators of healthcare professionals;
- Recognises there is a large cohort of people who are not service users who die or are harmed by actions or omissions of the HSC Service. That they are victims, their experiences of a SAI are very different to that of service users and they must be included in all policies, procedures and learning, related to SAIs;
- Recognises inquests as an integral part of the SAI process;
- Ensures cross organisational co-operation and learning, where appropriate, for example between the HSC Trust and the PSNI, NIPSO, Professional Regulators and the RQIA; and
- Is aligned to and meets the objectives of the Protect Life 2 Strategy.

56. The PCC's experience, and this is reflected in what the PCC hears from service users and families who have been involved in SAIs, is that the fundamental starting point for any new policy must be the objective of delivering a robust investigation, to a consistent standard, which establishes what happened. There can be no genuine learning, meaningful accountability or referral, if the policy, procedure and practices do not robustly and consistently establish what happened in a given safety incident. Any new policy must be accepted and supported by services users and families.

57. The SAI Engagement Platform, in valuing the HSC system in Northern Ireland, want it to be trusted, responsive to the public, capable of learning, genuinely fulfilling the duty of candour, being open and accountable. They provided a series of personal vignettes, which reflected some of their experiences of the current SAI process, and which should illustrate some of its current failings, as well as providing an evidence base for the recommendations they make for any new policy/procedure or process to address patient safety events.

58. There is an opportunity now through the implementation of recommendations from the Hyponatraemia Inquiry and the Redesign Programme to develop a robust SAI/service user safety event system which both supports the identification and application of learning and which can command the buy-in of those who have been adversely impacted by a SAI.

List of Acronyms and Abbreviations

HSC - Health and Social Care

HSCB - Health and Social Care Board

NISCC - Northern Ireland Social Care Council

PCC - Patient Client Council

PHA - Public Health Agency

RCA - Root Cause Analysis

RDG - Department of Health Redesign Development Group

RQIA - Regulation and Quality Improvement Authority

SAI - Serious Adverse Incident

SEA - Significant Event Audit

IHRD - Inquiry into Hyponatraemia-related Deaths

Appendix 1 Patient and Client Council legislation

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

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

a) **representing the interests of the public;**

In exercising this function, the Patient and Client Council must

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

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

b) **promoting involvement of the public;**

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

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

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

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

The Patient and Client Council shall

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

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

S 18 sets a Duty to co-operate with the Patient and Client Council

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

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

h) have regard to advice provided by the Council.

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

Appendix 2: PCC Delivery Model

PCC Connect

PCC Connect is about connecting the right person at the right time to the right information. Our PCC Connect Freephone service, often the first point of entry to the PCC, is the foundation of PCC Support; beginning with the provision of advice and information to the public.

PCC Connect also captures the initial stages of PCC Engage structures; particularly our Membership Scheme and our ‘Make Change Together’ involvement methodology, which seeks to ensure the public can access involvement opportunities with us, across the HSC and beyond. This is supported by working in partnership with external stakeholders through a ‘network of networks’ approach and the development of ‘positive passporting’.

PCC Support

PCC Support is our advocacy and support model. Our model focuses on **relationship building** and a **partnership approach**, putting the voice of the person at the centre of our work. This approach uses **advocacy and mediation skills** on an individual and group basis, to enable us to *provide assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care in the most effective way.*

Our focus is on finding early resolution of issues. We do this through conversation, engagement and connection to appropriate services to meet immediate need. Where early resolution cannot be achieved, our advocacy and support carry through to individual and group advocacy casework under PCC Support.

In some cases, this support and advocacy will progress to a formal complaint process. This can involve independent advocacy support in serious adverse incidents (SAIs) and Public Inquiries.

PCC Engage

Themed engagement platforms under PCC Engage provide members of the public with a forum for engagement on specific areas of work and connect them with representatives across health and social care and voluntary and community sectors. This is critical in fulfilling our statutory functions of *promoting the involvement of the public* and *representing their interests.*

An Engagement Platform is a space to bring together a group of people, with a common theme or interest and lived experience, to work together and make change in health and social care. Engagement Platforms allow participants to communicate their experiences and thoughts, related to a policy programme, with the PCC, as well as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas under review, development and reform.

In line with our statutory function to *undertake research into the best methods and practices for consulting and engaging the public,* we continue to develop our engagement structures, working alongside the public and our partners, and building on the learning from previous years.

PCC Impact

PCC Impact focuses on measuring and demonstrating the impact of our work, and communicating this externally. Through PCC Impact we seek to bring change on an individual, collective and systems level. Our role is to secure a ‘seat at the table’ for the public. Our goal is to connect the evidence gathered through our advocacy and engagement work under PCC Connect, Engage and Support to influence change. Under PCC Impact, we aim to ensure a focus on the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care.

Appendix 3 List of SAI related Recommendations

IHRD Recommendation delegated to Workstream 1 – Duty of Candour

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
1 (i)	1	Duty of Candour Workstream 1	A statutory duty of candour should now be enacted in Northern Ireland so that: (i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public
1 (ii)	2	Duty of Candour Workstream 1	ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances
1 (iii)	3	Duty of Candour Workstream 1	iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
1 (iv)	4	Duty of Candour Workstream 1	(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
1 (v)	5	Duty of Candour Workstream 1	(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
1 (vi)	6	Duty of Candour Workstream 1	vi) Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
			patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.
1 (vii)	7	Duty of Candour Workstream 1	(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.
2	8	Duty of Candour Workstream 1	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.
3[10]	9	Duty of Candour Workstream 1	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty
4[6]	10	Duty of Candour Workstream 1	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.
6	11	Duty of Candour Workstream 1	Support and protection should be given to those who properly fulfil their duty of candour.

IHRD Recommendation delegated to Being Open Sub-group

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
3	9	Being Open Sub-group	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty
4	10	Being Open Sub-group	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.

IHRD Recommendation delegated to Workstream 2 – Death Certification Implementation Working Group

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
36	1	Death Certification Implementation Working Group – Workstream 2	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
54	17	Death Certification Implementation Working Group – Workstream 2	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.

IHRD Recommendation delegated to the Preparation for Inquests [and Litigation] Sub-group

IHRD Number	Workstream Action	Workstream/ Sub Group	Recommendation
36	1	Preparation for Inquests [and Litigation] Sub-group	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.

IHRD Recommendation delegated to the HSC Bereavement and Pathology Networks

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
54	17	HSC Bereavement and Pathology Networks Sub Group	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.

IHRD Recommendation delegated to Workstream 3 – Duty of Quality

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
34[6]	3	Duty of Quality Workstream	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses
40	4	Duty of Quality Workstream	Learning and trends identified in SAI investigations should inform programmes of clinical audit
41	5	Duty of Quality Workstream	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
55	6	Duty of Quality Workstream	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
56	7	Duty of Quality Workstream	All Trust Board Members should receive induction training in their statutory duties.
67	8	Duty of Quality Workstream	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed
69 (i)	10	Duty of Quality Workstream	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour
69 (iii)	12	Duty of Quality Workstream	(iii) Learning from SAI related patient deaths.
70	13	Duty of Quality Workstream	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
72	15	Duty of Quality Workstream	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director
80	20	Duty of Quality Workstream	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.
81	21	Duty of Quality Workstream	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
86 (i) [6]	23	Duty of Quality Workstream	The Department should expand both the remit and resources of the RQIA in order that it might (i) Maintain oversight of the SAI process
86 (ii) [6]	24	Duty of Quality Workstream	(ii) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and
86 (iii) [6]	25	Duty of Quality Workstream	(iii) Scrutinise adherence to duty of candour.

IHRD Recommendation delegated to ALB Board Effectiveness Sub-group

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
69 (i)	10	ALB Board Effectiveness Sub-group	Trusts should appoint and train Executive Directors with specific responsibility for Issues of Candour
69 (iii)	12	ALB Board Effectiveness Sub-group	Trusts should appoint and train Executive Directors with specific responsibility for Learning from SAI related patient deaths.

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
72	15	ALB Board Effectiveness Sub-group	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director

IHRD Recommendation delegated to Workstream 5 - SAI

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
31	1	SAI	**SAI Reporting:** Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents (‘SAIs’).
33	2	SAI	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.
37 (i)	3	SAI	**SAI Investigation:** Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
37 (ii)	4	SAI	(ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.
37 (iii)	5	SAI	(iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.
37 (v)	6	SAI	(v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.
37 (vi)	7	SAI	(vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.
37 (vii)	8	SAI	(vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.
37 (viii)	9	SAI	(viii) Family GPs should, with family consent, receive copies of feedback provided.
37 (ix)	10	SAI	(ix) Families should be formally advised of the lessons learned and the changes effected

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
37 (x)	11	SAI	(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation
38	12	SAI	Investigations should be subject to multi-disciplinary peer review.
39	13	SAI	Investigation teams should reconvene after an agreed period to assess both investigation and response.
42	14	SAI	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.
66	15	SAI	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.
82	16	SAI	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.
83	17	SAI	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.
91	18	SAI	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.

IHRD Recommendation delegated to Workstream 6 – Training

IHRD Number	Workstream Action	Workstream /Sub Group	Recommendation
62	4	Training	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.
64	5	Training	Parents should be involved in the preparation and provision of any such training programme.
65	6	Training	Training in SAI investigation methods and procedures should be provided to those employed to investigate.

IHRD Recommendation delegated to Workstream 7 – User Experience and Advocacy

IHRD Number	Workstream Action	Workstream Sub Group	Recommendation
37 (iv)	1	User Experience and Advocacy	(iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.

IHRD Number	Workstream Action	Workstream Sub Group	Recommendation
63	2	User Experience and Advocacy	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.
89	3	User Experience and Advocacy	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.

IHRD Recommendation delegated to Workstream 8 – Workforce and Professional Regulation

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
5	1	Workforce and Professional Regulation	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the Duty of Candour.
7	2	Workforce and Professional Regulation	Trusts should monitor compliance and take disciplinary action against breach (of Duty of Candour).

IHRD Number	Workstream Action	Workstream / Sub Group	Recommendation
32	3	Workforce and Professional Regulation	Failure to report an SAI should be a disciplinary offence.
35	4	Workforce and Professional Regulation	Failure to co-operate with investigation should be a disciplinary offence.

Recommendations from Reports- Serious Adverse Incidents

RQIA Review of the Systems and Processes for Learning from SAIs in NI

R1 The Department of Health should work collaboratively with patient, carer and victim representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.

R2 Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.

R3 The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.

R4 The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by ‘just culture’ principles and a clear evidence-based framework that delivers measurable and sustainable improvements.

R5 The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.

Neurology Inquiry Report

R23 The NI Department of Health should review (and if necessary, change) the early warning alert process and the serious adverse incident process to assure itself that these processes are clear, well understood and operate in the interests of patients.

COPNI ‘Home Truths’ Report

10 The Commissioner reiterates Recommendation 31 of the Inquiry into Hyponatraemia-related Deaths that, “Trusts should ensure that all healthcare professionals understand what is required and expected of them in relation to reporting of Serious Adverse Incidents (SAIs).

11 The Commissioner reiterates Recommendation 32 from the Inquiry into Hyponatraemia-related Deaths that Failure to report an SAI should be a disciplinary offence.

12 Failure to have an initial six-week care review meeting should trigger a report in line with SAI procedures.

GAIN/RQIA – A Project examining Learning arising from SAIs involving Suicide, Homicide and Serious Self-Harm

Recommendation 1: The reporting arrangements and criteria for incidents involving homicide should remain unchanged and these should continue to be reported via the existing SAI process.

Recommendation 2: Incidents of self-harm should be taken out of the SAI reporting system and reviewed at trust level, ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

However, this approach must allow discretion to report an incident as an SAI when the trust deems it necessary to do so.

Recommendation 3: Incidents related to suicide should be taken out of the SAI reporting system. Trusts must continue to review suicides, using an appropriate level of review with discretion to escalate, as an SAI, when the trust deems it necessary to do so; ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

Suicides that occur within an inpatient setting/trust facility must continue to be reported using the SAI reporting and learning system.

Recommendation 4: A task and finish group should be established, with oversight provided by the Department of Health, to develop a standardised process for trusts to follow, for review of the suicide of an individual known to mental health services, that occurs outside an inpatient setting/trust facility and has not been escalated as an SAI.

Appendix 4 Scottish Independent Advocacy Alliance (SIAA)

Independence of advocacy

Independence is at the core of the effectiveness and efficacy of advocacy. This in particular is of relevance to the third sector providers. It is important to note the Scottish Independent Advocacy Alliance (SIAA) /www.siaa.org.uk Their aim is to ensure that independent advocacy is available to anyone in Scotland. It is funded by the Scottish government planning division. The SIAA define '***Independent advocacy'*** as being structurally, financially and psychologically separate from service providers and other services, which means it is a separate organisation in its own right, has its own funding and is true to the principles of independent advocacy as described below:

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

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

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