Serious Adverse Incident Redesign Programme

Serious Adverse Incident and HSC Complaints Policy Branch

Department of Health

Castle Buildings, Stormont Estate

Belfast,

BT4 3SQ

20 June 2025

BY EMAIL ONLY

Dear Sir/Madam

Ref: Framework for Learning and Improvement from Patient Safety Incidents Consultation

A welcome consultation

1. The Patient and Client Council (PCC) welcomes this consultation and the opportunity to respond to the Framework for Learning and Improvement from Patient Safety Incidents Consultation, which is set to replace the current Serious Adverse Incident (SAI) Procedure in Northern Ireland. We acknowledge that other jurisdictions have not carried out a public consultation on similar policies. PCC considers this policy to be a key element in the Department’s overall patient safety and learning framework, which every member of the public in Northern Ireland has the potential to need and utilise

at some point in their life, and therefore consider it right and proper that this policy, and similar policies, are subject to a public consultation.

2. During the policy development phase, the PCC has sought to influence the Department's development of these proposals in two ways. Firstly, in contributing through the Department's Redesign Development Group, and subsequent workstreams, and also by facilitating PCC's Serious Adverse Incident (SAI) Engagement Platform, which has seen 5 members of the public with significant experience of the current SAI process, directly feedback to the Department on its proposals from Autumn of 2023[1].

3. The PCC published a SAI Overview Report in August 2024.

4. On 15 May 2025, at the request of the Department, PCC facilitated an online consultation event to engage people in conversation about the proposals. We encouraged individuals with experience of the existing SAI review process to register for the event, as well as those who did not.

5. PCC submitted a report on what we heard during this event to the Department of Health and published the report, which can be found on our website.

6. In developing this response, we have considered our role, experience through our advocacy case work (in particular our SAI cases), what we have heard from people's lived experience - through our SAI Engagement Platform and the consultation event of 15 May 2025 - and our general policy work, including reflecting upon numerous responses to health-related public inquiries in Northern Ireland. This response has been reviewed and approved by PCC's Council.

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[1] You can find out more about the work of the SAI Engagement Platform, via PCC Annual Reports: https://pcc-ni.net/about-us/corporate-documents/

The role of the PCC

7. The PCC is a statutory corporate body established under the Health and Social Care (Reform) Act (2009). The HSC Framework Document (2011), produced by the Department, describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. The document stipulates that ‘the overarching objective of the PCC is to provide a powerful and independent voice for patients, clients, carers and communities on health and social care issues through the exercise of its legislative functions’[2], which are:

    - 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.

8. The HSC Framework document further outlines that the PCC has an important independent assurance role for the Minister of Health, based on our statutory functions. The only other organisation that has such a role is the RQIA. The PCC is directly funded by the Department of Health to safeguard its independence from HSC organisations.

9. Paragraphs 6.40 to 6.42 of the HSC Framework Document (2011) further outlines the independent challenge function the Department conferred on the PCC and the RQIA.[3]

10. Further information on the role of the PCC, our delivery model and services can be found at **Appendix 1**.

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[2] DHSSPS Framework Document - September 2011 | Department of Health

[3] DHSSPS Framework Document - September 2011 | Department of Health

Current Deficit of Trust

11. The majority of the public who seek advocacy support in relation to SAI's from the PCC have experienced significant harm including, potentially, the loss of a loved one resulting from the service received from statutory providers. It is our experience that the typical motivation of service users and families is to ensure learning and to protect / safeguard others from a repeat of their experience and 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 and for members of the public with whom we have engaged. Those to whom we provide support have regularly 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.

12. Similar sentiments were shared during the consultation event facilitated by the PCC in May 2025. People with lived experience expressed concern about a lack of transparency, and a process which was an isolating experience, which did not provide them with the answers they sought, nor assurance that lessons had been learnt and/or changes implemented.

13. Whilst the PCC recognises that there is a spectrum of experiences of people who have gone through the current SAI process in Northern Ireland, the findings of numerous inquiries and our experience demonstrates that there is currently a considerable lack of trust in the existing process amongst the public. Building trust and maintaining it, must be a key priority for the Department of Health with any new process. The proposals under consideration make progress in this regard, but PCC believe that there are a number of gaps which still exist to deliver a framework which can build

confidence across the public and HSC staff alike. It is within this broader context that we offer this response.

Vision

14. PCC broadly welcomes the vision for the Regional Framework and particularly welcomes the ambition that the vision will help ensure that reviews are of a high quality, focused on meaningful engagement with all those affected, concluded in a more timely manner, focused on understanding how and why the incident occurred, and identifying system wide learning leading to demonstrable and sustainable improvements in care.

15. Delivering on these ambitions should form the basis for definitive assessment of the success of the new Framework and should be the basis for the further development of oversight and assurance mechanisms.

Framework, Standards and Guidance

16. PCC welcomes the general approach of having a regional framework which is accompanied by Standards. We consider that ‘The Regional Standards’ offer an opportunity to develop an outcome-based regional assurance and oversight framework, which is focused on the quality and impact of patient safety reviews, as opposed to a process-and data-driven assurance model.

17. PCC further welcomes the accompanying principles documents for engaging and involving all those affected by a Patient Safety Incident, and staff.

18. PCC notes that the Framework document will have a number of additional supporting documents which are referred to at a high level in the consultation document, but which are not being consulted upon. These include:

    - Methodology and Toolkit Guidance
    - Managing the Learning Review Process
    - Governance, Oversight and Accountability Guidance
    - Roles and Responsibilities

- Education and Training Requirements
- Learning and Improvement Systems
- Learning and Improvement ‘How to’ Implementation Guide

19. Based on the consultation document, the content of these additional pieces of guidance will have a significant impact on all aspects of implementing the framework. This is particularly the case for the ‘Methodology and Toolkit Guidance’. In light of this it is difficult to give a comprehensive assessment or response to the current consultation as there are a number of gaps which may be addressed by related documents which are not consulted upon.

Baseline Assessment

20. A baseline assessment of the resources currently used by Trusts on SAIs would have valuably informed this process, as part of this redesign project and consultation, alongside an assessment of the investment required to deliver a new and more effective framework. Ensuring Trusts and the Department place adequate resources towards successfully implementation of the Framework is vital. Building on a baseline assessment and the logic that meaningful learning should reduce future Patient Safety Incidents, an invest to save approach may be beneficial.

What should members of the public expect from a new Patient Safety Incident Framework?

21. A new framework should deliver the following key components when harm or death occurs through the actions or omissions on the part of an HSC service:

    - A robust investigation, to a consistent standard, which establishes what happened and;
    - 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 and involves all those affected 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.
- Panels should be free to make any recommendations that they feel could / would address the issues raised during the investigation and the recipients of the report should then be tasked with implementing them. There should be no prejudice / preconceptions offered by the panel as to whether or not these recommendations will be possible to implement. Feasibility assessments should not restrict recommendations at review stage.

A robust investigation to a consistent standard

22. The consultation document outlines that an Operational Methodology guidance will be developed to assist organisations in the conduct of Patient Safety Incident learning reviews, and will describe how Patient Safety Incidents should be reviewed. This will outline the different types of review, and methodologies**,** all of which are underpinned by a system-based approach which recognise the important role of contributory factors.

23. The consultation document outlines the ways in which Patient Safety Incidents can be identified, including complaints, and gives a headline overview of the types of review: concise, thematic and comprehensive.

24. At present it is very unclear what process will be followed between an initial issue being identified, the determination of whether the issue/incident amounts to a Patient Safety Incident, and subsequent determination of which type of review will be undertaken. What is the evidence basis upon which a decision on methodology will be made? This decision should be based on initial investigations carried out to a universal standard to establish what happened. This should take place between the step of identifying a potential Patient Safety Incident and deciding which type of review to undertake.

Whilst PCC recognise that this initial investigation needs to be proportionate, it must be robust, transparent and consistent.

25. It is equally unclear who within a Trust will carry out investigations and what training they will have had in order to do so.

26. After an initial investigation to find out the fundamentals of what happened, a threshold should be applied to determine whether the incident amounts to a Patient Safety Incident and therefore should be further investigated through the chosen methodology to identify and implement appropriate learning. Quality assurance should be provided to the initial investigation, by assessing if those making the determination had adequate information and evidence to make their decision (which speaks to the quality of the initial investigation). The ability of all those affected to understand what happened and for genuine learning to be provided, requires this baseline assessment of factual information.

27. Adopting this approach would address some of the issues PCC have raised and which have been highlighted by members of the public. For example, through our advocacy support PCC has recurrent experience of advocating in incidents that met the threshold of a SAI but was not recognised as such. In some instances, incidents have moved from no SAI being acknowledged to a Level 3 SAI being initiated. The concern around lack of clarity in the proposed framework on how these decisions will be made is reflected in feedback from the May 2025 consultation event, where a participant stated: *"If the Trust refuses to acknowledge a SAI, how is one going to be obtained? There's nothing in these proposals to address that".*

28. Acknowledging the requirement to carry out preliminary investigations to a universal standard, in order to determine whether an issue meets the threshold of a Patient Safety Incident is crucially important. Failure to transparently articulate the decision-making process runs the risk of introducing opaqueness at the early stages, which in turn impacts on trust and confidence in the process.

29. There is also a need to articulate the ability for those affected by the incident to challenge the initial decision as to whether an issue amounts to a patient safety issue, and the mechanism through which they can do so.

30. Members of the public have expressed concern that removing the current criteria for a Serious Adverse Incident, introducing greater flexibility in the process with an emphasis on taking a proportionate approach, may lead to a reduction in the number of Patient Safety Incident reviews being undertaken, which does not correlate to an increase in patient safety.

31. Failure to address this concern will also impact on Trusts' ability to openly and consistently engage with all those affected, as uncertainty may be 'baked in' to the system from the beginning.

Regional Consistency

32. Regional consistency is critical but it is not clear that it will be delivered under this framework. It is a clear expectation of the public that people who have experienced similar incidents in different Trusts should have consistent expectations of the baseline standards to which review processes adhere. Not including universal standards of investigation reduces this likelihood considerably, as decision-makers will have the scope to base their decisions on different standards of evidence/information or different thresholds.

Methodologies

33. As outlined above PCC notes that the detail of the methodologies determining which type of review to undertake are not included in this consultation. Our understanding is that their development to date has not been subject to public engagement. PCC considers that it is vitally important that the public understands and has a say in this crucial aspect of the overall framework and would expect engagement to take place as part of the next phase of this project. Not having had sight or input into the development of these

methodologies limits a comprehensive assessment of the proposed Framework and its effectiveness.

Independence and assurance

34. Those with lived experience of the current SAI process have expressed that it is of paramount importance that those carrying out Patient Safety Incident investigations and reviews are independent of the Trusts involved. Whilst PCC recognises that not all reviews can or should be wholly independent of HSC delivery organisations, there should be a degree of independent oversight and assurance within the process. This needs to be strengthened in the current proposals. The importance of independent investigations is a long-established principle and practice in other equivalent spheres and is of principle importance in relation to public trust in the process.

35. PCC notes the section in the consultation document which relates to independence and the statement that '*the decision on the requirement for independence either internal or external to HSC organisation should be decided at the outset of the review process and the rationale clearly documented and explained to All those Affected and Staff Affected*. *The requirement for the decision on the level of independence will have no set criteria, however, to assist HSC organisations there will be a set of guiding principles to inform their discussions and decisions in this regard'.*

36. As highlighted above, such decisions will only be possible based on an initial standardised investigation stage. It is unclear under the proposed model on what basis decisions on independence will be made and at exactly what stage of the process.

37. Whilst the PCC notes the intention to develop guiding principles in this area, we are of the view that there should be a set criteria/threshold applied, by which an independent review should be initiated.

38. Application of this criteria, and the evidence upon which the decision was made, should then be subject to oversight and quality assurance. Within the

Standards document, the current example of evidence that should be provided for assurance, against the standard for independence, states: *A record of the HSC Organisation's assessment and decision making around the level of independence*. Evidencing that an assessment has taken place is different to being assured that this was an appropriate decision based on suitable evidence. Within the current proposals, there is scope for assurance to be provided that a process has taken place, rather than assurance that the decision is appropriate based on criteria and suitable evidence.

39. Equally, under current proposals, those affected will not be able to fully understand and assess why a level of independence has or has not been applied in a particular set of circumstances. The standard for the required level of independence should be closely linked to the criteria for determining the type of review to be undertaken.

Oversight and Governance

40. PCC notes the sections in the consultation document titled '*consistency*' and '*oversight and governance*'. PCC also notes the statement that '*all organisations will be required to demonstrate how the Standards are met by establishing robust and rigorous governance structures, policies and procedures. Overall responsibility for oversight and governance of this process will rest with organisational Boards, supported by collective leadership through the organisation. There will also be external oversight, governance and accountability – for example from SPPG/PHA who will ensure consistency across the Region when appropriate'*

41. The level of consistency, regionally and across Trusts, and subsequently the level and extent of meaningful external assurance that it is possible to achieve e.g. from SPPG/PHA within these proposals is unclear and may be limited. This results from the lack of a universal standard of investigation/evidence upon which the decisions on methodology of reviews are based, and no standardised approach to the level of independence which must be applied.

Patient Safety Learning and Improvement Plans

42. The PCC welcome the assurance and governance mechanism included in the consultation document. However, PCC notes that a heavy reliance is being placed on the proposed ‘Patient Safety Learning and Improvement Plans’, which are to be developed by each Trust and approved regionally. PCC notes a key aspect of these plans is that decisions on the type of review to undertake and the methodology to use may vary, based on individual Trust data and ongoing quality systems. We again reiterate that without an agreed evidential standard of investigation and decision making, significant uncertainty as to why decisions have been made will remain.

43. More information is required on the proposed assurance and governance frameworks, both at a Trust and Regional level, alongside enhanced public engagement on this aspect of the framework. Robust, transparent and consistent oversight and assurance is critical for delivering effective learning and building and maintaining trust in any new process. Consideration should be given as to how systematic contribution from those with lived experience and the voice of the public can be established as part of the regional oversight and assurance model. Members of the public have expressed concern to the PCC that this proposed framework delegates more power and flexibility to HSC Trusts. It is critical that the regional oversight, assurance and accountability mechanisms are robust, effective and focused on quality and improvement.

Regionally Trained Independent Facilitators

44. PCC welcomes and supports the proposal the Department is considering to establish a team of regional trained independent facilitators which organisations can utilise for those Patient Safety Incidents that will require the highest level of independence. PCC considers that this proposal must be based on a transparent set of criteria for deciding which incidents require an independent review.

45. These regionally trained independent facilitators could form part of a wider independent patient safety hub of expertise, providing independent expert analysis to Trust Boards and the Department on patterns, trends, clusters and emerging quality and safety concerns. There may also be a role for undertaking/advising on Patient Safety Incidents and offering independent advice to Trust Boards, the Department and other agencies on individual incidences and reviews. The PCC considers that an open HSC system needs to give more consideration on how it uses and coordinates and considers the data and intelligence that it holds to learn from good practice, learn early from emerging issues and when things go wrong.

Regional Approach

46. Members of the public do not currently experience care pathways which are confined to individual Trust areas, and as proposals such as those on regional hospital reconfiguration develop, movement across Trust boundaries is likely to increase. People also experience pathways between private healthcare and the HSC, as well as across jurisdictional boundaries. Any new framework or process needs to be designed around how patients and families experience and encounter the health and social care system.

47. Consequently, the ‘flexibility’ being provided for the development of individual Trust’s Patient Safety Incident Learning Improvement Plans, - which will impact upon approaches, evidential thresholds and methodologies – has potential implications for the consistency with which incidents that occur across Trust boundaries are dealt with. Key considerations include; will individual Trust Patient Safety Incident Learning Improvement Plans allow for an appropriate level of co-operation and interoperability for cross-trust Patient Safety Incidents? And how will governance and assurance mechanisms work in such circumstances? The framework does not provide clarity on this and further information is needed to address these concerns.

Independent Advocacy Services

48. The importance of independent advocacy services was recognised by the Inquiry into Hyponatraemia-Related Deaths (IHRD) report[4], with its recommendations outlining the need for service users, and families, to ***have access to independent advocacy support in relation to SAIs***. Recommendation 37 (iv) being: '*Trusts should seek to maximise the involvement of families in SAI investigations and in particular: 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'.*

49. Whilst the PCC welcomes the reference in the Standards and Guidance documents to '*Signposting to support services must be provided, through the organisation or via an independent advocacy service'*, we do not consider that this meets recommendation 37(iv) of the IHRD public inquiry. In light of the issues of trust and confidence outlined above, coupled with PCC's experience in providing independent advocacy support, as well as our experience from public inquiries, we believe there is need for greater emphasis on the importance of independent support and advocacy.

50. The PCC expects, and we believe the public expect, that organisations providing advocacy services should be independent of service providers i.e. structurally, financially and psychologically independent. Ensuring the integrity of independence, advocacy service providers' accountability arrangements should be independent of Trusts to ensure freedom to act without potential adverse consequence on the contractual arrangement. 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.

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[4] Inquiry into Hyponatraemia related Deaths (2018) The Inquiry into Hyponatraemia-related Deaths Report Full-Report.pdf

51. In the context of Patient Safety Incidents, the PCC believes that the Advocacy Service which is consistent with the recommendations of the Hyponatraemia Inquiry Report, should first and foremost, attend to the needs of families engaged in Patient Safety Incidents 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 Patient Safety Incidents reports with families when they receive them)
    - Provide expert advice and information about the Patient Safety Incidents review process to enable families to understand what is going on and to enable families to make decisions and to ask questions.

52. 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.

53. The PCC believes the following aspects should underpin the provision of advocacy services within the Health and Social Care system:
    - Advocacy services should be commissioned as regional services;
    - Advocacy services should be commissioned independently of HSC Trusts;
    - Advocacy services should be commissioned on the basis of agreed standards which include addressing the role of these advocacy services in dealing with complaints and concerns raised by clients, responding to

safeguarding issues, and systems of regulation of services and the workforce;

- The service specification with providers commissioned to provide advocacy services should specify how these service providers relate to the Patient and Client Council in the discharge of its statutory roles (where the PCC is not the provider or commissioner of the service);
- The same specification should specify a minimum data set to be collected by the service provider both for the purposes of monitoring the provider's performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts; and
- Access to these advocacy services should be client-led and not solely dependent on a referral by HSC Trust.

54. The PCC's interest is in having systems and structures which promote and maximise openness, patient outcomes, purpose, quality and safety of services and governance and assurance. The PCC is not seeking to position itself to be involved in every complaint / SAI or Review. PCC recognises the expertise and contribution of a wide range of voluntary sector organisations which provide specialist knowledge-based advocacy services and the PCC itself avails of those services. The PCC is not seeking to displace or replace those providers. It is critically about how to "connect the system to more of itself "(Myron's Maxims) and to deliver better outcomes for the public.

55. The PCC provides independent advocacy support to members of the public, including in relation to SAIs currently, though the organisation is not resourced to do so. The demand for independent advocacy support from the PCC in SAIs is on an upward trajectory. The SAI process as it is currently operating and resourced, means that there is often a need to provide advocacy support to families engaged in SAIs for up to five years. For example, in 2024-25 PCC opened 22 new SAI support cases, but at the year end, we had 47 open SAI support cases. 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. 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.

56. Although the PCC has a broad range of functions in relation to HSC, competing functions need to be balanced against a consistently constrained budget position. In this regard PCC considers that to meet the recommendation as outlined in the IHRD report, additional commitment and investment in regional independent advocacy services needs to take place.

57. PCC considers it a missed opportunity that the draft Being Open Framework, and this consultation have not taken the opportunity to acknowledge and embrace recommendation 37 (iv) of the IHRD public inquiry.

58. PCC further considers that IHRD recommendations relating to bereavement counselling have not been addressed as part of the development of the draft Framework, which is also a missed opportunity.

Definition of all those affected and victims

59. PCC considers that the current definitions of ‘all those affected’ and ‘victims’ within the proposals are too narrow and potentially exclude certain categories of people, including those who are not patients or patient’s families, and who suffer death and harm as the direct result of a Patient Safety Incident. Proposed definitions should be amended to address this.

Public Participation in the Implementation Stage

60. PCC has been encouraged by the Department’s willingness to engage with members of the public with lived experience as the policy development stage of this project progressed. However, we consider that this engagement could have been more expansive and more integrated into, and across, the redesign structures, allowing those involved to understand and feed into the

project in its entirety. We can see the benefits that engagement with those with lived experience has had on the proposals, but we believe the full potential of this impact is still to be realised. PCC would encourage the Department to continue, deepen and expand this approach as a key component of developing a more strategic approach to public participation, both within this policy development process, the implementation phase, and across other policy areas in development.

61. As outlined, there are other documents and guidance outstanding which will significantly influence how this proposed Framework and associated proposals are further shaped and then implemented. PCC considers that further and ongoing engagement with those with lived experience on this project - as it develops and at the implementation stage - is critical to its success. PCC is happy to engage with the Department on this matter going forward.

Yours faithfully

Ruth Sutherland M. Monaghan

Ruth Sutherland, CBE
Chair

Meadhbha Monaghan
Chief Executive

Appendix 1

The Role of the PCC

The Patient and Client Council (PCC) is a statutory corporate body established in 2009 under the Reform Act[5] to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues within Northern Ireland 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.

In addition, PCC has an important independent assurance role for the Minister of Health, as set out in the HSC Framework document[6], one of only two organisations that have this role, the other being the RQIA.

The PCC's effectiveness in fulfilling its' functions is partly dependent on building constructive and productive relationships and arrangements with service providers, the third sector and other statutory bodies who have powers to investigate and take enforcement action where there are problems with the quality and availability of health and social care services. The approach of establishing partnerships and building relationships with others can mean that the PCC is able to exercise a positive influence on the sector – albeit via ***soft skills*** such as mediation and collaboration rather than though hard statutory obligation. However, this approach requires a significant commitment of time and resources for a small organisation like PCC and can take longer to reach a point when results are being achieved.

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[5] Health and Social Care (Reform) Act (Northern Ireland) 2009
[6] Department of Health (2011) DHSSPS Framework Document

The PCC is a small Arm’s-Length Body with an annual budget in 2024-2025 of £2.1m. £1.8m of this is recurrent funds, £0.3m is non-recurrent funds relating to inquiry related work. PCC employs 31 members of staff, excluding Council members.

The PCC has a Council made up of a Chair and Council Members, recruited from across Northern Ireland under the Public Appointments Process. It currently has 13 members[7].

With a budget of £1.8m – equivalent to less than £1 for each member of the public in Northern Ireland that PCC is tasked to serve – it is a challenge to fulfil the statutory functions outlined below, 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.

Our vision is for a Health and Social Care Service, actively shaped by the needs and experience of patients, clients, carers and communities, and that in achieving this, the public voice would be influential regionally and locally in planning and commissioning, and that the system responds openly and honestly when things go wrong.

The PCC has developed a Statement of Strategic Intent 2022-2025[8], setting out the strategic direction of the organisation over the next three years. 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

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[7] https://pcc-ni.net/about-us/our-council/council-members/

[8] PCC (2022) Statement of Strategic Intent

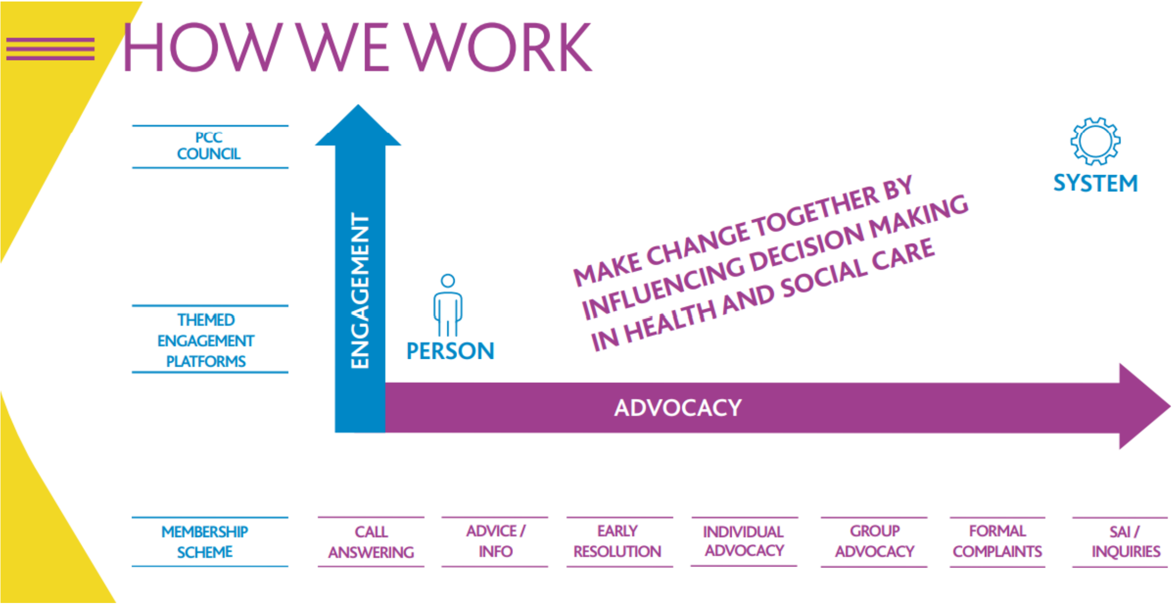
openness, honesty and compassion to address difficulties or failures in standards of care.

PCC provides advocacy services for the public, which range from helpline advice, early resolution of issues, individual advocacy, to supporting people through formal complaints and serious adverse incidents. If we identify a specific need that we cannot help with, we will connect individuals to a partner organisation within the voluntary and community sector or beyond, seeking to ensure people do not fall through gaps in the system.

We also bring members of the public, with common interest and lived experience, together with decision makers from the Department of Health (DoH) and Health and Social Care (HSC) organisations to improve existing HSC services and plan for the future.

PCC Delivery Model

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



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 advocacy and support model focus 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.*

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

Our focus is on seeking ***early resolution of issues*** through facilitated conversations with parties involved in a particular case. This can include a wide range of other service providers, HSC bodies and individual professionals. Our advocacy and support can include signposting and 'positive passporting' as noted above.

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

In some cases, this support and advocacy will however progress to a formal complaint process. The PCC also provides independent advocacy support in relation to serious adverse incidents (SAIs) and Public Inquiries.

PCC Engage

The objective of the PCC is to provide a powerful, independent voice for patients, clients carers and communities on health and social care issues through the exercise of its functions. PCC's new practice model provides the best method of facilitating the conversations, having their voice heard and building relationships between service users, patients, carers and families and the system which serves them. To meet this objective, PCC designed and created a ***theme-based engagement platform*** model of practice. Themed engagement platforms provide members of the public with a forum for engagement on specific areas of work and connect them with the Department and 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.

Running alongside our engagement and involvement structures is the continuum of ***advocacy and support*** that the PCC offer in meeting our core statutory function of providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care.

Engagement Platforms can also provide the opportunity for participants to raise their individual issues and concerns with the PCC directly whilst engaging in ongoing theme-based work. This may be in the course of a participation event itself and as part of group discussions. Online technology allows the PCC team to place a participant into a separate virtual room, during these discussions, where they can, in private or on a one-to-one basis, seek advice and discuss concerns with PCC staff. It can also happen after a session or event has concluded when PCC staff are approached by an attendee to raise an issue or complaint they have. In both cases, PCC staff would offer the individual support and advocacy to assist to address the issue they have raised during engagement.

In line with our statutory function to *undertake research into the best methods and practices for consulting and engaging the public,* PCC continues 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. PCC has a critical role in securing a '***seat at the table'*** for the public. The goal is to connect the evidence gathered through PCC advocacy and engagement work under PCC Connect, Engage and Support to influence change. Under PCC Impact, the aim is 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.

The PCC policy advocacy role is the process of negotiating and mediating a dialogue through which influential networks, opinion leaders, and ultimately, decision makers take ownership of the ideas, evidence, and proposals, presented by PCC on behalf of the public and subsequently act upon them.

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