Muckamore Abbey Hospital Inquiry

Witness Statement

Statement of Vivian McConvey

Date: 27 January 2023

I, Vivian McConvey, make the following statement for the purpose of the Muckamore Abbey (MAH) Inquiry. I have been the Chief Executive Officer of the Patient and Client Council ('the PCC') since 8th April 2019 and I have qualifications in BA (Hons) Social Work, MSc Advanced Award Social Work, Certificate in Company Direction**,** Diploma in Company Direction, Leading Social Work: Executive Leadership Development Programme. Prior to my appointment as Chief Executive Officer I was Chief Executive Officer, Voice of Young People in Care (VOYPIC) from Sept 2002 – April 2019.

This statement is made on behalf of the PCC in response to a request for evidence by the Inquiry Panel.

This is my first statement to the inquiry.

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

Introduction (Including history, statutory functions, statutory objectives, chronology of the PCC, structure of PCC, accountability)

1. The PCC was established as an Arms Length Body (ALB) of the Department of Health (hereafter 'the Department') on 1st April 2009. The creation of the PCC was part of a major reform of health and social care in Northern Ireland, provided for by the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter 'the 2009 Act'). The functions of the PCC are described in the 2009 Act and have remained unaltered since 2009. Please see exhibit VM/4.

2. Whilst the PCC's statutory functions have remained unchanged since 2009, the PCC's internal structures and the PCC's approaches to delivering its functions have evolved and changed over time. The way in which the management structure of the PCC had changed and adapted over time is illustrated by the PCC structure diagrams referred to in paragraph 80 below and the identification of Chairs and as well as lead officials and their roles listed at paragraph 82 below. The current PCC organisational structure is enclosed at exhibit VM/3.

3. As a result of various lessons learned exercises and operational reviews the PCC can be considered to be a significantly different organisation post-2019 when compared to the pre-2019 PCC. The post-2019 PCC practice model has increased its operational focus on matters such as:

    - Increased engagement with patients through a range of mechanisms including themed Engagement Platforms and localized Citizen Hubs;
    - Securing *increased* funding has led to an increased focus on Muckamore Abbey Hospital through the provision of a dedicated advocacy practitioner;
    - Using data and evidence to drive and improve our policy functions;
    - Improved methodology with respect to how PCC supports members of the public across a continuum of advocacy interventions.

4. The PCC began in April 2009 with a management structure based on local district offices with five area managers. In more recent years the structure has changed to reflect the functions of PCC and the area manager posts have been replaced by new management posts focusing on PCC functions. Late 2020 heralded another significant change in the service delivery, with the development of a new practice model. The table below illustrates these changes by highlighting the Job Titles of posts below the Senior Management level:

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

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

    - Corporate Governance documentation such as Annual Reports; Risk Registers; Business Plans; Corporate Plans; Internal Audit Reports; and Assurance Frameworks providing extensive information about the operation of the PCC throughout its existence;

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

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

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

    The information provided in this statement for the period prior to 2019 is based on this extensive range of documentation.

6. The functions and powers of the PCC are set out in the Health and Social Care (Reform) Act (Northern Ireland) Act 2009[1] (see exhibit VM/4) which provides:

[1] Health and Social Care (Reform) Act (Northern Ireland) 2009 (legislation.gov.uk)

Functions of the Patient and Client Council

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

(a)representing the interests of the public;

(b)promoting involvement of the public;

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

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

(e)such other functions as may be prescribed.

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

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

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

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

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

[3] a) Inquiry Reference PCC - H - 00755 - PCC legislation and b) Inquiry Reference PCC - H - 00756 - Legislation pat rep UK and ROI

Ireland. The functions and role of the PCC are also described in management statements and in PCC Annual reports.

Post 2019 – Organisational Review

8. Prior to April 2019, the PCC had experienced a number of years of leadership instability with year on year decreases in its funding. With the appointment of a new Chair (Christine Collins in March 2019), three new Council Members and a new Chief Executive Officer (Vivian McConvey in April 2019) it was judged to be timely to review the practice, strategic direction and to test this against need and the PCC statutory functions. A new Executive Team and Operational Management Team have led and supported the organisational change process.

9. In the summer of 2019 the PCC commenced a period of significant organisational review and change. The HSC Leadership Centre was commissioned to undertake the independent organisational review with the aim of assessing how PCC currently delivers on the vision and to propose new organisation design structures.

10. The review findings proposed a number of recommendations, which set out the need for a significant change process. Key to the changes required was a refocus on the PCC's statutory and legislative base alongside a subsequent realignment of the organisation's operational functions and practice. This directed the development and re-design work undertaken in relation to:

    i. Purpose and Core Business
    ii. Roles and Responsibilities
    iii. Capacity and Capability

iv. Systems and Processes

v. Estate

Post-2019 Practice Model

11. The new practice model updated and re-designed how the PCC provide support to the public across three core functions:

Advocacy

Advocacy is provided across a continuum. This ranges from advice and information over the phone or via email, or a focus on seeking early resolution of issues through facilitated conversations, or signposting and 'supportive passporting' to appropriate services to meet immediate need, through to individual and group advocacy casework.

Engagement

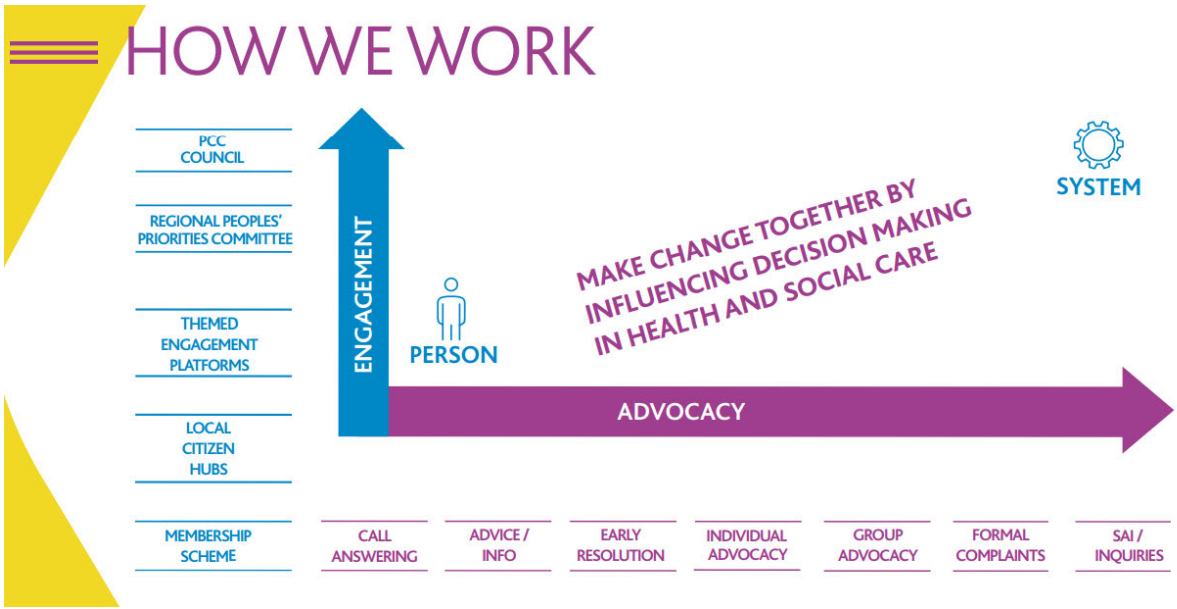
The foundation for our engagement is our PCC Membership Scheme for those interested in regular updates about more general information and developments in health and social care. The PCC Citizen Hubs, offer a more interactive and two-way process for engagement, operating in each of the Trust areas. The PCC Engagement Platforms offer the opportunity to engage in theme-based, task-oriented work at a more strategic level, with representation from the public, as well as the health and social care, and voluntary and community sectors.

Policy Impact & Influence

The PCC aim to utilise the data gathered through its advocacy and engagement work to undertake a policy advocacy role. This is the

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

12. The following diagram illustrates the new practice model as described above:



PCC Operations with respect to Muckamore Abbey Hospital

13. The PCC has undertaken actions and activity focussed specifically on Muckamore Abbey Hospital since 2019. Prior to this, Muckamore patients and their families will have been included in generic PCC activity and will have featured within the general work and activity of the Bamford Monitoring Group. With the exception of two pieces of research which are detailed below, our review of PCC records and documentation has found no evidence of any specific focus on Muckamore Abbey Hospital as an institution pre-2019 and after the PCC Council (Board) considered feedback from a Council (Board) members visit to Muckamore in November 2009, at the November 2009

Council (Board) meeting. However, as I discuss below, a different approach was taken post-2019.

2019 – 2020 Muckamore Abbey Hospital – Dedicated Resource

14. Under the leadership of the new CEO, Vivian McConvey, the PCC set out to proactively engage with families and patients residing at Muckamore Abbey Hospital (MAH), alongside other advocacy providers on the Muckamore site, and with Management of the Belfast Trust. In September 2019 Ms Vivian McConvey, CEO as part of her induction into her new role spoke with the Department of Health Sponsoring Branch leads Charlotte McArdle, Chief Nursing Officer and Rodney Morten, Deputy Chief Nursing Officer. Sponsor Branches are the Arms Length Bodies (ALB's) primary point of contact with the Department on assurance and accountability. Ms McArdle, was also at that time co-chair of the Regional Forum, the Muckamore Departmental Assurance Group (MDAG). Through these conversations Ms McConvey was briefed on the work of the MDAG regional forum.

15. The MDAG was established to provide the Department (and any incoming Minister) with assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH. The review was undertaken in response to allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018.

16. MDAG is intended to provide the Department with a clear line of sight on progress towards delivering the commitments set out in the MAH HSC Action Plan, and provide a forum for the escalation of issues and risks from the mental health and learning disability sector. This action plan identified 43 actions to be completed over a period between November 2019 and March 2022. Family

and patient representatives are members of the group. Both Ms McArdle and Mr Morten highlighted the need to explore the requirement for independent advocacy for families and residents.

Membership Muckamore Departmental Assurance Group (MDAG)

17. An invitation was extended to attend an MDAG meeting on 30th Oct 2019 in which Ms McConvey was introduced to two family representatives, [redacted], and [redacted]. Both family representatives invited Ms McConvey to attend the Society of Parents & Friends of Muckamore Group meeting on Monday 4th November 2019. The meeting was attended by the Department through Sean Holland, Chief Social Worker, Charlotte McArdle, Chief Nursing Office, Mark Lee and Jackie McIlroy. The agenda was as follows:

    1. Updates and elaboration on ongoing work in the following areas: -
        - Role of Muckamore Departmental Assurance Group (MDAG)
        - Actions to ensure Muckamore Abbey Hospital is safe, and contingency plans
        - Update on work for future of Learning Disability services
        - Muckamore Abbey Hospital Action Plan
        - Ongoing engagement with families /carers
    2. Presentation on Patient & Client Council, and how they can assist relatives/carers
    3. Open platform for relatives/carers to ask questions, voice concerns, etc.

18. The following issues were identified in discussion with the 26 family members and carers present:

- Lack of reliable information and communication between the Trust and family members on all aspects of the service including names of lead managers, information on the future of the hospital and individual plans for patients;

- A range of needs and wishes among the families present including concern that community placements were unavailable/unsustainable and that there were no apparent options for those who felt Muckamore Abbey was the best long-term solution for their family member; and

- Lack of confidence in the review and investigation processes ongoing including that all relevant staff would be held to account.

19. Internally the PCC Client Support Manager, Richard Dixon, was provided dedicated time to explore the advocacy options for patients and families of Muckamore Abbey Hospital. Mr Dixon met with the lead advocacy organisations and key staff in Belfast Trust and at Muckamore Abbey Hospital. He identified that the current coverage in November 2019 for Muckamore by Advocates was as follows:

• Belfast Trust Patients	Bryson House
• South Eastern Trust Patients	Bryson House
• Northern Trust Patients	Mencap
• Southern Trust Patients	Disability Action
• Western Trust Patients	Ad Hoc by Bryson House
• Families (Northern Ireland)	Bryson House

20. The time commitment provided by the advocacy organisations was identified as 50 hours per week in total from Bryson House (All groups); 25 Hours per week from Mencap. A work plan for the PCC Advocate and for the Client Support Manager was developed to focus on:

    - Engagement with current advocacy providers and reaching an understanding on work with patients;
    - Engagement at depth by the PCC with all carers, friends and families
    - Advocacy to include working on individual issues but also on;
        - Patient/family involvement in development plans for Muckamore
        - Identifying general as well as specific concerns or patients, friends and families including:
            - Information needs as regards ongoing investigation; current service provision and future planning
            - Recommendations for future advocacy needs for this patient group and their families
            - Addressing the needs of families as a traumatised group of people

21. On the 10th December 2019, Ms McConvey was formally invited by joint Chairs, Sean Holland and Charlotte McArdle to join the MDAG Group as a permanent member. She attended the first meeting as a formal member in February 2020.

Advocacy

22. The new PCC leadership team considered it an operational priority to secure funding specifically for MAH and as such PCC submitted a business case to the Department to support the appointment of a dedicated independent advocate to provide support for families and patients at Muckamore Abbey Hospital.

Towards the end of the financial year 2019-2020, PCC secured non-recurrent funding to provide advocacy services as required to any patient, carer or family of Muckamore Abbey Hospital past and present as required and in particular to address any unmet need outside the remit or capacity of the existing advocacy services. The aim was to work constructively with the commissioned advocacy service providers and to support them in their work with patients, carers and families to ensure that patients, carers and families had access to a trained advocate irrespective of their specific status (i.e. resettlement; new admission; inpatient treatment and care; assessment). For the first time the PCC was funded to dedicate an advocacy resource specifically to Muckamore Abbey Hospital, whereas previously our work relating to the hospital formed part of larger work relating to learning disabilities and mental health more generally.

23. The extra funding which facilitated this advocacy resource meant that we were now able to give Muckamore Abbey Hospital a dedicated focus. The Patient and Client Council decided to undertake scoping work to assess the need for advocacy support for patients and families of Muckamore Abbey Hospital. This work included direct engagement with patients and with families. The initial phase was undertaken by Richard Dixon, Client Support Manager. In the last quarter of 2019/2020, the Patient and Client Council secured short term funding to begin work on developing advocacy proposals at Muckamore Abbey Hospital to employ a full-time advocate to work at Muckamore Abbey Hospital. In November 2020, PCC employed a full-time dedicated advocate to provide a service for residents and families at Muckamore Abbey Hospital.

Supporting Family-Carer Advocacy Groups

24. Richard Dixon, PCC Client Support Services Manager met with [redacted], Secretary, Society of Friends and Families of Muckamore Abbey Hospital. [redacted] requested support from the PCC to organise and facilitate an engagement session with key stakeholders and families who had a

relative living in Muckamore Abbey Hospital. This event was scheduled for February 6th 2020 between 6.00 to 8.00 p.m.

25. The event was organised to allow families of patients of Muckamore Abbey Hospital to meet with key stakeholders and to ask questions, make comments and raise concerns in an informal atmosphere. This was a drop-in session for coffee and a chat for families who might like the opportunity to discuss their concerns and obtain information. The stakeholders present were people from Health and Social Care organisations who are responsible for patients in Muckamore Abbey and involved with the programme of improvement, change and development that is ongoing there. It also included an opportunity to meet and talk to organisations providing advocacy and support for patients and families at the Hospital.

26. The Organisations invited to this event were:

- Department of Health and Social Care Northern Ireland
- Regulation and Quality Improvement Authority
- Belfast Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- Mencap
- Disability Action
- Bryson House Charitable Group
- Patient and Client Council

Leadership and Governance Review

27. An independent review of leadership and governance at Muckamore Abbey Hospital was commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department in January 2020. The team that led the review completed their work by end July 2020. The Minister of Health decided that parents and other relatives of patients in Muckamore should be given the opportunity to hear the outcome of the review before it was published. The Patient Client Council were asked to facilitate a briefing session on Wednesday the 5th August 2020 at 6:30 pm in Hilton Hotel, Templepatrick, BT39 0DD.

28. Families were invited to come and hear from the report's authors, share their views and have the opportunity to put questions to the review team members in a private forum, ahead of the report findings being issued to the wider public.

Engagement on the Terms of Reference for the Muckamore Public Inquiry and associated advocacy to patients, families and carers

29. On 8th September 2020, the Minister for Health, Robin Swann MLA, announced his intention to invoke his powers under the Inquiries Act 2005 to call a Public Inquiry into abuse at Muckamore Abbey Hospital.

30. Minister Swann committed to consult with families, carers, and current and former patients on the Inquiry's Terms of Reference and the identity of its Chair. He asked the Patient and Client Council (PCC) to carry out these consultations on his behalf. This was in keeping with the PCC's statutory mandate to consult the public, promote the involvement of the public and to represent the interests of the public.

31. The Patient and Client Council held three engagement events in December 2020 at which families and carers met with representatives from the Department of Health, the Inquiry Team, and the Patient and Client Council to learn more about the Public Inquiry and discuss their views on its Chair and Terms of Reference. These events were conducted remotely due to public health guidance and were attended by over 47 individuals.

32. In addition to these public events, Patient and Client Council staff members spoke privately with current patients and devoted resource to supporting former patients, carers, families, and advocates from November 2020-February 2021 to discuss their views on the Terms of Reference and Inquiry Chair. They met with current patients in person on the hospital site, visited former Muckamore Abbey Hospital patients in supported housing, and spoke to small groups of former patients in day centres and self-advocacy groups. These facilitated formal conversations occurred with 59 individuals, including 22 current or former patients. This ensured that the Inquiry had a data set from both past and present patients. The Patient and Client Council also received 29 written submissions via email and post in which patients, families, and carers shared their views on the Inquiry. Throughout this process, many respondents shared their personal experience of Muckamore Abbey Hospital.

33. The PCC's engagement process sought views on the following topics, which were agreed in advance with the Inquiry Team. These were not exhaustive:

i. The purpose of the Inquiry (what people want the Inquiry to achieve).
ii. The substantive scope of the Inquiry (what people think the Inquiry shouldinvestigate).
iii. The time frame of the Inquiry (which years the Inquiry should consider in itsinvestigation).

iv. Whether the Inquiry should have the power to make recommendations.
v. The types of evidence the Inquiry should consider.
vi. The background of the Inquiry Chair.
vii. The types of support that should be offered to patients and their families,carers, and friends throughout the Inquiry process.

34. All contributions to group discussions, individual responses, and group submissions were considered in full, and a wide range of topics were covered. A report entitled '*Report on the Engagement with current and former patients, families, and carers regarding The Terms of Reference of the Public Inquiry into Muckamore Abbey Hospital'* was produced by the PCC. The report summarised the views that patients, families and carers shared with the Patient and Client Council. It did not lay out the specific details of each response, but rather outlined the key themes that emerged from patient, family, and carer responses on the whole.

35. This report was shared in draft format with all those who contributed to the engagement process to ensure that it reflected the views they expressed during the engagement process. The report was amended to reflect feedback received and to incorporate any additional information provided. The PCC has provided to the Inquiry supporting documentation relating to the engagement process and related casework including all written submissions received.

36. Feedback on the report was received via email and phone from 14 relatives, carers, and advocates. Whilst feedback on the extent to which the content of the report reflected their views was positive, several carers shared that reading it was emotionally difficult or asked for further clarification about next steps in the Inquiry process.

37. The final report was submitted to Minister Swann and the Department in March 2021 and was published to the Department's website in June 2021 (Inquiry Reference PCC - B - 00041P). The PCC also produced an easy-read and audible version of the report.

38. The engagement work regarding the Terms of Reference of the Public Inquiry led to additional advocacy casework and work related to safeguarding. The PCC's advocate assisted patients and carers to raise historic and/or ongoing adult safeguarding concerns in the hospital and the community, and provided ongoing advocacy support to patients and carers throughout the adult safeguarding investigation process. In the period November 2020 to July 2021 the PCC advocate escalated 25 cases to the relevant Trusts for safeguarding investigations and attended 33 meetings in relation to safeguarding investigations/SAIs.

39. Over the course of 2021-22, the PCC's designated advocate for Muckamore Abbey Hospital (MAH) provided individual advocacy support to 4 current MAH patients, and 16 former patients and their carers. This included supporting carers and patients with: formal and informal complaints proceedings, information requests, NIPSO complaints, and Serious Adverse Incident Reviews in relation to developments in the hospital and community settings.

40. In addition to complaints and adult safeguarding work, the PCC advocate assisted service users and carers to become involved in care planning for individuals who were moving from hospital to community settings or who had experienced a breakdown in care in the community.

41. Outside of individual advocacy work, the PCC's advocate supported family engagement at the Muckamore Carer's Forum, which took place monthly until October 2021, and every six weeks thereafter. They also worked closely with the Belfast Trust's Carer Involvement and PPI Lead for Learning Disability in order to promote alternative methods of carer involvement in Muckamore Abbey Hospital, including an information session in which carers shared their views on the hospital with RQIA inspectors in December 2021.

Beyond Bamford

42. In 2020 the Department of Health set out the strategic direction of travel for Mental Health including a Mental Health Action plan, appointment of a Mental Health Champion, preparation of a new 10 year strategy, and recognised the impacts of COVID 19 to be addressed as follows;

    i. The recent Department Mental Health Action Plan has set out specific responsibilities for Patient and Client Council (PCC) in section under 'Enhanced user involvement… *.....to enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning. The envisaged action includes:*
    ii. To embed co-production in all service improvement processes
    iii. To create a regional service user and carer structure and ensure that processes are in place to support this by restructuring the Bamford Monitoring Group (the latter includes consideration of the role of the Patient and Client Council and the Bamford Monitoring Group as well as a new terms of reference and name for Bamford Monitoring Group).

43. In the 2021/2022 financial year, the PCC proposed a reconfiguration of the existing operational model under the Bamford Monitoring Group (BMG) funding

allocation, with a move to a more constructive model aligned with the emerging policy directives which it supports. This reconfiguration of funding and model PCC was entitled 'Beyond Bamford'. The reconfiguration resulted in the development of three distinct areas of work; mental health, learning disability and an independent public advocate in relation to mental health and learning disability, including in relation to the Muckamore Abbey Hospital Inquiry.

44. This new approach included the introduction of a **'**Beyond Bamford' Coordinator who will oversee, implement and lead on Learning Disability and Mental Health work programmes and establish an engagement platform for both Learning Disability and Mental Health.

45. In the period April 2021 – Jan 2022, the Beyond Bamford Coordinator held 8 Mental Health-themed engagement platforms & 12 Learning Disability themed engagement platforms with both families and service users.

PCC Funding and Resource

46. The PCC is an Arm's Length Body (ALB) of the Department. The Chief Executive of the PCC is the accounting officer for the organisation and PCC is directly accountable to the Department for its use of resources and the discharge of its functions.

47. The PCC is a small organisation in the context of the Health and Social Care system, currently operating with a budget of £1.9m in 2022/2023 with 34.9 Whole Time Equivalent (WTE) staff posts serving the needs of a population of approaching 1.9 million people in Northern Ireland.

48. The PCC budget had reduced significantly over a 7-year period from £1.804m (2012/13) to £1,435,984 in 2019/20. To set this in context, this represented a reduction of circa £368,000 over that seven-year time period without taking into consideration inflationary costs. The expected increases in line with inflation were circa 2% each year, thus in net terms the expected PCC budget allocation in 2019/20 was worth 40% less than the 2012/13 allocation. This level of funding requires us to exercise a great deal of prudence in terms of resource allocation and means we take a highly evidence-based approach to designating resource given the opportunity cost of dedicating resource on a challenging budget.

PCC Accountability Arrangements

49. The accountability arrangements for the PCC are the same as those for all other Department ALBs including for example Health and Social Care (HSC) Trusts and the Regulation and Quality Improvement Authority (RQIA). The relationships between ALBs and their sponsoring Departments are managed under Department of Finance Guidance – Managing Public Money Northern Ireland (MPMNI). The Chief Executive of the PCC is appointed as Accounting Officer for the organisation by the Permanent Secretary of the Department. The Permanent Secretary is ultimately responsible for the expenditure of the Department and all of its ALBs. The relationship between the Department and its ALBs is described in a 'Framework Document[4]' which was produced by the Department itself, to meet a requirement of the 2009 Act, and which has been subject to updates by the Department.

50. The specific relationship between the PCC and the Department is governed by a Management Statement which describes the role of the PCC and within the PCC the roles of the PCC Chair, PCC Council (Board) and the PCC Chief

[4] HSC Framework Document

Executive. The Management Statement also describes the role of the Department including the role of the Permanent Secretary in the Department. The Management Statement, which is produced to comply with the requirements of MPMNI, has been subject to some updates over the past thirteen years.

51. The PCC produces its annual report and accounts which once approved by the PCC Council (Board) is submitted to the Department and then laid before the Northern Ireland Assembly. The PCC also participates in mid and end year accountability meetings with the Department. These are normally organised through the Department's sponsor branch for the PCC. The Annual Report summarises the PCC's main achievements and work undertaken in the previous year. It would also describe 'control issues' which are issues which have arisen and for which additional steps need to be taken. There is no evidence in PCC annual reports (or in other Governance documentation) of control issues having arisen specifically in relation to Muckamore Abbey Hospital.

Role and responsibilities – an evolving picture

52. The 2009 Act dissolved the four Health and Social Services Boards (Northern, Southern, Eastern and Western) and the four Health and Social Services Councils (Northern, Southern, Eastern and Western), which were created under 1991 legislation and ceased to exist at the end of March 2009. The four Councils were not in their own right ALBs of the Department. Instead each Councils was embedded in its respective 'Host' Health and Social Services (HSS) Board. The Chief Executives of HSS Boards were also the accounting officer for their respective Health and Social Services Councils ultimately responsible for the proper use of resources by the Council for which they discharged this Accounting officer role. Health and Social Services Council

employees were recruited, paid and performance managed through the systems established by their host HSS Board.

53. The 2009 Act refers to a 'scheme of transfer' which governed the transfer of staff and assets from the legacy councils to the PCC. Under this arrangement a number of staff from the four Health and Social Services Councils were appointed to positions within the PCC on 'protected' Terms and Conditions. However, the functions of the PCC were wider ranging than those of the Health and Social Services Councils and the PCC succeeded rather than replaced the four Health and Social Services Councils (HSSCs). It was also left to each of the four individual Health and Social Services Councils to determine what records and documents they should transfer to the newly established PCC. This accounts for the disparities in what records the PCC inherited from each of the Health and Social Services Councils. A short paper describing the HSSCs and their role is enclosed – exhibit VM/1.

Statutory Functions

54. The PCC is a regional body which means that its' remit with regard to its statutory functions is Northern Ireland-wide. The PCC has local offices in Belfast, Lurgan, Omagh and Ballymena and as indicated previously its statutory functions under legislation are set out as follows:

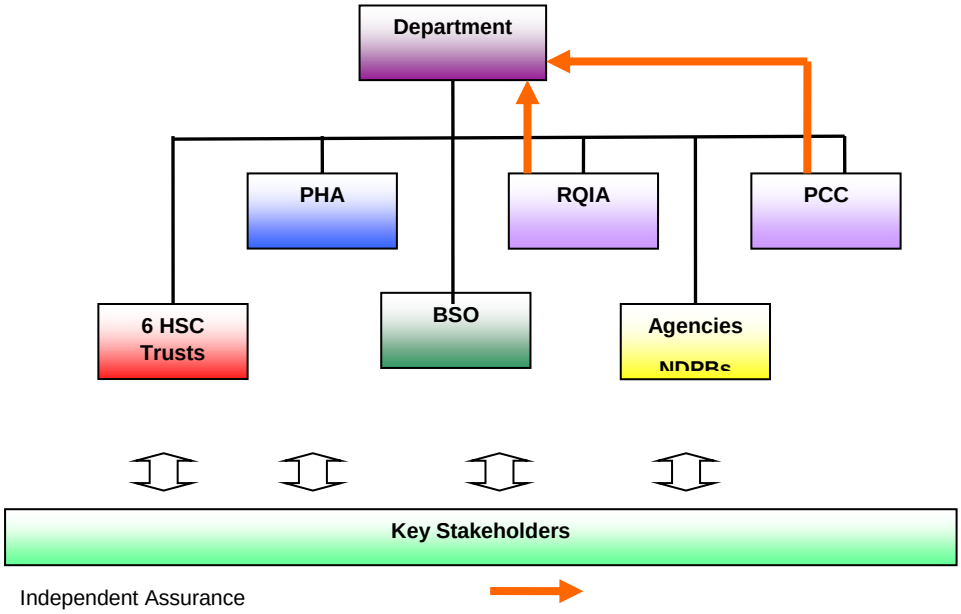
(a) representing the interests of the public;
(b) promoting involvement of the public;
(c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

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

55. The PCC has a role in consultations and in supporting the involvement of patients in consultations. The PCC also has a function of undertaking research into the best methods of involving the public.

The Structure of the Health and Social Care Sector in Northern Ireland

56. The structure of the HSC is described in the Department's Framework Document[5] as follows:



Key: PHA= Public Health Agency

BSO = Business Services Organisation

RQIA = Regulation and Quality Improvement Authority

PCC = Patient and Client Council

[5] HSC Framework Document

57. Agencies/NDPBs includes Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency), Northern Ireland Social Care Council, Northern Ireland Fire and Rescue Service (NIFRS) and Northern Ireland Practice and Education Council.

Statutory Functions, Learning Disabilities and Mental Health

58. We consider it helpful for the Inquiry to understand how the PCC executes its statutory functions in practice with respect to learning disabilities, mental health and Muckamore Abbey Hospital specifically where appropriate. It should be stressed that the PCC work in the area of learning disabilities was often also equally applicable to mental health and it is not always practical to separate out these two as separate work streams. Services provided to patients and families at Muckamore or with a connection to Muckamore formed a part of this larger work stream, flowing from our work in the area of Mental Health and Learning Disability more generally. From our understanding of a review of available documentation relating to the period pre-2019, this was the case until the introduction of a dedicated resource related to Muckamore Abbey Hospital, as set out in paragraph 23 of this statement.

59. Consistent with its role and functions the PCC had from its establishment in April 2009 engaged extensively with stakeholders on both how PCC should best discharge its functions and in reviewing or evaluating how well the PCC has discharged its functions. The PCC has also undertaken research to try to establish how effective it has been in influencing priorities and services in the HSC.

60. These reviews, evaluations etc. have routinely included seeking the views of stakeholders representing service users as well as providing opportunities for

individual members of the public to input to a number of these pieces of work. These engagements will have included one or more of: offering stakeholders the opportunity to make written submissions; workshops; roadshows; conferences; focus groups and surveys. Reports of each of these pieces of work are submitted to the PCC Council (Board) as either 'Board' or 'Information' papers. In addition, the functions and governance of the PCC have been subject to regular audit by the Business Services Organisation Audit Team.

61. The mechanisms for how PCC gather feedback from those who have sought PCC assistance with making a complaint or who have engaged with PCC, have changed and evolved over time, as has the consistency with which such mechanisms have been implemented.

62. Examples of Information and Board papers held by the PCC which demonstrate the PCC's approach to seeking feedback include:

- **August 2010**: A 'Are You Being Heard' Workshop held in June 2010 asking service users and families a) How can we make sure people with Learning Disabilities get their voices heard? b) How can families, carers and organisations who support people with Learning Disabilities tell us what is happening in their area? What do you think are the most important issues we need to think about? And How can we let you know what the Bamford Monitoring Group is doing?

- **August 2010**: Focus Groups on the PCC membership scheme to seek their views on the development of the scheme.

- **December 2011**: The PCC developed an advocacy toolkit 'SOMEONE TO STAND UP FOR ME?' in collaboration with representatives from 4 care homes for older people, the SHSCT, Alzheimers' Society and also input from RQIA and a mental health advocate. The Toolkit was piloted

and evaluated by 8 care homes in the Southern Area who used the Toolkit with their staff teams over a period of 3 months. There was also support from the Voice of Young People in Care (a specialist advocacy organisation), RQIA, the DHSSPS Older People's Nurses' Forum and the SHSCT Care Home Forum.

- **January 2012**: Report on feedback from PCC Roadshows. "The overall response from those attending the events was positive and some constructive suggestions were made. Feedback shows that people value the opportunity to discuss issues with key decision makers and want more events like the roadshows to take place. People wished to see a greater attendance from members of the public and more time allowed to debate important issues."
- **December 2012**: Information paper – Evaluation of PCC Roadshows. The evaluation report included results from a survey of roadshow participants which showed that 57% knew how to make a complaint about HSC services, 30% did not and 13% were not sure.

- **September 2014**: Review of PCC projects. This paper looked specifically at three PCC reports, 'Peoples Priorities', 'Care When I Need It' and 'The Painful Truth', in order to assess the impact and influence on change at a policy level, through commissioning and/or a service level.

- **January 2015**: Evaluation of PCC roadshows 2014.

- **March 2015**: Review of PCC Membership Scheme.

- **March 2016**: People's experiences of the HSC complaints process. The focus of the report is on people's experience of how the HSC responds when complaints are made. The report was a source of information for the PCC on how it might work with Trusts to try to ensure they improve the experience of complainants.

- **September 2016**: Experience of children and young people making a complaint about Health and Social Care (HSC) services. The PCC engaged with several community-based organisations who advocate on behalf of children and young people.

- **March 2018**: Follow up on PCC Projects. The report followed up on five PCC Projects: A) the care experience of people with Dementia. B) the experience of families engaging with social workers. C) the experience of people waiting longer than Ministerial waiting time targets. D) Residents' experience of care in nursing homes. And E) Carer's assessment for carers of people who have a mental illness and/or a learning disability. The review of the Carers Support and Needs Assessment (CSNA) included three panels and eight one to one interviews were set up with carers of those with either a mental illness and/or a learning disability. The purpose of these panels / interviews was to explore carers views on the CSNA process and find out if improvements have been made since the previous report was published.

Practice Methodology 2009-2019

63. Advocacy for the PCC meant working with or for patients, clients and carers to achieve change in health and social care. As defined in a 2009 paper[6] to the PCC Council (Board), in practice this meant that PCC Officers providing:

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

[6] Inquiry Reference PCC - H - 00447 - Complaints Report

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

65. Based on a review of available records and the Complaints Support Service Handbook that was in existence, the PCC approach to advocacy and complaints support pre-2019 was predominantly administrative. As set out in the Complaints Support Service Handbook (2015) for the organisation, the role of PCC Complaints Support Officers as advocates were described as follows:

> *'Activities as an Advocate*
>
> *The specific activities of the Complaints Support Officer in support of clients are described in the HSC Complaints Process – Standards and Guidelines and include:*
>
> - *providing information on the complaint's procedure and advice on how to take a complaint forward*
> - *discussing a complaint with the complainant and drafting letters*
> - *making telephone calls on the complainant's behalf*
> - *helping the complainant prepare for meetings and going with them to meetings*
> - *preparing a complaint to the Ombudsman*
> - *referral to other agencies, for example, specialist advocacy services*
> - *help in accessing medical/social services records'*

66. In 2009 the PCC was tasked with a new role of providing support to the Bamford Monitoring Group. This role is specifically relevant to MHLD services

including to issues such as resettlement from Muckamore. The detail of this role is described in a paper submitted to the PCC Council (Board) in April 2009[7]. Further updates on the Bamford Monitoring Group were provided to the PCC Council (Board) in April, August and September 2010; January and August 2011; and March 2015. Other updates were provided more regularly as part of papers etc. covering the wider functions of PCC.

67. As set out earlier in this statement, we can find no evidence of a defined role or focus in PCC regarding Muckamore Abbey Hospital prior to the dedicated resource introduced in late 2019.

68. As set out at paragraph 47- 48 of this statement, the PCC is a small organisation in HSC terms, with a budget that had reduced significantly over a 6-year period from 2012 to 2019, starting the year 2019/2020 with a Budget Allocation that was worth 40% less than the opening 2012/13 allocation. The geographical remit of the PCC is all of Northern Ireland, across the breadth of health and social care. This presents challenges in managing competing priorities and defining the scope of roles within constrained resources.

69. In late 2019 additional resource allocation allowed the PCC to dedicate resources to Muckamore and as noted, the organisation was on the cusp of implementing a new practice model.

Practice Methodology Post-2019

70. With the implementation of the recommendations of the 2019 organisational review, work was undertaken from late 2020 onwards to redesign the practice model of the PCC. This involved redesigning the methodology of how the PCC

[7] Inquiry Reference PCC - H - 00754 - Bamford_Board paper April 27

supported members of the public who came to the PCC with issues they experienced in health and social care and how the PCC engaged the public regarding health and social care. The implementation of this new practice model and methodology has been an iterative process since its redesign in 2020 and has necessitated, and been supported by, other aspects of the organisational review (job redesign, staff restructure etc.). Implementation of this new practice model and methodology has also necessitated the development of new policies and procedures, and training of staff.

71. The practice model and methodology, implemented from late 2020 onwards is set out below:

Advocacy

72. Our 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[8] (the official government website for Northern Ireland citizens), within the HSCNI Complaints Procedure, within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support, on the PCC website, social media platforms and in literature shared by PCC.

73. Our focus is on seeking early resolution of issues through facilitated conversations, signposting and 'supportive passporting' to appropriate services to meet immediate need.

[8] Patient and Client Council | nidirect

74. Where immediate early resolution cannot be achieved our advocacy and support carries through to individual and group advocacy casework. In some cases, this *support* and advocacy will, of necessity, progress to formal complaint processes. This can include the provision of independent advocacy services within SAIs (serious adverse incidents), and Public Inquiries.

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

Engagement

76. PCC engagement structures provide the public with a range of opportunities to get involved according to their interest in health and social care, across different levels of complexity. The foundation for our *engagement* is our PCC Membership Scheme for those interested in regular updates about more general information and developments in health and social care. The membership of the PCC Membership Scheme currently numbers approximately 8,000.

77. This base 'keeping in touch' engagement with PCC and health and social care is enhanced at the next level with our *PCC Citizen Hubs,* which offer a more interactive and two-way process for engagement. PCC Citizen Hubs operate in each of the Trust areas. They provide an opportunity for involvement locally, embedding a 'network of networks' approach at a local Trust level by providing a forum for network development, regular updates, connections, discussions

and capacity building. PCC Citizen Hubs are advertised through the PCC Membership Scheme, on the PCC website, across social media platforms and by direct email invitation to the local network contact lists (comprising of statutory, voluntary and community sector organisations and interested individuals within the particular Trust area).

78. At the next level, the focus of the work becomes more subject-specific. Our PCC Engagement Platforms offer the opportunity to engage in theme-based, task-oriented work at a more strategic level, with representation from the public, as well as the health and social care, and voluntary and community sectors. The intelligence we gather about what the public tells us about health and social care, the issues and concerns they need support with, and the policy initiatives they want to impact and influence, formulates and guides the policy influencing work.

79. The PCC Council is the board of the Patient and Client Council. It sets the strategic direction of the organisation as a whole, informed by the intelligence of the engagement, advocacy and policy advocacy work and the wider public voice**.**

Key Officials – PCC and HSS Councils

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

81. Health and Social Services Council members were appointed by the Department. Council staff were employed through host Health and Social Services Boards. The PCC does not have records of Council members and staff. However, it would be possible to identify the names of some Council

members and staff using minutes of Council meetings for the Northern HSS Council (2005 to 2009) and the Eastern Council (1993 to 2009). There are also a small number of minutes of four Council Chief Officers and complaints managers meetings which identify names of participants.

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

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

Post	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Western Area Manager	Vacant	Maggie Reilly	Maggie Reilly	Fiona McCourt						
External Relations & Policy Manager	New post created				Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick	Joanne McKissick
Involvement Manager	New posts created					Jackie McNeill	Jackie McNeill	Jackie McNeill	Jackie McNeill	Margaret Anderson
Complaints Manager						Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon	Richard Dixon
Advice & Information Manager	New post created				Deepak Samson	Deepak Samson	Deepak Samson	Deepak Samson	Deepak Samson	
Research Manager	New post created				Vacant	Vacant	Susanne McKenna	Susanne McKenna	Susanne McKenna	Susanne McKenna

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

Relationship with patients

83. The PCC policy on involving patients is called 'Involving You' and is dated December 2012 and following public consultation was approved by the PCC Board in March 2013[9]. The policy provides a guide on how the PCC involves people in its work. It describes a range of techniques that PCC use to ensure its work is inclusive, innovative and makes a difference. The policy was reviewed in 2016 and approved again by the PCC Board in January 2017[10]. The policy was shared with the Board again in April 2018[11] before being submitted to and again agreed by the Board in September 2018[12].

84. The PCC established a membership scheme in 2010 which at its peak had over 15,000 members. In 2017 the PCC commissioned "The Democratic Society" to undertake a review of the scheme[13].

85. Since 2009, the PCC has undertaken research and regularly organised a wide range of both engagement and consultation events which were open to the general public as well as to voluntary and community sector organisations representing and advocating on behalf of different groups and populations of service users.

86. As part of the discharge of its functions the PCC has led or participated in a wide range of projects, engagements and research since 2009 as well as

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[9] Inquiry Reference PCC - H - 00354 - Board Paper No. 207 PCC Policy-Involving You Cover Sheet Inquiry Reference PCC - H - 00490 - Information Paper-Consultations request list 2012-13

[10] Inquiry Reference PCC - H - 00490 - Information Paper-Consultations request list 2012-13

[11] Inquiry Reference PCC - H - 00515 - Paper Emailed to the Board-PCC Involving You Policy

[12] Inquiry Reference PCC - H - 00423 - Board Paper No. 534 Involving You Policy

[13] The document is called 'Board Paper No. 493 PCC Membership Scheme Report' and can be provided on request

providing complaints and advocacy services to individual and groups of families, carers, patients and service users. To assist the Inquiry the PCC has reviewed the records PCC holds and identified any complaints relevant to Muckamore Abbey Hospital Public Inquiry from 2009 until 2022. PCC took a broad view of relevance based on the Terms of Reference for the Inquiry. The PCC has forwarded to the Inquiry the documents which PCC holds about each of these complaints.

Review of complaints relevant to the Inquiry

Casework on the PCC Alemba system 2012 – 2022

87. From 2012 PCC implemented a case management system called 'Alemba' to record case files in relation to complaints referred to the organisation.

88. A review of 236 cases on the Alemba system, which were recorded as being referred to the PCC for support during the period from 1/1/2012 until the date of the review at 16/3/2022, was undertaken. These cases were identified using a broad key word search, based on the Terms of Reference of the Inquiry.

89. Within the review of these 236 cases 33 referrals were specifically related to Muckamore Abbey Hospital. In all of these 33 cases there was evidence of PCC follow up on the referral and where appropriate through to other agencies. In many of the case files there was evidence that families had sought the support of the PCC in relation to a previous complaint made to a Trust and surrounding their loved one's care and treatment in Muckamore Abbey Hospital. The records in these case files provide evidence of requests for support by the PCC from families who had fears and anxieties about the

provision of care by Muckamore Abbey Hospital often alongside their engagement in complaints processes with respective Trusts.

Health and Social Services (HSS) Council Casework Pre-2009

90. The PCC is also in possession of a number of case files transferred from the legacy Health and Social Services (HSS) Councils when PCC was set up in 2009. A review of all hard copy case files held by PCC from the legacy HSS Councils was undertaken as part of PCC's document review related to the Inquiry. Hard copy case files that fell under the categories of Mental Health, Learning Disability and Muckamore Abbey Hospital were identified for submission to the Inquiry.

91. The number of hard copy case files from the HSS Councils identified across these categories numbered 52. These contained individual case records pertaining to individuals referred to the relevant HSS Council and therefore contained cases from across all areas of Northern Ireland. From the review of all the above 52 files, 33 Cases were within the Mental Health Category and contained information which identified issues of concern relating to the provision of care to individuals by Mental Health Teams or In-Patient Care and Treatment in Hospitals across different localities in Northern Ireland. The nature of these complaints includes alleged assault/sexual assault while an inpatient, restraint, care and treatment.

92. Within the 52 cases reviewed 4 cases were complaints specific to Muckamore Abbey Hospital. Issues identified pertaining to Muckamore Abbey Hospital include complaints about inpatient care and treatment, alleged maltreatment of a loved one and lack of continuity of care.

93. The final category within the file review of casework from the HSS Councils was Learning Disability and a total of 15 Cases were reviewed. The reasons for referral identified in the majority of cases related to the care and treatment by a range of day/residential care providers many of which are named on the files. A number of complaints refer to alleged abuse and management of finances within specific care institutions.

94. In summary this review involved an analysis of 52 hard-copy case files, 33 of which were related to Mental Health Services, 4 related to Muckamore Abbey Hospital and 15 were related to Learning Disability Services, primarily care providers. The areas of concern which were evidenced in files as being the source of complaint were care and treatment, particularly inpatient care in Mental Health Hospitals, Day and Residential Units for Learning Disability and complaints regarding alleged abuse.

95. There is an absence of information on some of these records which would evidence the HSS Council (and latterly PCC's) implementation of relevant safeguarding procedures or specific actions on the follow up of information received with relevant agencies. While some files were substantive and held clear records of HSS Council/PCC engagement and follow up, many files contained little information and held only a single referral form or illegible written notes. The review identified the absence of a standardised recording practice across the region and there were vast variations on what and how actions were recorded. In many cases there was a lack of clarity on purpose or role for the involvement of the HSS Council/PCC or evidence of decision-making processes and follow up within casework practice.

PCC – Issues of concern from Research

96. To assist the Inquiry the PCC has reviewed records PCC holds from consultations, engagement and research events to identify any material which highlights issues or concerns relevant to Muckamore Abbey Hospital. This review covered records of discussions at individual focus groups and

conferences as well as questionnaires completed by patients, clients and families.

97. Examples of engagements and research led by or involving PCC include research targeted at identifying HSC priorities for the Department and for HSC Bodies such as 'The People's Priorities' research undertaken by PCC in 2010, 2014 and 2016. This is an example of one of the many generic pieces of research conducted by the PCC which was open to the entire population and all stakeholders including voluntary & community sector organisations and any other group representing stakeholders to contribute to. Other pieces of PCC research have focussed specifically on particular groups of service users or specific services e.g. carers, young people and end of life care. This also includes research and engagements focussed specifically on Mental Health and Learning Disability services provided in both Community settings and in institutions as such Muckamore Abbey Hospital. Examples include Resettlement/Life After Hospital (2013), What Matters To Me (2015), Disability Priorities (2015), Carers Assessments (2017).

98. The PCC has reviewed records of these engagement events, consultation events, focus groups and surveys to find any records of concerns being raised in relation to Muckamore Abbey Hospital. As a result of this search records have been identified in relation to two pieces of research through which concerns were raised in relation to Muckamore.

99. The first piece of research was published on 13th August 2013 and the final report was called "Life after living in hospital - The experiences of people with a

learning disability."[14] The second piece of research was published in October 2015 and was called "What Matters To Me? - Service users' and carers' views on learning disability services."[15]

Life after living in hospital - The experiences of people with a learning disability

100. This research involved interviews with 15 people with a learning disability and 2 family members who told PCC about their experience of resettlement from hospital and into a community setting. Participants in the research were former patients/carers from Muckamore Abbey Hospital in the Belfast Trust area and Longstone Hospital in the Southern Trust area. Interviewees were individually interviewed between one and three times.

101. The interview records highlighted a number of concerns about both Muckamore and Longstone some, but not all of which, were included in the final report. The records of these interviews have been provided to the Inquiry[16].

What Matters To Me? - Service users' and carers' views on learning disability services

102. This research was based on a number of focus groups which the PCC organised in conjunction with voluntary and community sector organisations. The report published in October 2015 covered what was referred to as ''Phase 2' of the research. As with the 'Life After Hospital' research the information

[14] Inquiry Reference PCC - B - 00053 - Life after living in hospital and PCC - H - 00351 - Board Paper No. 195 Resettlement, Life after living in hospital

[15] Inquiry Reference PCC - B - 00062 - What Matters To Me Final Report

[16] PCC DP submission under S21 and Rule 9, deadline of 31 January 2023

gathered through these focus groups highlighted a number of concerns about Muckamore some, but not all of which, were included in the final report.

103. The records of these focus group have been provided to the Inquiry. However, according to the final report, one of the focus groups listed as having taken place is the “Downs Syndrome Association Support Group”, but there does not appear to be a record of that focus group discussion.

104. The origins of the ‘What Matters To Me’ research dated back to late 2012. A number of focus groups were conducted in 2012/13 and multiple questionnaires were completed by patients and carers in 2013. This research data was collected prior to the phase 2 research. The information collected as part of these earlier focus groups and through these questionnaires highlighted a number of concerns which were not published in any report. The records of these earlier interviews and questionnaires have also been provided to the Inquiry

105. Both the ‘Life After Hospital’ and ‘What Matters To Me (Phase 2)’ reports were published[17] and, based on a review of the project communication plan, widely circulated including to the Department and Trusts[18].

[17] Link to Belfast Telegraph article following the publication of ‘Life After Living in Hospital’ report Patient treated 'like a prisoner' | BelfastTelegraph.co.uk and press release on report launch for ‘What Matters to Me?’ including launch event (Inquiry Reference PCC - H – 00528)

[18] Communication Plan for ‘What Matters to Me’ report (Inquiry Reference PCC - H – 00527)

106. The PCC are unable to track, which, if any, of the concerns highlighted through these two pieces of research were subsequently raised as complaints or as would seem appropriate in some cases, as safeguarding concerns. However, when the What Matters To Me report was discussed at the PCC Board meeting in October 2015 the minutes record the following:

> *"The objective of this project was to gain a clearer understanding of the learning disability services from the perspective of service users and carers'.*
> *Dr Edmondson asked Members if they agree that the conclusions reflect the data available in the report and if the recommendations made are based on these conclusions.*
> *Members agreed that this is an important piece of work but that it is 'the tip of the iceberg'. As the sample size was limited Members agreed that the PCC should carry out a review to identify what local evidence is available to support the findings in the report as major work is done on learning disability services by some of the voluntary and community sectors that specialise in this area."*
>
> *AND*
>
> *"On discussion Members agreed: The recommendations but asked that it be made clearer that the issues identified are the 'tip of the iceberg' with more work needed by the HSC system.!"*

PCC Engagement with Stakeholders

107. The PCC has undertaken a wide range of work in relation to specific projects since 2009 in line with the functions described in the 2009 Act and involving engagement with the public, service users, families and patients. Some examples from the PCC's early years are a) the Bamford Monitoring Group (2010 onwards) and b) 'Transforming Your Care' Review of Health and Social Care in Northern Ireland (2011). More recent examples include PCC

work in relation to c) Work undertaken with patients and families in Muckamore Abbey Hospital in the lead up to the current Public Inquiry (2019 onwards) and d) work undertaken by PCC in relation to Covid-19 including specifically in relation to the Clinically Extremely Vulnerable groups and Care Home residents.

108. Throughout its existence the PCC has regularly engaged with individual members of the public, with families, carers and with groups and organisations (most often from the voluntary and community sector) representing particular groups of stakeholders, service users or families and carers. This engagement has often taken the form of research usually conducted through workshops, focus groups and surveys.

109. The PCC has also engaged with the same groups as part of conferences, roadshows, consultations, reviews and evaluations. These engagements may be as part of the PCC's role in supporting the involvement with the development of policy or the setting of priorities by the Department or one if its ALBs. They may also be as part of work to set the PCC's own priorities, develop methodologies to underpin the discharge of its functions or to review or evaluate the work of the PCC. The PCC understands that in the course of any of these engagements' individuals, families or groups may raise specific issues or complaints about HSC services which need to be addressed. In some case these issues and concerns may be raised as part of discussions. In other cases, PCC staff are approached after the conclusion of an event when those raising the issue or complaint wish to do so privately. When these issues or concerns are raised PCC staff will record the details. Historically PCC staff used pre-printed cards to record the details of issues or complaints raised including the contact details for the person raising them. These cards were then forwarded to PCC Complaint Services Officers (PCSO) for action.

110. For research projects which included the running of focus groups there is evidence that the PCC team would draft guidelines for PCC staff which would include information on what action to take if an issue or concern is disclosed by a participant. The guidance for 'What Matters To Me' (2014) for example stated "Where an individual identifies a current issue which needs resolved, the PPI officer will record the details on a comment / complaint card and will ensure that a PCSO officer is informed as soon as possible. The individual should be provided with approximate timescales for returned contact with the PC."

111. Discussion with the current PCC staff who participated in different events at that time confirms that this was the approach with which they were familiar and that they used pre-printed cards to record the details of the issue or complaint.

112. The PCC Board approved an 'Escalation Procedure[19]' in April 2009. Over the following years guidance for PCC staff running consultation or focus groups prompted staff to raise issues and complaints with PPI officers. There is no indication that the April 2009 escalation procedure featured in this subsequent guidance on handling complaints/issues.

113. In addition to organising and participating in a wide range of events, both generic and focussed on the MHLD sector, the PCC established a membership scheme which at its peak had 15,000 members. The membership scheme has proved to be an important resource in seeking the views of the general public as part of e.g. consultations and research; disseminating information and also in identifying members of the public who can participate as service users on e.g. policy formulation, review and implementation groups established by the Department or any of its HSC Bodies.

[19] Inquiry Reference PCC - H - 00525 - PCC_Escalation_Procedure

Engagement Muckamore – Pre 2019

114. The PCC Board visited Muckamore Abbey Hospital in November 2009. The Board had received presentations from both the Society of Parents and Friends of Muckamore and the TiLLi groups (representing families and patients from Muckamore at a Board meeting in September 2009. The documentation suggests that these engagements were focussed on the ongoing programme of resettlement rather than the adequacy or quality of the ongoing care provided in the institution. The Chief Executive provided an update to the PCC Board in August 2009 in which she stated:

> *"In September we will focus on the resettlement programme of patients with learning disabilities, who have been long-stay residents in hospital. Importantly resettlement in the community is in the spirit of the Bamford Review, of social inclusion and human rights. We will be inviting along people who have been working with and are involved in the programme. They will be describing some of the progress to date and some of the obstacles to this initiative."*

115. The PCC Board considered a paper on resettlement at its December 2009 meeting. The focus of the PCC Board included 'balancing rights'[20] between patients and their carers and between those who wish to be resettled and the concern of some families who did not want their loved ones to be resettled from Muckamore Hospital and into the community. The December paper[21] reflects feedback from some families on the 'high standard' of care being provided in Muckamore.

[20] PCC Board minutes 15 December 2009 (Inquiry Reference PCC – H – 00449)

[21] PCC Board minutes 15 December 2009 (Inquiry Reference PCC – H – 00449)

116. After these meetings took place and this discussion paper was presented to the PCC Board, prior to 2019 there is no obvious focus at PCC Board level on direct engagement with Muckamore patients and families. However, by 2010 the Bamford Monitoring Group (BMG) had been established, supported by the PCC, and discussion at the PCC Board level was focussed on reports of the progress of the BMG.

117. Mental health and Learning Disability services is unique in that this was the only service for which the PCC was resourced by the Department to provide a dedicated focussed service, through the BMG. Whilst the PCC sought to generally influence the Department's priorities through engagement with the public about the Department's annual 'Priorities for Action' plan, the BMG was able to target its efforts on influencing priorities for mental health and Learning Disability through the Bamford implementation project. The implementation of the Bamford recommendations was overseen by an Inter-Departmental Group led by the Department and the Bamford Action Plan was submitted to the Northern Ireland Executive in late 2009.

118. The Bamford Action Plan and therefore the work of the BMG was focussed on both Mental Health and Learning Disability and this is reflected in the BMG work programme, the events it organised and its engagements with stakeholders. Within the programme of work progressed through Bamford implementation the provision of care through Muckamore and similar institutions was only one element. Even then the focus on these institutions including Muckamore tended to be on the resettlement of patients out of institutions and into the community. This is also reflected in the Department's Priorities for Action targets from around the years 2011/12.

119. The BMG organised a number of events and conferences focussing on Mental Health and Learning Disability e.g. the 'Our Stories' conference held on Friday 26th November 2010 with over 120 people with a learning disability, parents and carers in attendance. The BMG also produced its own reports including for example 'The Bamford Monitoring Group…Our Journey So far' in September 2010. There does not appear to be any evidence or documents (other than the Life After Hospital research) which highlight concerns being raised about the care provided in Muckamore Abbey Hospital of the type being considered by the Inquiry. The BMG also provided its own input through the PCC to consultations issued by the Department and HSC bodies.

Department for Health

120. The PCC is an Arms Length Body of the Department. This means that the PCC is accountable to the Department for how it uses its resources and how well it delivers on its functions. However, the PCC has a high degree of being operationally independent of the Department of Health and is wholly independent of all other HSC bodies. The Chief Executive is accountable to the PCC Council (Board). The Chair of the Council and its members are appointed by the Minister of Health and they are accountable to the Minister for how the Council discharges its oversight responsibilities within the PCC.

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

122. The PCC has twice yearly accountability meetings with the Department. As an ALB of the Department the PCC Management team have on occasions given evidence to the NI Assembly Health Committee.

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

Advocacy and Patient groups

124. The PCC has sought on an ongoing basis to establish and maintain relationships with the voluntary and community sector. Organisations which advocate on behalf of MHLD patients, carers and families would have been invited to be represented at engagement and consultation events. This would include events targeted at MHLD services and issues. It would also include events targeted at the wider Health and Social Care system e.g. identifying priorities or proposals to change Health and Social Care Services generally.

125. The PCC has employed the services of some of these advocacy groups e.g. ARC to support the participations of learning-disabled service users in PCC research e.g. Life After Hospital. PCC computerised records show that on some occasions complainants who approached the PCC regarding Muckamore were passported on to Bryson House, a voluntary sector advocacy organisation, which is commissioned by the Belfast Trust to provide advocacy services to patients in Muckamore Abbey Hospital.

126. The PCC has also historically signposted complainants to other organisations with expertise in human rights, equality and disability.

127. In recent years the PCC had identified a potential issue with advocacy services which arises from fragmentation and a lack of co-ordination of the advocacy services provided by voluntary and community sector organisations and the PCC. With specific reference to Muckamore the primary provider of advocacy services appears to be Bryson House who have a team of six advocates who spend part of their time at Muckamore and the larger part of their time in the community. Bryson House provided support as requested to all families/carers; to patients from the Belfast and South Eastern Trust (covering admission; stay and resettlement) and on an ad hoc basis to patients from the Western Trust. An advocacy service for Northern Trust patients is provided by Mindwise and for Southern Trust patients by Disability Action. In late 2019, PCC secured additional funding to establish the first dedicated advocacy post for patients and families in Muckamore.

128. There is also a patient self-advocacy group called 'Telling it Like it is' (TILLI) which is supported by ARC (Association for Real Change). TILLI has been in existence since before the creation of the PCC and was one of the first external groups to give a presentation to the newly formed PCC Board on 22 September 2009. The PCC Board received a power point presentation from TILLI. The group represented patients in the hospital who wanted to get out and live in the community and two patients from the group gave the presentations along with the Chair and Secretary of the Society of Parents and Friends of Muckamore Abbey, Mr P91 and Mr P92 The PCC has subsequently worked closely with ARC when undertaking research involving MHLD patients from Muckamore.

129. On 10th November 2009 the PCC Board visited Muckamore Abbey Hospital. During the visit staff gave them a presentation on the many challenges facing them at the time. Board members also met with patients' relatives and families.

PCC and MAH Pre 2019 – complaints mechanism, steps taken on receipt of a complaint, actions taken and outcomes

130. The PCC provides a support service to patients who wish to make a complaint about health and social care services. These complaints mostly arise through direct contact being made by a patient or their representative with the PCC. In many cases the patient will have been referred to the PCC by a member of HSC staff. 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.

131. In some cases a patient, carer or family member will raise an issue in the course of one of the consultation or engagement events organised or facilitated by the PCC. This may be in the course of the event itself and as part of group discussions. This can also happen after the event has concluded when PCC staff are approached by an attendee to raise an issue or complaint they have. In these cases PCC staff would record the details on an issues/complaints card and pass the details to a PPI officer or the complaints manager. However, it is not possible to separately identify these complaints, flagged up to PCC staff at events, from complaints raised directly with the PCC by telephone, email or letter.

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

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

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

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

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

136. The PCC Chief Executive and Senior Staff participated as members of some steering and implementation groups established by Department and the its Arms Length Bodies. An example is the implementation of the Bamford review recommendations were the PCC was represented on the implementation group led by the HSCB and the Inter Departmental Steering Group led by Department.

137. The PCC promoted and actively sought to identify the involvement of service users on groups established by Department and its ALBs. An example is the Bamford Implementation Group.

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

139. The PCC also sought to routinely influence the agenda and priorities being set by Department and ALBs by undertaking research, an example being work to engage with the general public to identify their priorities. This included 'People's Priorities' and 'Young People's Priorities' reports. The PCC also commissioned research into specific topics, services and issues. Some of these were aligned with the implementation of Bamford recommendations after the PCC assumed responsibility for supporting the work of the Bamford Monitoring Group (BMG). The PCC supported the work of the BMG in both assessing the implementation of Bamford recommendations and in seeking to influence Departmental priorities in implementing Bamford recommendations.

Reflections and lessons learned

Lessons Learned

140. We understand that the Inquiry will take a lessons learned approach and seek to make recommendations. To that end, reflecting on the experience and practice within the PCC commencing in October 2019 and the key messages from patients, families and advocates has informed the following suggestions on how to improve the support provided to families.

141. In summary we consider that the following actions would go a long way to preventing the miscalculations, missed opportunities and mistakes at Muckamore Abbey Hospital:

1. Developing an advocacy model that meets individualised needs;
2. Facilitating a centralised coordination of advocacy, that is designed to spot trends and patterns in complaints and act on them or refer them for action;
3. Understanding the importance and urgency of safeguarding and delivering the same at pace;
4. Improved training on and monitoring of complaints handling across the healthcare system.

Understanding advocacy

142. Advocacy support can and is provided to patients and families in Muckamore through a range of models, that is independent advocacy, peer advocacy, self-advocacy and family advocates. Critical to the successful promotion of and family engagement with advocacy services is to a large degree determined by the Trust's commitment to and investment in advocacy.

Listening and hearing people's experience is the first line of defence when safeguarding vulnerable people.

143. Trust's should invest in training for staff in:

- understanding the role of advocacy in safeguarding vulnerable people, the different 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

Co-ordination of advocacy service providers

144. In terms of the provision of advocacy to patients and families in Muckamore, the primary providers were third sector organisations with a patient self-advocacy group (TILLI) which is supported by ARC. The referral to a service was dependent upon which Health and Social Care Trust the patient resided in before admission. In contrast the PCC provide a regional service and thus can provide advocacy for all patients and their families.

145. This can present as a confusing landscape for the families and patients and requires co-ordination and facilitation of an independent forum, which is connected directly into each Health and Social Care Trust governance structures. The aim would be to:

- Collaborate with the existing advocacy service providers and to support them in their work with patients and families agreeing through a Memorandum of Understanding with each advocacy service provider how this collaboration will operate to the benefit of patients

- Hold regular meetings with Trust management on all aspects of their work and to guarantee the timely and sustained reporting of any and all issues, concerns, compliments and complaints received by the advocate in the course of their work
- Work with Trust management and with the current advocacy providers to develop an Advocacy Strategy for patients of Muckamore Abbey Hospital, their families and carers
- Voice and Choice. Patients and families require clear information about the advocacy services available, an introduction to the service and must be given space and time to choose how and which service they wish to avail of.

To leave matters as they are risks the persistence of the confused patchwork of advocacy and miscommunication which contributed to the failures at Muckamore Abbey Hospital.

Safeguarding

146. When engaging with families, particularly during the Terms of Reference, (Inquiry Reference PCC - B – 00041P**)** they described situations in which they felt that they were ignored when they attempted to alert hospital staff, regulatory agencies, and other authorities about their concerns regarding patient care and treatment in Muckamore Abbey Hospital. This pointed to how families and patients experienced trying to be heard and alerting safeguarding matters. Initial complaints may have been safeguarding matters and required a clear process and rapid response to address, which is different from the complaints process. Responding to safeguarding in a different way going forward would assist families to navigate the complexity of safeguarding investigations:

A. Families and patients require an understanding of the safeguarding process with a plain English leaflet and clear map of:

- Advocacy supports available

- how to raise a concern and who to contact
- what action should be taken by whom and when
- routinely monitoring complaints handling
- how to escalate concerns if they feel that they are not being addressed appropriately
- an appointed independent senior designated officer within the Trust who the family or advocate can contact if they experience challenges or concerns with the safeguarding investigation (see point C below)

B. Joint training with Trust staff and advocacy providers with regard to safeguarding procedures for children and vulnerable adults, ensuring that patients and families are fully informed and guided through the process.

C. A clear escalation process for safeguarding concerns being investigated in each Trust could be mapped out on one page to support patients, families and advocates to enact when they feel or experience challenges, blockage or delays in addressing their concerns. Appoint an independent senior designated officer who is not operationally responsible for the programme of care as the person to whom matters are escalated.

D. Families and patients require a feedback loop for understanding how the safeguarding matter is being investigated, how it has been addressed and what remedial measures or learning has been identified to prevent a repeat of similar incidents in the future.

E. Consideration needs to be given to how lessons learned from safeguarding incidents are communicated in a similar way to that of learning identified in Serious Adverse Incidents (SAI's) i.e. regional/cross-sectoral/cross-organisational.

The contents of this witness statement are true to the best of my knowledge and belief.

Signed: 

Date: **30th January 2023**

List of Exhibits (Vivian McConvey)

VM/1 Background Paper – Health and Social Services Councils

VM/2 HSS Councils Three year Joint Work Programme 2004 – 2007

VM/3 Current PCC Organisational Structure January 2023

VM/4 Provisions of the Health and Social Care (Reform) Act (Northern Ireland) Act 2009

VM/1

BACKGROUND PAPER – HEALTH AND SOCIAL SERVICES COUNCILS

7 January 2023

Introduction

1.1 The Patient and Client Council (PCC) was established from 1st April 2009, replacing four separate Health and Social Services Councils (HSSCs). The purpose of this paper is to provide some background information on the HSSCs for the purposes of the Muckamore Abbey Hospital Inquiry. The paper is not reflective of the totality of the work of HSSCs but is skewed towards Mental Health and Learning Disability.

1.2 There are currently no senior staff working within the PCC who had previously worked in one of the four HSSCs. This paper is based on records inherited by the PCC from the four HSSCs. Unfortunately, these records are not complete. Paper documents primarily relate to the Eastern HSSC. Whilst agendas and minutes of many meetings of the Eastern HSSC were retained, the associated papers tabled at meetings of the Council have not. This severely limits the analysis in this paper.

1.3 The minutes of meetings of the Eastern HSSC show that around the beginning of 2007 the Council made changes to the format of its meetings allowing 45 minutes to hour discussion of a range of issues followed by a focus on a particular theme often with an invited attendee to present on or discuss the theme. This change is reflected in the minutes of these meetings.

1.4 The PCC have sought information from its former Head of Operations and then Head of Complaints (2009-2018) who had also been the Chief Officer with the Eastern HSSC (2005-2009). The purpose of this engagement was to seek to establish what records had been held by PCC (including records from the four HSSCs) and seek to understand what had been done with them.
His recollections in relation to the transition from HSSCs to the PCC are listed below:

- There was clear guidance in terms of what needed to be retained and what could be destroyed. Guidance was taken from PRONI. They defined what they wanted to see, what could be kept forever and what they just wanted samples of (case studies or examples of work but he was not sure that this was taken);
- In transition from the EHSSC to the PCC, he disposed of everything they didn't have to keep. He said that not all of the Councils will necessarily have done the same thing, particularly where it came to case/client files;
- He said that: 'our attitude to client work was that they weren't complaints records, so didn't have to be kept for 10 years, but only 2 years. Therefore, they were either destroyed or returned to the complainant. Anything older than 2007, assuming it wasn't a longstanding complaint that wasn't still being worked would have been destroyed or returned'. He explained that the records were deemed not to be complaints record as such, because a complaint record was between the Trust and complainant and the client records from the HSSC Council just detailed the support the HSSC Council provided to clients.
- He is aware that the Western Health and Social Care Council took a different view. They treated these as complaints which needed to be retained for 10 years. These records were stored in the filing cabinets in the PCC's Lurgan Office.

Health and Social Services Councils

2.1 Up until the end of March 2009 there were four Health and Social Services Councils in Northern Ireland; Eastern, Northern, Western and Southern. They

were established under Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1991. Article 4 stated:

Health and Social Services Councils

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

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

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

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

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

2.3 Section 2 to schedule 1 states that:

Regulations may make provision as to:
(a) the membership of Councils (including the appointment or election of a chairman of each Council);

(b) the proceedings of Councils;

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

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

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

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

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

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

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

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

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

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

2.4 Section 3 to Schedule 1 states that:

Regulations made under paragraph 2(a) shall provide for the members of Councils to be appointed by the Department and shall secure, as respects each Council, that:
(a) at least one member of the Council is so appointed on the nomination of each district council of which the area or part of it is included in the Council's area;

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

2.5 The four HSSCs were co-terminous with the four Health and Social Services Boards (HSSBs) which existed up until the end of March 2009. More than this, all corporate support and finance, funding etc. came to them from their respective HSSBs. Each of the four HSSCs was effectively hosted by their respective HSSBs. The Eastern HSSC minutes of the meeting in May 2004 record "Under Councils current set up and structure the Governance arrangements come under the Eastern Health and Social Services Board. Therefore the Chief Executive of the Eastern Health and Social Services Board is responsible for carrying the risks for the Council."

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

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

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

Muckamore Abbey Hospital and the HSSCs

2.8 The two HSSCs which are likely to be most relevant to Muckamore Abbey Hospital are the Eastern and the Northern HSSCs. The minutes of a meeting of the Eastern HSSC, dated 18 January 2007, show that, at that date, 121 patients in Muckamore Abbey Hospital were awaiting resettlement into community-based provision. The minute records that 60% of these patients were from the Eastern Board area and 40% from the Northern Board area. Other records retained by the PCC of a meeting between the Eastern HSSC and the north and West Belfast Trust (which operated Muckmore up until 2007) show that the funding of Muckamore came from both the Eastern and Northern HSSBs.

2.9 The PCC do not know if this geographic split of the population of patients awaiting resettlement in 2007 was representative of all patients in Muckamore Abbey Hospital throughout its ecistence. In addition, minutes of the Eastern HSSC meeting on 15th November 2001 record a member stating that 20 years previously there were 1000 patients in Muckamore Abbey Hospital. The PCC documents do not show how this geographic split of Muckamore patients between the Eastern and Northern Board areas may have changed over time.

2.10 Muckamore Abbey Hospital was managed by the North and West Belfast Trust which in April 2007 became part of the current Belfast Health and Social Care Trust. Both Trusts were in the Eastern Board Area. In 2009, coinciding with the establishment of the Patient and Client Council to replace four HSSCs, the

Regional Health and Social Care Board (HSCB) was established to replace the four Health and Social Services Boards (HSSBs).

2.11 The minutes of meetings of the Eastern HSSC show that, in line with the management responsibility for Muckamore Abbey Hospital being in the Eastern HSSB area, major issues regarding Muckamore were regularly considered by the Eastern HSSC, often informed by the work of the Eastern HSSB. On the basis of the management role for Muckamore Abbey Hospital being in the Eastern Board Area and the majority of patients being from that area it is likely that issues raised by patients, carers and families in relation to Muckamore Abbey Hospital would have been raised with the Eastern HSSC. However, this cannot be confirmed from paper documents because of the paucity of documents available from the Northern HSSC. The Northern HSSB did however retain an interest in Muckamore Abbey hospital.

North and West Belfast Trust

2.12 North and West Belfast Trust was responsible for the management of Muckamore Abbey Hospital. The Trust was located within the Eastern Health and Social Services Board Area. It is one of six Trusts which, in April 2007, merged to become the Belfast Health and Social Care Trust (BHSCT).

2.13 In October 2001 the Eastern HSSC discussed a circular (HSS PPM 4/2001) which had been issued by the Department of Health (DHSSPS) to the health service and which included an expectation that the HSSCs would be given the right to attend and speaking rights at Board meetings of Trusts. The minutes record that the Eastern HSSC had already had attendance and speaking rights at the North and West Belfast Trust Board's meetings for several years. The Eastern HSSC minutes record instances of feedback being provided from council members who had attended meetings of the North and West Belfast Trust.

2.14 Reference is also made in minutes of the Eastern HSSC to a North and West Belfast Community Liaison Group (17/9/1998).

Eastern HSSC

2.15 On the basis of information provided by a former staff member, the staff in the Eastern Council consisted of:

- A Chief Officer
- A Senior Manager (covering corporate affairs and assisting in complaints). This was only in the EHSSC
- A Complaints Officer
- 3 WTE admin staff (Receptionist, PA to Chief Officer and an Office Manager who mainly supported Council meetings).

2.16 The Eastern HSSC minutes show that the Council could have a maximum of 30 members. However, the minutes also show that due to the time taken for public appointments, the actual number of members at any one time could be much lower than this. The minutes of the meeting of the 15th November 2001 show that nine new members were attending for the first time and that there were still 5 vacancies. Minutes of Eastern HSSC meetings show that the numbers of council members attending meeting was often around 12-15.

2.17 The Eastern HSSC worked very closely with the Eastern Board. The Chief Officer of the HSSC attended meetings of the Eastern Board's Board, had speaking rights at those meetings and reported back on those meetings to meetings of the council. Papers from meetings of the Eastern Board's Board were also shared with the members of the Eastern HSSC.

2.18 The Chief Executive of the Eastern Board routinely attended meetings of the Eastern HSSC and provided briefings to the council. Senior Directors from the Eastern Board attended meetings of the Eastern HSSC on a rotational basis to provide the Council with briefings on issues and ongoing work within their areas of responsibility. The minutes show that the Council Chair and Chief Officer met with the Eastern Health and Social Board Senior Management Team once a month. The minutes suggest that Council members were also members of a range of groups established by the Eastern Board as part of its internal structures and also of groups established within Trusts and Agencies.

2.19 The minutes also record the Eastern Council planning for joint events involving Council members and Board members from the Eastern HSSB. The minutes of the Eastern HSSC meeting from April 2004 record that the Eastern Board and the Eastern HSSC were required to have an annual joint meeting. The minutes of the May 2004 Eastern HSSC meeting record that the joint meeting that year took place on 13th May 2004.

2.20 Much of the information and many of the issues considered at meetings of the Eastern HSSC reflect issues which were being raised and discussed within the Eastern HSSB and in the North and West Belfast Trust. These included issues of perceived underfunding in general; underfunding arising from the DHSSPS capitation formulae used to allocate funding to each of the four HSSBs; and a lack of funding in relation to Mental Health and Learning Disability services including for Muckamore Abbey Hospital and resettlement.

Resettlement/Reprofiling

2.21 The minutes of the Eastern HSSC show that from the mid 1990s onwards resettlement of Learning Disability patients out of Muckamore Abbey Hospital and into smaller community based homes was a generally accepted policy direction for learning disability. This generally accepted policy set a context for the work of the Eastern HSSB, the work of North and West Belfast Trust and the work of the Eastern HSSC. In December 2001, for example, the Council

considered a report from Professor Roy McConkey entitled ‘Moving on from Muckamore’.

2.22 Whilst some of the discussion within the council focussed on the speed of resettlement and the availability of funding to support resettlement, the Council was raising the need for advocacy services to be available for patients who might be resettled to ensure that their individual interests were being protected and to ensure they had a choice. Resettlement features regularly on the agenda of the Council between 1999 and 2004 and again from 2007. Information was periodically discussed at Council meetings on the numbers of patients awaiting resettlement:

- Nov 1998: North and West Belfast Trust staff attended a council meeting to discuss ‘reprofiling’ to establish which patients could be resettled from the hospital and which patients could not be resettled. Patients who could be resettled were initially being co-located in wards i.e. reprofiling. Of these patients, 130 were moved to a new ward within the hospital. There were 180 patients currently ready for discharge if packages of care were available, 70% of these patients had been in Muckamore for 20 years or more. The current number of beds in Muckamore was 400 but that number was planned to reduce to 150 by the year 2002.

- Sep 2000; the Eastern Board and North & West Belfast Trust issued a consultation on a change process for North and West Belfast Trust suggesting that 250 patients could be resettled from Muckamore.
- Dec 2001; A EHSSB Director briefed the Council that the Board had been funded under ‘Priorities for Action’ to resettle 20 patients from Muckamore. However due to pressures arising from delayed discharges, the Board/Trust had diverted some of these resources into Treatment wards. As a result only 10 patients would be resettled by March 2002. Priorities for Action was an annual plan issued by DHSSPS to both Boards and Trust, setting targets to be delivered in the year ahead.

2.23 The minutes of Council meetings record Council members raising a variety of concerns in regard to resettlement. These included the issues of choice and advocacy; the need for engagement with families; the impact of reprofiling (moving) patients within the hospital on the patients; the need for capacity for new admissions and concerns that resettlement plans may be being driven by financial pressures.

2.24 Minutes also record Council members also raising and discussing other issues in relation to Muckamore and learning disability, for example:

- A paper on personal relationships for people with a Learning Disability (11/12/03);
- The use of seclusion (March 1999). The Council minutes state that they would write to the Minister to ask who was responsible for monitoring the use of seclusion;
- Children and young people being accommodated and treated alongside adults;
- Respite Care within Muckamore (15/3/01);
- The practice of Boarding Out/Sleeping Out where patients were placed in beds outside of Muckamore, whilst under the care of Muckamore. This was an issue between 2003 and 2005;
- Mansell report on services for people with a Learning Disability (17/1/08); and
- The Ministerial Action Plan for Muckamore Abbey Hospital in 2007.

2.25 The Council also discussed matters relating to the Children Matter Task force (CMTF) which was led and Chaired by DHSSPS staff and operated in the early to mid 2000s. The taskforce was focussed on children and young people, including learning disabled, who were living in large institutions, developing plans for these children and young people to be resettled into homes in the community, typically 6-8 bedded homes. Whilst the focus of the CMTF was not on learning disabled exclusively, it was open to the Boards and Trusts to bring

forward proposals to the taskforce for the building and operation of homes to include relocation of children and young people then living in Muckamore Abbey Hospital.

Registration and Inspection Units

2.26 Minutes of Council Meetings in 2004 (March) refer to a Registration and Inspection Advisory Committee. One of the issues addressed by the Committee was restraint, when restraint should be used and the appropriateness of restraint in view of human rights. These discussions are likely to have been in relation to community based facilities including nursing homes.

Corporate Parenting

2.27 Corporate parenting reports were regularly provided to the Board of the EHSSB and the contents of same were discussed by the EHSSC (Feb 2004). Corporate parenting reports related to children who were 'looked after' (in care) by Trusts, some of whom were accommodated in Muckamore Abbey Hospital.

Visits to Muckamore

2.28 Minutes of a Council meeting in April 1998 refer to 'Visiting Guidelines'. There is evidence that members of the Council made visits to the Muckamore Abbey Hospital including references to what appears to be a joint visit with the Assembly Health Committee (10/9/07, 15/11/07). Minutes of the Council meeting held in April 2004 record that the HSSCs had the power to visit facilities for monitoring and inspection purposes.

Complaints

2.29 Complaints by patients and service users were a significant area of focus for the Eastern HSSC. The Council received updates from the Chief Officer, on the number of complainants which the Council was supporting. This was usually

between 150 and complaints per year. The Council also received periodic reports analysing the types of issues being raised in these complaints.

2.30 In February 2007, the Council established a Complaints Sub-group. There is little information in Council minutes to explain the purpose and remit of this group. The approach to records retention in the Eastern HSSC means that only records for 'live' complaints and complaints less than two years old were retained and transferred to the PCC in April 2009.

2.31 Eastern Council staff appear to have been members of an Eastern Board Complaints group. The paper records inherited by the PCC do not include information on the remit or activities of this group.

Eastern HSSC Business Planning

2.32 Minutes of the Eastern HSSC show that the Council was required to produce an Annual Work programme. The programme was also sometimes referred to as an Annual Work Plan. Minutes also suggest that the council was expected to share the programme with the Eastern Board.

2.33 There is reference in minutes from the August 2004 Council meeting that the four Councils, following a joint event in June 2004, had agreed a three-year joint Work Programme(19/8/04,16/9/04) – see enclosed exhibit VM/2. The August minutes also record an intention to establish a joint steering group. The agreed work programme included 7 objectives. The wording of Objective 2 was as follows:

> *Monitor the Health and Personal Social Services provided to the public. The Councils propose to develop visiting Guidelines. Members will receive awareness training on these guidelines which will be used for visits and subsequent feedback to facilities. To date, the issues which have been identified as needing further monitoring are:*
>
> - *MRSA*
> - *Mental Health Wards*

- *Child and Adolescent Mental Health Services*
- *The implementation of the new General Medical Services Contract*
- *The implementation of recommendations made in a number of Reports including the Human Organ Enquiry, Children as Complainants, Regional Prosthetics Service, and Cancer Services.*

2.34 There is a reference in the minutes to a Work Programme Sub-group but no other information about the remit or activities of the group (15/3/07).

2.35 There are multiple references in minutes to the Chief Officer providing updates to the Council on progress against objectives in the different iterations of the work programme. These are sometimes referred to as quarterly updates, but they do not feature in the agendas or in the minutes with this regularity and the minutes rarely refer to the detail of what the objectives were or what the progress was.

2.36 Prior to December 1999 the minutes include a reference to the Council producing an annual report which was signed off by the Chair, not the Council. However, this was replaced with an annual review which was presented by the Chief Officer. There is no indication that these annual reviews were published and paper copies have not been retained. Minutes from 2003 include a reference to producing a report on the Council's work over the previous ten years (17/4/03).

<u>Collaborative Working Between Councils</u>

2.37 The Eastern Board minutes include evidence of meetings and communication between the four HSS Councils. This includes references to Joint Council meetings. There were also meetings of the Chief Officers of the four HSSCs. Minutes also refer to a Northern Ireland Association of HSSCs (17/12/1998). Several minutes of meetings from 2006 onwards refer to meetings of the HSSC Executive. It is assumed that these were meetings of the four Councils.

2.38 Minutes from April 2004 record that the four Councils were going to be subject to a review by DHSSPS. The four councils at that time agreed a three year joint work programme in 2004. (Para. 2.30 above). There is some evidence that the Councils collaborated on responses to e.g. some DHSSPS consultations such as the Bamford review, but for the most part they operated independently of each other. It is possible that some of the references to updates on the work programme in minutes of the Eastern HSSC may refer to this three year joint work programme. It is not clear whether or not this joint work programme replaced the Eastern council's own annual work programme.

2.39 After it became apparent that the DHSSPS intended to replace the four Councils with the Patient and Client Council, the minutes of an Eastern Council meeting (21/9/06) record that each Council was to manage its own dissolution and address its own issues.

HSS Executive

2.40 Minutes of the Eastern HSSC refer to the HSS Executive. The Executive was based in the DHSSPS and its membership was comprised of Civil Servants. The role of the Executive was to oversee the entire Health and Social Services infrastructure, holding HSS Boards and Trusts to account for delivery against DHSSPS targets. There is one reference in the Eastern HSSC minutes to an accountability meeting with the Executive in the minutes of the meeting of 18/6/1998.

Responses to Consultations

2.41 There are multiple references in the minutes to the Eastern Council discussing and responding to Consultations by the DHSSPS, Eastern Board and Trusts. In some instances, these were joint responses by the four HSSCs. In addition to responding to consultations, the Council sometimes facilitated workshops and consultation events. The Council also met with the teams responsible for developing consultation proposals both whilst they were in the process of developing proposals and as part of consultations on final consultation

documents. Examples relevant to Mental Health and Learning Disability include:

- Review of the Mental Health Commission in 2000;
- The Bamford review of Mental Health and Learning Disability between 2005 and 2007;
- Various consultations and proposals from the DHSSPS, Eastern Board and Trusts on the future/reconfiguration of Mental Health and Learning Disability Services (15/3/01, 20/11/03, 11/12/03, 18/3/04,16/11/06, 15/1107);
- BHSCT Ten year 'New Directions' consultation (16/10/08).

User Involvement/PPI and Advocacy

2.42 Minutes of Eastern HSSC Meetings record a regular focus on the issues of user involvement, Public and Patient Involvement and Advocacy. The minutes record discussion and efforts by the council to promote these within the Health and Social Services sector.

RPA and the Patient and Client Council

2.43 In March 2007 the Eastern Council established an RPA Sub-group. There are no paper documents retained which explain the remit of this sub-group or the work which it undertook.

2.44 The Minutes record a focus at meetings of the Council on various models for the work and role of the proposed new Patient and Client Council (PCC) between the years 2006 and 2009. This included planning for the transition. The four Councils worked collaboratively on various workstreams developing proposals on the structure and role of the PCC (21/8/08). One of the last actions of the Eastern HSSC was to produce a Joint Councils report suggesting the themes which the new PCC should focus on from April 2009 onwards and a report on Joint Councils activities (19/3/09).

Research and Surveys

2.45 There is some evidence in the minutes that the Eastern Council conducted or commissioned research and surveys but little information on the topics or on what research reports were actually produced or subsequently published. The minutes includes a reference to a Research and Development Advisory Group (18/5/06)

DHSSPS Minister

2.46 There are a number of instances were Eastern Council Minutes record the Council writing to the Minister. This includes issues specific to Muckamore e.g. the use of seclusion (2000) and the Minister's Action Plan for Muckamore (2007). A number of these communications were prompted by issues around funding of services including Mental Health and Learning Disability within the Eastern Board Area.

VM/2

HSS Councils Three Year Joint Work Programme 2004 - 2007

The Chief Executives worked together to develop a joint Work Programme. Minutes of the August 2004 meeting of the Eastern HSSC stated that the main objectives of the Councils for 2004 to 2007 would be as follows:-

1. To increase visibility and accessibility to members of the public. The Councils:

    - are developing a policy on public and community engagement.

    - will develop a public Awareness Campaign, which was one of the recommendations made as a result of the Human Organ Enquiry

    - will use the Joint Council logo on any publicity materials

    - are currently making enquiries about implementing one Freephone number for all four Councils.

    - will produce a new information leaflet for circulation to the public

    - propose to hold some workshops throughout the province to raise awareness of the work of the Councils.

    - will develop a joint Council website for publicising joint work initiatives. This website will have links to the four individual websites.

    - will review the format of their monthly public meetings

2. Monitor the Health and Personal Social Services provided to the public. The Councils propose to develop visiting Guidelines. Members will receive awareness training on these guidelines which will be used for visits and subsequent feedback to facilities. To date, the issues which have been identified as needing further monitoring are:

- MRSA

- Mental Health Wards

- Child and Adolescent Mental Health Services

- The implementation of the new General Medical Services Contract

- The implementation of recommendations made in a number of Reports including the Human Organ Enquiry, Children as Complainants, Regional Prosthetics Service, and Cancer Services.

3. Advise on Health and Personal Social Services policies, strategies and operation. The Councils propose to:

   - facilitate and monitor user involvement.

   - establish criteria for prioritising consultation responses and agree methods of response to consultation documents

   - review current Committee representation and audit the effectiveness of this representation in influencing public wellbeing.

4. To provide complaints assistance and monitor complaints processes. Mrs Graham explained that within the legislation Councils are required to provide complaints advice, but Councils are increasingly providing an advocacy service which Councils are not resourced for.

5. To develop a medium/long term Strategy/Plan for the Councils. The Working Group will carry out this work with a view to influencing proposals for the future work of the Council and planning for change.

6. To fulfil organisational requirements. Mrs Graham reported that a recent survey of work demonstrated that 50% of time is spent on administrative requirements. The statutory obligations include Targeting Social Needs, Equality, Human Rights and Freedom of Information.

7. To respond to local issues in the provision of Health and Personal Social Services to the public.

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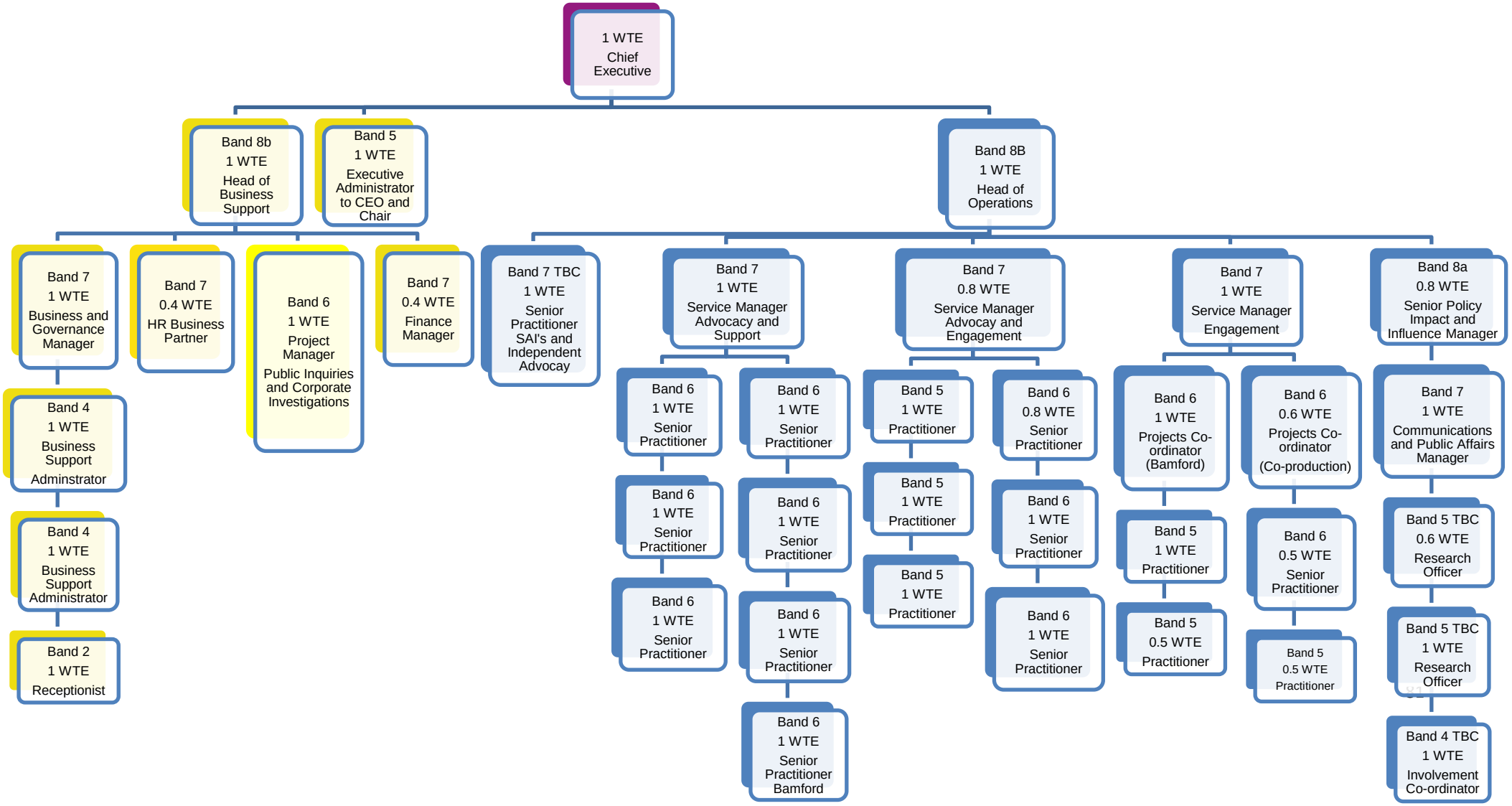
VM/3

Current PCC Organisational Structure January 2023



VM/4

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

The Patient and Client Council

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

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

Commencement Information

I1S. 16 wholly in operation at 1.4.2009; s. 16(2) in operation for certain purposes at Royal Assent see s. 34(2)(e); s. 16 in operation at 1.4.2009 insofar as not already in operation by S.R. 2009/114, **art. 2**

Functions of the Patient and Client Council

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

(a) representing the interests of the public;

(b) promoting involvement of the public;

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

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

(e)such other functions as may be prescribed.

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

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

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

(3) In exercising its functions under subsection (1)(b), the Patient and Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body to which this section applies which would or might affect (whether directly or not) the health and social well-being of the public.

(4) In exercising its functions under subsection (1)(c), the Patient and Client Council shall arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision (by way of

representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.

(5) The Patient and Client Council shall—

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

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

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

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

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

(a)the Department;

(b)the Regional Board;

(c)the Regional Agency;

(d)HSC trusts; and

(e)special agencies.

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

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

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

(i)at that body's direction;

(ii)on its behalf; or

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

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

Commencement Information

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

Duty to co-operate with the Patient and Client Council

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

(2) In particular, such a body must—

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

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

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

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

(4) Those premises are—

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

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

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

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

Commencement Information

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

Public involvement and consultation

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

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

(b)to obtain information about—

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

(ii)the efficacy of that care;

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

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

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

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

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

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

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

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

Public involvement: consultation schemes

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

(a)the Patient and Client Council;

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

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

(2) Those matters are—

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

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

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

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

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

(b)to prepare a written statement which—

(i)summarises the comments received; and

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

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