c/o The Clerk to the Health Committee
Mr Philip McGuigan
Chairperson
NI Assembly Health Committee
Room 410, Parliament Buildings,
Ballymiscaw, Stormont,
Belfast, BT4 3XX

BY EMAIL ONLY

31st October 2025

Dear Mr McGuigan

Ref: Adult Protection Bill 2025

The Patient and Client Council (PCC) is a statutory corporate body established in 2009 to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues within Northern Ireland, through:

- Representing the interests of the public;
- Promoting the involvement of the public;
- Assisting people making, or intending to make, a complaint;
- Promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of services; and
- Undertaking research into the best methods and practices for consulting and engaging the public[1]

We meet our statutory duties through a delivery model focused on direct engagement with the public and providing independent advocacy support. This includes providing independent advocacy support to individuals and families.
The PCC welcome the introduction of the Adult Protection Bill as presented by the Health Minister on 17th June 2025. The Bill is intended to provide a legislative and statutory footing to the policy around Adult Safeguarding, in response to the CPEA Report commissioned by the Department of Health in relation to the care failings arising from the 'Home Truths' report on Dunmurry Manor and the Muckamore Abbey Hospital Inquiry. PCC echo the Health Minister's statement when launching

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

the call for evidence that "*there is a very clear need to establish a robust statutory framework for the protection of adults at risk of harm*".

The PCC would like to thank the Committee for Health for the extension of time granted for this submission on the Adult Protection Bill in response to the call for evidence. This facilitated PCC to engage with Department of Health to explore issues arising from the Adult Protection Bill, particularly PCC's direct membership of the Adult Protection Board and broader issues relating to Independent Advocacy. We wish to acknowledge the work and progress of the Adult Protection Bill Team in the drafting of this legislation. The PCC Adult Protection Engagement Platform worked with Departmental Officials on aspects of this Bill to bring the voice of family members with experience of safeguarding issues to effect in shaping the Bill. The PCC, as a body corporate was, however, not engaged with in the development of the Bill and this was, in our view, a missed opportunity in which the PCC may have provided early reflections and assistance to the Bill Team, including the content reflected in this submission.

We would like to table the enclosed paper for the consideration of the Health Committee which provides our reflections on this important area and we hope that it is of value to the Health Committee in its work in respect of the Bill.

The PCC welcome the opportunity to provide oral evidence to the Health Committee on any aspect of this consultation response, and are committed to continuing our ongoing conversations with the Department on the content of this submission and any proposed amendments.

Yours Sincerely,

Meadhbha Monaghan
Chief Executive

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PCC Submission to the Health Committee on the Adult Protection Bill 311025

PCC Submission to the Committee for Health re. Adult Protection Bill 2025.

1. The Patient and Client Council would like to thank the Committee for Health for the extension of time granted for this submission. This facilitated PCC to engage with the Department of Health to explore issues arising from the Adult Protection Bill, particularly PCC's direct Membership of the Adult Protection Board and broader issues relating to Independent Advocacy.

2. The PCC welcome the introduction of the Adult Protection Bill and we echo the Health Minister's statement when launching the call for evidence that "*there is a very clear need to establish a robust statutory framework for the protection of adults at risk of harm*"[1].

3. We wish to acknowledge the work and progress of the Bill Team in the drafting of this legislation. The PCC's Adult Protection Engagement Platform[2] worked with Departmental Officials on aspects of this Bill to bring the voice of family members with experience of safe guarding issues to effect in shaping the Bill. The Engagement Platform's work primarily focused on aspects related to the involvement of family members in safeguarding investigations, especially for people with vulnerabilities (Clause 28) and on issues related to the use of CCTV (Part 4).

4. The PCC, as a body corporate has, however, not been engaged with in the development of this Bill.This was in our view, a missed opportunity in which the PCC may have provided early reflections and assistance to the Bill Team, including content reflected in this submission.

[1] NI Assembly Call for Evidence Adult Protection Bill 30.05.25

[2] The PCC operates a number of regional Engagement Platforms. Engagement Platforms are a space to bring together members of the public, with a common theme or interest and lived experience, to work together and represent their interests in health and social care. They allow participants to communicate their experiences and insights, related to a policy programme, with the PCC, as well as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas under review, development and reform.

5. There are matters contained within the Bill that pose a challenge for the Patient and Client Council (PCC). These impact PCC's duty to act in accordance with its statutory purpose and to maintain its independence.

6. This submission addresses those challenges, and invites the Department of Health and the Minister to give consideration to a number of proposed amendments.

7. The key areas that the PCC would like to draw to the attention of the Health Committee can be broken down into the following sections:

    a. PCC's proposed membership of the Adult Protection Board and its conflict with the independent role and functions of the PCC.
    b. PCC's proposal that, in light of its role and functions, it be a Designated Consultee to the Adult Protection Board, and on the development of Guidance and Training relating to other clauses in the Bill.
    c. As set out in previously established positions, and in the interests of the public and vulnerable people, there is a need to develop a regional independent advocacy service in NI. Current provisions within the Bill, relating to independent advocates, whilst welcome, are too narrow and limited in scope and independence. PCC propose that the Bill should and can be future-proofed to accommodate the development of a more robust regional advocacy model, reflecting on IHRD Recommendation 37 iv, and subsequent inquiry recommendations, and consideration of Clause 3c of Mental Health (Northern Ireland) Order 1986.
    d. Additional considerations including Governance & Assurance, duty to report/cooperate and CCTV.

The Role of the PCC[3]

[3] being-open-framework-pcc-response.pdf

8. The PCC is a statutory corporate body established under the Health and Social Care (Reform) Act (2009). The HSC Framework Document (2011), produced by the Department, describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

9. The document stipulates that 'the overarching objective of the PCC is to provide a powerful and independent voice for patients, clients, carers and communities on health and social care issues through the exercise of its legislative functions' which are:

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

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

11. Paragraphs 6.40 to 6.42 of the HSC Framework Document (2011) further outlines the independent challenge function the Department conferred on the PCC and the RQIA, which is as follows:

DHSSPS Framework Document - September 2011 | Department of Health

6 Independent Challenge[4]:

"6.40. *In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.*

6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.

6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

12. PCC's Council (Board) is constituted differently to other Boards across the HSC to reflect the public and attest independence, with specified representation from the public, elected Councillors, trade unions and the voluntary and community sector. Reflecting on these obligations, the PCC's Council (Board) developed a Statement of Strategic Intent 2022-2025[5], setting out the vision and strategic direction of the organisation. Our vision is for a Health and Social Care Service, actively shaped by the needs and experience of patients, clients, carers and communities, and

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

[5] PCC (2022) Statement of Strategic Intent

that in achieving this, the public voice would be influential regionally and locally in planning and commissioning, and that the system would respond openly and honestly when things go wrong.

13. In the long term the PCC hope to see two big differences:
    a. Strategic Objective One: Through our engagement and impact work, the public voice is influential regionally and locally in the design, planning, commissioning and delivery of health and social care.
    b. Strategic Objective Two: Through our work in advocacy, engagement and impact, the health and social care system responds regularly to people with openness, honesty and compassion to address difficulties or failures in standards of care.

14. To fulfil our statutory obligations the PCC has developed a delivery model focused on 4 key areas. These are PCC Connect, PCC Support, PCC Engage and PCC Impact. The model places an emphasis on relationship building; meeting people at their point of need and tailoring our support to each individual. The PCC understands its role within the system of governance and assurance as providing the wider public, HSC Trusts and other service providers and the Department itself with information, insights and evidence gathered as part of discharging our statutory functions. This includes our role in providing advocacy support, and advice on the best methods to engage with the public, and is primarily based on engagement with service users, patients, carers and families.

15. As can be seen from our Strategic Objectives we consider that this work can and does have a clear impact on the commissioning, design and delivery of health and social care, and ensuring the HSC system responds to the public with openness, honesty and compassion to address difficulties or failures in standards of care. This aligns with, the rationale behind the Adult Protection Bill, of underpinning the need to put Adult Protection on a statutory footing.

16. To be effective, it is essential that the PCC not only speaks and acts with authority as an independent voice for service users, carers, and families, but that it is perceived and trusted by the public to be independent from those who provide services and those who commission services. That independence also underpins the assurance required by the Minister and the Department of Health. Over the past 5 years the PCC has utilised the learning from innovating new PCC practice models, particularly in advocacy and engagement, and learning from PCC's engagement with 4 Public Inquiries; that is Neurology, Muckamore Abbey Hospital Inquiry, Urology and Covid-19.

17. This learning has informed the PCC's response to this Draft Bill, which also provides an opportunity to progress specific elements of the policy agenda which PCC has identified arising from this learning, including issues beyond the immediate confines of the Bill.

19. PCC can foresee that in responding to the draft Bill it is relevant to consider the Department of Health's work on implementing recommendations from the Inquiry into Hyponatraemia Related Deaths; DoH's work on changes to the Serious Adverse Incident Review system, and the development of the DoH policy on Candour/Being Open, to which PCC has made a separate submissions[6].

Membership of the Adult Protection Board and its conflict with the role and functions of the Patient and Client Council.

20. The Adult Protection Bill at Part 2 Clause 30 (1) states that the Department "*must establish in accordance with this section a Board to be known as the Adult Protection Board NI" (*APBNI). The PCC welcome the proposed establishment of an Adult Protection Board with a duty placed upon the

[6] being-open-framework-pcc-response.pdf

Department to establish it. The PCC are proposed as a direct member of the Board at Clause 30 (3) (c).

21. Direct Membership of the proposed Adult Protection Board is problematic for PCC, in that there are significant legal implications for the PCC within the proposed Bill at Clause 30 (3) (c) as written. Direct membership of the Board would pose a risk to PCC'sindependence, both perceived and practical, to our standing as an arms-length body, and to our ability to discharge our statutory function, as outlined in the HSC Framework Document (2011).

22. The PCC therefore seek an amendment to the Bill to remove the reference to the Patient and Client Council at Clause 30 (3). This is necessary to maintain our independence, public trust and confidence in the PCC, our standing as an arms-length body, and to our ability to discharge our statutory function.

23. Having engaged with the Bill Team directly on this matter, PCC understand that the proposed amendment and removal of the Patient and Client Council from the wording of Clause 30 (3) is not objected to by the Department and it is our understanding that it will be recommended to the Minister by the Bill Team and the Adult Transformation Board, as a Ministerial/Departmental Amendment.

Patient and Client Council as a Designated Consultee

24. In light of this recommendation, i.e. removal of PCC from direct membership of the Board, the PCC believe that in line with our statutory functions, we would be better positioned as a designated consultee to the Board.

25. The PCC have engaged with the Department in relation to a proposal that the PCC should be a named or designated consultee to the Adult

Protection Board, as referred to in the Bill, and further as a designated consultee in relation to the additional provisions such as the development of training and guidance, referred to below.

26. The Department have provided an indication that there is a general policy not to include PCC as a consultee to avoid confusion and to avoid duplication and overlap of statutory duties in HSC legislation. PCC are currently engaging with the Department to understand more about this policy. At this time, PCC has not had sight of this policy or the rationale underpinning it.

27. There is a specific duty on HSC bodies to co-operate with the PCC and this is set out in the HSC Framework document (2011) and at S18-20 of the Reform Act. The role of the PCC goes beyond straightforward information or advocacy role. It includes working with HSC bodies to promote the active involvement of patients, clients, carers, and communities, in the design, delivery and evaluation of services.

28. PCC are of the understanding that the Adult Protection Board, as proposed by the Bill, would not be covered by the 2009 Act and that subsequently there would be no overlap or duplication. PCC are engaged in ongoing discussions with the Department that have not concluded at time of writing.

29. Clause 32 (6) states: "*The Board must make arrangements for consultation and engagement with persons or bodies (other than those represented on the Board) with an interest in the protection of adults at risk."* It is not clear from this definition if PCC will be included as a consultee to the proposed Adult Protection Board. It is our understanding, at the moment, that the Department consider that PCC may be covered by this Clause, however, there remains a risk, with the passage of time and change of personnel, for drop-off.

30. The maintenance of public confidence and independence alongside assurance are vital components of the PCC's statutory role. Maintaining a position as a designated consultee independent of membership of the Adult Protection Board would fulfil and protect the intent of PCC's statutory functions without compromising them.

31. PCC believe there should be a mechanism for direct lived experience input to/on the Adult Protection Board and acknowledge the inclusion of Clause 30 (3) (f). Establishing such a mechanism for direct lived experience input goes to the heart of public confidence. It is a public expectation that the public, and those with lived experience, should be at the centre of decision-making in health and social care. This approach recognises the growing body of evidence which demonstrates the value of harnessing the energy and agency of citizens as assets in resetting and reshaping public services for the future [*people to partners*].

32. However, PCC would welcome assurance, and would encourage the Health Committee to seek assurance, that the input of those with "lived experience" with be adequately reflected and incorporated into the Adult Protection Board.

33. New practice, guidance, and policies require training and ongoing development to implement and maintain a change process. The PCC would welcome the development of a training course for Adult Protection Board members and advocate for direct engagement of the lived experience from service users within this training. This would ensure that Board members would be alive to their experience and the need to have that voice amplified when monitoring patient safety. PCC would welcome the opportunity to be consulted with and to participate in the development and delivery of this training.

34. Despite the statutory roles and functions referred to above, [paras 9-15] the draft Bill currently includes no explicit requirement to engage or consult with the PCC on any matter, including in relation to Article 22. The

inclusion of PCC as a designated consultee would provide the scope for PCC to fulfil its statutory functions as relevant to the work of the Adult Protection Bill.

Independent Advocacy: Future-Proofing the Legislation

35. The next key consideration that the PCC would like to draw to the Health Committee's attention is the provision of Independent Advocacy (Clause 26). The PCC welcome the inclusion, and recognition, of Independent Advocates within the proposed Bill.

36. Advocacy plays an important role in supporting people to express their views and in providing a source of support which gives them confidence to speak out. Advocacy is vital in cultivating trust and effectively supporting people to ensure their views are considered and heard. It should also provide an environment in which they can confidently raise any concerns they may have with their advocate in the knowledge that there are no conflicts of interest.

37. Advocacy:

- Safeguards people who can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social and environmental circumstances that make them vulnerable.
- Empowers people who need a stronger voice by enabling them to express their own needs and make their own decisions.
- Enables people to gain access to information, explore and understand their options, and to make their views and wishes known.
- Speak up on behalf of people who are unable to do so for themselves."[7]

[7] NHS Scotland. (2013) Independent Advocacy Guide for Commissioners. Independent Advocacy Guide for Commissioners

38. The importance of advocacy services was recognised by the Inquiry into Hyponatraemia-Related Deaths (IHRD) report[8], with its recommendations outlining the need for service users, and families, to ***have access to independent advocacy support***. Recommendation 37 (iv) being: '*Trusts should seek to maximise the involvement of families in SAI investigations and in particular: a fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases'.*

39. The availability of independent advocacy assists in creating a culture of openness and transparency and plays a fundamental role in governance, assurance and addressing inequality.

40. PCC believe that appropriately supporting independent advocacy services provides a level of assurance that HSC Trusts and organisations are committed to being learning organisations, committed to meeting their Statutory Duty of Quality, are appropriately invested in the Duty of Candour and, most importantly, to protecting patients[9].

41. PCC have demonstrated that access to early resolution through independent advocacy saves money and delivers better outcomes for the public, for services and for staff, preventing concerns from escalating[10] and enabling earlier intervention. "*Our drive towards early resolution and a focus on restorative practice is reflected in 60% of cases being resolved prior to formal complaint, an increase from 57% in 2023-24 and 45% in 2022-23.*" [11]

42. The PCC expects, and we believe the public expect, that organisations providing advocacy services should be independent of service providers

[8] Inquiry into Hyponatraemia related Deaths (2018) The Inquiry into Hyponatraemia-related Deaths Report Full-Report.pdf
[9] being-open-framework-pcc-response.pdf
[10] Reference the ICS report which will be forthcoming
[11] Chief Executive's Summary, page 6, PCC Annual Report 2024-2025 pcc-annual-report-and-accounts-2024-2025-final-with-cert-october-2025.pdf

i.e. **structurally, financially and psychologically independent**[12]. Ensuring the integrity of independence, advocacy service providers' accountability arrangements should be independent of Trusts to ensure freedom to act without potential adverse consequence on the contractual arrangement.

43. The PCC believes the following aspects should underpin the provision of advocacy services within the Health and Social Care system:

- Advocacy services should be commissioned as regional services;
- Advocacy services should be commissioned independently of HSC Trusts;
- Advocacy services should be commissioned on the basis of agreed standards which include addressing the role of these advocacy services in dealing with complaints and concerns raised by clients, responding to safeguarding issues, and systems of regulation of services and the workforce;
- The service specification with providers commissioned to provide advocacy services should specify how these service providers relate to the Patient and Client Council in the discharge of its statutory roles (where the PCC is not the provider or commissioner of the service);
- The same specification should specify a minimum data set to be collected by the service provider both for the purposes of monitoring the provider's performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts; and
- Access to these advocacy services should be client-led and not solely dependent on a referral by HSC Trust.

44. The PCC's interest is in having systems and structures which promote and maximise openness, patient outcomes, purpose, quality and safety of services and governance and assurance. The PCC is not seeking to position itself to be involved in every complaint / SAI or Review. PCC

[12] Independent Advocacy Principles, Standards & Code of Best Practice - Scottish Independent Advocacy Alliance

recognises the expertise and contribution of a wide range of voluntary sector organisations which provide specialist knowledge-based advocacy services and the PCC itself avails of those services. The PCC is not seeking to displace or replace those providers. It is critically about how to "connect the system to more of itself "(Myron's Maxims) and to deliver better outcomes for the public.

45. There are similar models currently operating, for example, the Scottish model - SIAA[13]).

46. In relation to current provision, there remains a fragmented approach regionally to advocacy support as commissioned by the Trusts and there are challenges to the operational independence of providers resulting from current commissioning arrangements. This was acknowledged and highlighted by the evidence provided to the Muckamore Abbey Hospital Inquiry by Ms Marley, retired Director of Bryson Care, at paragraph 73 day 84 *"The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which dilutes the true independence of the service".* Ms Marley stated that it needs *"total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome".* Further, Ms Marley acknowledged *"..if you're receiving funding and you're in a contractual relationship with the Trust, it does make it difficult to feel totally independent of them, and we would prefer to have some kind of arm's length arrangement where the funder or commissioner is not the Trust". She further explained that on occasions the Trust had reminded Bryson House that this was a "contract with the Trust" when staff were raising an issue with the Trust"*.

47. It is clear that the provision of advocacy in its current form is insufficient to meet the growing need and demand for independent advocacy for adults-at-risk, for those with Learning Disabilities, for those accessing Mental

[13] Home - Scottish Independent Advocacy Alliance

Health services and for those transitioning into adult services. Although Independent Advocacy is before the Health Committee in this context in relation to the Adult Protection Bill and in relation to Adults at Risk specifically, there are a range of other current consultations ongoing within Health and Social Care e.g. in relation to the Mental Health Strategy, the consultation on the Learning Disability Model, Neighbourhood Health Model and on the Mental Health Codes of Practice which will inform and provide guidance to advocacy practitioners. To avoid further fragmentation, it would be helpful for the Bill team and Health Committee to have cognisance of these so as not to make the picture even more fragmented.

48. Whilst PCC acknowledge that the creation of a regional, independent advocacy model is outside the scope of this Adult Protection Bill, the Bill does provide an opportunity, and the ability to future-proof this legislation - both to support, but most critically not to complicate/impede, the fulfilment of the Department's commitment to the implementation of the IHRD Inquiry recommendation and any potential future recommendations in relation to independent advocacy.

49. The provision of and access to Independent advocacy must be consistent, equal and equitable across the region .There is an interdependency between the ongoing consultations and policy programmes mentioned above, and this Bill. It is therefore an interface issue for adults at risk. There is opportunity through this Bill to make provision to address such interface issue and to facilitate consideration of a strategic and co-ordinated approach to the provision of independent advocacy, which the PCC considers to be essential.

50. PCC have carefully considered the wording of the current Bill and suggest that the Bill could be amended to future-proof the wording at Clause 26, in such a way as to offer flexibility to the Department of Health to accommodate structures for the provision of independent advocacy that

may exist in the future and in relation to potential future models for the delivery of Independent Advocacy.

51. The Bill, as it is currently presented, makes only narrow provision for Independent Advocates to be engaged for 'adults at risk' and this is confined to Part 1 of the Bill at Clause 26 (1). There is a need to ensure that the Bill extends the provision of Independent Advocacy support to the remainder of the Bill in particular Parts 2 and 3 and to include Serious Case Reviews (Clause 32 (5)).

52. PCC welcome the commitment to the provision of Regulations, to a set of Advocacy Standards, and propose that the PCC should be identified as a designated consultee in line with the rationale set out above.

53. In making this proposal, to future-proof the wording at Clause 26, PCC are not setting out a new legislative approach in relation to independent advocacy. Upon review of the existing legislation, the Mental Health (Northern Ireland) Order 1986, Clause 3 C states "*The Department must make regulations about independent advocates*".

54. We consider that Clause 3 C reflects the policy intent of our proposals. In accordance with that Order, which PCC understand remains in force, the Department must make regulations, and the clause sets out that those regulations should make provision for arrangements, assignments, and functions of independent advocates.

> **Mental Health (Northern Ireland) Order 1986 states:**
> **"**Independent Advocates
> 3C—(*1) The Department must make regulations about independent advocates*.
> *(2) An "independent advocate" means a person who has been appointed by an HSC trust, in accordance with the regulations, to be a person to whom the trust may from time to time offer*

instructions to represent and provide support to a patient who is under 16 in relation to matters specified in the instructions.
The regulations may in particular—
(a)require HSC trusts to make arrangements for the purpose of ensuring that independent advocates are available to be instructed;
(b)make provision about such arrangements (including provision providing that a person may be appointed as mentioned in paragraph (2) only if the person meets prescribed conditions);
(c) make provision for the purpose of securing the independence of independent advocates;
(d)make provision in relation to the instruction of independent advocates (including provision permitting or requiring a prescribed person, in prescribed circumstances, to request an HSC trust to instruct an independent advocate);
(e)make provision about the functions of independent advocates.
(4) The conditions that may be prescribed by virtue of paragraph (3) (b) include—
(a)a condition that the person is approved, or belongs to a description of persons approved, in accordance with the regulations;
(b)a condition that the person has prescribed qualifications or skills or has undertaken prescribed training" .

55. The 1986 Order further states it must "*make provision for the purpose of securing the independence of independent advocates*"[14]. The 1986 Order, the PCC understands, remains in force, leaving an opening for the creation of regulations to support a Regional Independent Advocacy Service model.

56. Based on experience and insights from listening to, and working with, members of the public, along with the evidence provided to a number of public inquiries, PCC believe that the independence of independent advocates, understood in financial, psychological and structural terms, is

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the expectation of the public. Perception is reality. The Bill, in future-proofing the independence of independent advocacy should be seen to guard against any "dilution of true independence" and as such the perception of independence must be clear.

57. The PCC would therefore ask that the Department consider the wording of Clause 3 C of the Mental Health (Northern Ireland) Order 1986 that the "*Department must make regulations in relation to the provision of independent advocates*" and maintain a similar provision "*for the purpose of securing the independence of independent advocates*" in the proposed Adult Protection Bill.

58. The PCC have engaged with the Department of Health regarding these proposals and are committed to continued engagement with the Department in relation to proposed amendments to Clause 26 and 28, and to extend the provision of Independent Advocates to all parts of the Bill (including Clause 32 (5)).

Other Key Considerations:

59. There are other key considerations that PCC would like to bring to the attention of the Health Committee. PCC would suggest that these be considered in light of the current proposed legislation, and associated consultations, relating to Duty of Candour, patient safety incidents and the promotion of a culture of openness and honesty within HSC, as well as the demonstrable depth of public concern in relation to these matters. PCC have submitted a number of consultation responses[15], referred to above, which may be of assistance to the Committee in their considerations.

Offences – Part 3 of Adult Protection Bill

[15] being-open-framework-pcc-response.pdf

60. PCC consider that the question of whether the duty to report or cooperate with an investigation, under the current Bill, is applicable to individuals as well as organisations warrants exploration. The duty to report applies to HSC Trusts as an organisation, and to independent providers commissioned to provide health or social care. However, under the Bill it does not appear to apply to HSC Trust employees as an individual-led duty in the same way that it applies that duty to, for example, 'members of police force'. Other external individual care providers, may potentially, fall outside the scope of an organisation in this regard.

61. Whilst the Bill does create offences of ill-treatment and wilful neglect, listed at Part 3 of the Bill at Clauses 38 – 42, it does not create a specific criminal offence for failing to report or cooperate with an investigation. It remains possible that an investigation could still occur, under Clause 23, if the failure amounts to an offence of obstruction of an inquiry. Nothing in the Bill precludes disciplinary action being taken by an employment and/or professional regulatory body.

62. This emphasises the need to converse in "an open and honest way in relation to the provision of health and social care services with patients and service users". The PCC's position, based on direct engagement with the public[16], is that the statutory Duty of Candour should extend both to individuals as well as to organisations. Organisations cannot deliver on a Duty of Candour unless the individual staff within them consistently report incidents and are open and honest in recording what has happened, particularly when things go wrong.

63. PCC have also been engaging with the public and working actively in the general areas of patient safety, culture, openness and honesty; including responding to the Department of Health's consultations on the Being Open Framework and the proposed Regional Framework for Learning and

[16] sai-framework-pcc-consulation-response_final.pdf

Improvement from Patient Safety Incidents (SAI Redesign).[17] Based on this work and our direct engagement with members of the public who have been affected, PCC recommend the value in developing regulations in consultation and through engagement with, people with lived experience.

CCTV - Part 4 of the Proposed Bill

64. Following recent Public Inquiries, it is clear that the issue of CCTV is a matter of significant importance to patients, families, carers, communities, and members of the public. It has certainly been a focus of participants on the PCC Adult Protection Engagement Platform and was a significant feature in the recent Muckamore Abbey Hospital Inquiry.

65. PCC recognises the efforts made by the Bill Team, including through their engagement with participants on the PCC Adult Protection Engagement Platform, to ensure that any provision within the Bill in relation to CCTV is mindful of the delicate balance of rights that exist between the need to safeguard 'adults at risk' and the right to family and private life.

66. The Bill confers upon the Department the power to make Regulations on the installation and use of CCTV on listed establishments. It does not mean or intend mandatory installation of CCTV. The Regulations will need to consider whether CCTV should be installed, and how it should be managed, monitored and maintained. CCTV installations will be for the Regulation Quality Improvement Authority (RQIA) to monitor and enforce compliance.

67. PCC would highlight that the extent of what constitutes a CCTV system should be given further consideration given the fast moving pace of

[17] being-open-framework-pcc-response.pdf; sai-framework-pcc-consulation-response_final.pdf

technology in this area i.e. body worn cameras, fixed cameras, any other CCTV related devices.

68. The Bill at Clause 43 (1) has listed a number of establishments, however, gaps remain in relation to supported/independent living arrangements, transition arrangements and/or temporary accommodation i.e. hostels, and respite facilities. It is submitted that the Regulations as proposed at Clause 44 (1) (g) should be developed in consultation with people with 'lived experience' and through wider consultation to inform any proposed amendments.

Potential Circular Accountability – Adult Protection Board – Part 2 of the Proposed Bill

69. To fulfil their role appropriately, the proposed Adult Protection Board (referred to at Clause 30) should ensure effective and successful governance and assurance at Board level.

70. The Adult Protection Board, as proposed under Clause 32, *"must monitor, review and hold to account the exercise by bodies and persons represented to the Board of their functions relation to the protection of adults at risk*". This may raise an issue in relation to performance and accountability. Consideration should also be given to the wider issues for Governance and Accountability.

71. In relation to composition of the Board, is not clear who the representatives from the HSC Bodies would be ie Chairs, Non-Executive Directors, Chief Executives or Director. The accountability is circular in that it would be HSC staff nominated to the Adult Protection Board holding their own organisations to account. And, in the event that the Department prescribes membership of the Adult protection Board to include representatives from voluntary, community or private sector organisations which provide services to adults then these individuals would be holding to account HSC bodies which commission adult services from their host

organisation/employer. A further potential complication is the inclusion of the PSNI, accountable to another Minister and to the Policing Board.

72. Consideration should be given to the need to include Non-Executives with specific expertise in governance, information governance, data collection and analysis; performance management; and public participation, if they are to effectively execute their duties and responsibilities.

Conclusion

73. To conclude, PCC welcome the Adult Protection Bill and the recognition of the need for a robust statutory framework in matters related to adults at risk and adult protection. PCC acknowledge the challenge of the task, the work of the Bill Team to date, and the scrutiny of the Health Committee.

74. This submission seeks to address those challenges and represent the issues of key importance to the PCC, based on our direct experience of listening to, and working with, the public in the context of the statutory role PCC holds within the Health and Social Care system and the interests of the public we represent. PCC invites the Department of Health and the Minister to give consideration to the proposed amendments referred to above and, in particular, urges the Department to seize the opportunity to future-proof this legislation in relation to independent advocacy.

75. The PCC welcome an ongoing conversation with the Health Committee and the Department of Health on any aspect of this submission and on any proposed amendments.