Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Briefing from the Patient and Client Council

14 January 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Alex Easton
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:

Mrs Maeve Hully	)	Patient and Client Council
Mr John Keanie	)	

The Chairperson (Mr Wells):

Our witnesses today are John Keanie, whom many members will have known in his former role as a clerk of one of our leading councils, and Maeve Hully, chief executive of the Patient and Client Council. You are very welcome. I had the privilege of having an initial meeting with you several weeks ago, which I found most interesting. Today marks the Committee's first direct contact with the council. It is good to have you here, because you are one of the major players in the field, and your appearing before the Committee completes the set, as it were, as we have met everyone else.

Please feel free to introduce the work of the Patient and Client Council and describe what you hope to do. I realise that you are in the formative stage of setting up offices and getting the machine up and running. We are interested in hearing about the latest developments. We have the advantage of having had copies of your presentation submitted to members in good time. After the presentation, I will open the floor to members' questions.

Mr John Keanie (Patient and Client Council):
Thank you for the opportunity to speak to the Committee. We have spent quite a bit of time on setting up the organisation from scratch over the past few months. The establishment of the Patient and Client Council was announced on 1 April 2009. Maeve and I think that the timing of this meeting is good because, in considering what we do now, the balance between set-up work and public-facing work has changed significantly. Much of the Patient and Client Council's work from here on in will be public facing. We are building up a body of work with patients, clients and communities with whom we have been speaking and identifying some issues that are important to them.

With your permission, Chairperson, I will ask Maeve to take the Committee through the presentation that we submitted. She would like to make a few points on that.

Mrs Maeve Hully (Patient and Client Council):
Thank you very much. The Patient and Client Council was set up to be a powerful and independent voice in health and social care for patients, clients, carers and communities. It is important to cater for all those different groups. The council's uniqueness lies in the fact that it is a regional body. The legacy organisations, the four health and social care councils, were coterminous with the board areas. Since 1 April 2009, we have taken over from the four legacy organisations and added a fifth local office to represent the five trust areas. There is strength in the fact that we have the opportunity to look at what is happening in health and social care at a regional level, and we will be able to respond accordingly.

Under the legislation, we have four statutory functions: to engage with the public; to promote the involvement of the public; to help people making a complaint; and to provide advice and information. Helping people to make a complaint was among the core business of the legacy organisations. We will continue to help people who make a complaint to navigate their way through the health and social care complaints procedures. We also feel that the functions of engaging with the public, promoting their involvement in the development and delivery of health and social care, and providing advice and information, are important parts of what we do.

The structure of the organisation is that John Keanie is the chairperson, I am the chief executive, and there are 16 board members. There is representation on the board from the community and voluntary sector, local councillors, laypeople and the trade union. None of the officers of the Patient and Client Council sits on the board, although we attend the meetings. It is important to note that the board is set up in that way, as it demonstrates the independence of the organisation.

One of the challenges for us will be to hear the voice of people locally. Although we have a regional perspective, it is important that we know what is happening locally and what is important in health and social care in local areas. We set up five local advisory committees to address that. Those will be committees of the board, and we went through an advertising process to identify members. All committees are now staffed, and those people will be inducted in the next couple of weeks.

The committee comprises people who have shown an interest in health and social care in their local area and demonstrated that they will be able to voice the opinions of the public. They will be able to hear what is of concern to people and give them an avenue to feed that information up through us and ultimately through the board. The chairperson of each local advisory committee sits on the board of the Patient and Client Council. Therefore, there is a top-down and bottom-up approach being taken to hearing all the relevant information.

The Patient and Client Council will work in a way that demonstrates a wide remit in the external-facing part of its work. The board will be responsible for strategy, planning, policy and monitoring. We see ourselves as an integral part of the health and social care family and will work within that structure. We have other key partners, such as the Assembly, the Minister of Health, Social Services and Public Safety, local government, our colleagues in the Public Health Agency, the Health and Social Care Board, the Regulation and Quality Improvement Authority, GPs and the professional bodies.

Increasingly, and much more importantly, much of our work will focus on how we engage directly with the public and how we ensure that their voice is heard and fed up through the system, so that — whether those are experiences that individuals would want to repeat or otherwise — we can spread information about the public's experiences, share good practice across the region and identify areas of concern. We have a wide remit with respect to the people with whom we engage. It is important that we use all the opportunities that we have been given through this process to ensure that we can make a difference to patients and clients.

We have a regional office that is temporarily located in Belfast, but ultimately we will move to Antrim, and we are supported by five local offices, one in each trust area. We are keen to be seen as a part of the trust areas, but we are also keen to preserve our organisation's independence and, therefore, our local offices will not be situated on trust premises.

We are currently identifying appropriate local offices, and we want those to be accessible to the public. For people to be able to use us, they need to know that we are there. Therefore, we are thinking about where best those offices can be located to maximise opportunities for people to use our services. In Belfast, we are currently located in the offices of the Health and Social Care Council of the Eastern Board, and we are situated in similar offices in Lurgan. We are just about to move to Omagh and, for the first time, we are looking at premises in an area of high footfall in the town centre where people come to walk about or shop. That presents a greater opportunity to share information about what we do, and we hope that people will come to use us and that we will become familiar to them as a service. We have identified a brand new office in Newtownards, where we had no service in the past because the fifth trust was formerly part of the South Eastern Trust area, and we hope to open that office before April 2010. I hope that all our offices will be up and running within 12 months of our establishment. The recruitment of staff has been a laborious process and taken much longer than we had anticipated. We would like to have completed that by now and moved on.

I turn to some of our work since we came into being on 1 April 2009. Over 3,000 people have made contact with the Patient and Client Council for a variety of reasons. Some of them, as I described earlier, wanted support to make a complaint. Others were people whom we sought out in order to involve them in the planning of services; I will talk more about that in a minute.

Some 240 of those people sought support in making a complaint. The Patient and Client Council does not investigate complaints, but it will support people through the complaints process in health and social care. That is an important distinction and one that we make clear. However, it is a daunting process for people who want to make a complaint. Therefore, we can help people to navigate that system, which is complex, particularly since it changed on 1 April 2009, which added to the confusion. Therefore, we have a key role in supporting people through that process. Since 1 April 2009, we have asked more than 1,000 people for their views on health and social care.

In the past 10 months, one of our most important pieces of work involved asking the general public what their priorities would be if they were the Minister of Health, Social Services and Public Safety. That report is almost ready, and we will make it available to people should they want to read it. For many reasons, it was an important piece of work and one that we found interesting. Despite what some may think, people did not tell us that they wanted a hospital on every street corner. The public were extremely mature when it came to identifying the sorts of things that they felt they needed. They were realistic and recognised that there was not an endless pool of money for health. They were comfortable with that and recognised that, if they got some things, they would not get others.

The overwhelming majority of people told us that they wanted to be cared for as close to their own homes as possible and preferably in their own homes. They also wanted the correct structures to be in place to facilitate their wishes. People wanted to know that, on being discharged from hospital and advised that a district nurse or social worker would call on them, they could be comfortable that that would happen. They also wanted to be involved in the planning of their care through dialogue with those who provide it.

We heard another somewhat sobering request: people do not want to have to repeat their story every time they met a new healthcare professional. Some people’s stories are distressing and having to repeat them is frustrating and upsetting. However, people did not feel confident that those who were caring for them talked to each other, because they did not know their situation. People, therefore, were not confident that the system was joined up.

Interestingly, we found that people focused not on huge resources but on different ways of providing services. Furthermore, carers were happy to be involved in caring as long as they received the correct support. We plan to give that piece of work to the Minister in the hope that, when he considers the 2010 priorities for action, some of the ideas of the people who use the services can be incorporated in such a way that we can start to view them as targets. We are extremely glad that we carried out that significant piece of work and are pleased to have an opportunity now to share it.

We have also created forums so that people can be heard. It is a question of having patient representation on senior groups. For example, at meetings of the Regional Safety Forum groups, people approached us and asked whether a member of our staff could sit on a group to represent patients and clients. Our response was that we had never acquired a healthcare-associated infection, nor had we received chemotherapy, so we were not in a position to tell the forum about such experiences. However, we told them that we could find someone who has been through those experiences. We are starting to identify people who have been through, and come out the other end of, such experiences and are willing and prepared to share that experience, so that the people who provide the services know what it feels like to be on the receiving end of them.

On one level, including carers in such groups seems straightforward, but we came up against quite a lot of resistance. That resistance to including patients and carers was partly because of a perceived lack of familiarity with the workings of such groups and partly because it was felt that they might hold up business. That forced people to think about the jargon that they use. If some people around the table are unfamiliar with the proceedings, thought must be given to the use of certain words and acronyms. We will continue with that important work, because nobody is better placed to describe an experience than those who have been through it.

We are heavily involved in the work associated with the Bamford review. The Patient and Client Council has set up the Bamford monitoring group. It will ensure that people who use mental health or learning disability services are aware of the action plan kicking in. They will be able to tell the monitoring group which changes are working and which are not. We will direct their feedback through to the Bamford task force that implements the action plan.

It is important that we get the right representation on the group. We carried out extensive work to achieve a good spread of the users of mental health services and their carers, and learning disability service users and their carers, to ensure that the people who have experienced services on the ground are able to describe exactly what they are like. We have an opportunity to fashion for the task force what the priorities are for people on the ground, as opposed to the priorities for those who deliver the services.

We have also been working with providers on specific issues, and I shall give you three key examples. First, access to dental services is an issue for many people. It is something of a geographical issue, in that some areas are better served than others. Earlier in our existence, we conducted a baseline survey of access to dental services in various parts of Northern Ireland, with a view to repeating the survey in 18 months' time when new money and services had had an opportunity to bed down. We wanted to see whether money was starting to make a difference and whether people felt that they had better or quicker access to an NHS dentist.

The process threw up instances of people being taken off dental practice registers because they had not attended within a two-year period. In addition, some children with learning disabilities could access NHS dentists but others could not. We now have a raft of issues on which we can begin to work on directly with dentists and those who plan dental services. Once again, patients provided an interesting perspective. Geographically, one could almost draw a line across Northern Ireland to indicate where services are good and where they are less good.

Secondly, we have begun to examine what people think about access to GP out-of-hours services. That involves working with people who use those services most, such as, at one end of the spectrum, mothers with young children and, at the other end of the spectrum, carers of elderly relatives. We received the sort of information that could not be obtained without creating a forum for sitting down and talking to people about their experiences. Something else struck me about the GP out-of-hours service: if a parent takes a sick baby to a doctor and the doctor makes him or her better, that parent forgets about having to wait for an hour and a half to see that doctor or the drive to the surgery. Such parents are simply glad that they were able to access the service. However, there is much that we can do to make the whole experience a bit more positive for everybody.

The Chairperson:
There are only a couple of minutes left.

Mrs Hully:
OK. The final example of interest relates to the readmission to hospital of cancer patients. Patients who are receiving chemotherapy often have to be readmitted to hospital because their treatment makes them feel unwell. However, they may end up sitting in A&E before being readmitted, which makes them feel vulnerable and uncomfortable. On one hand, cancer patients

are told to stay at home and take life gently because of the chemotherapy, but, on the other hand, they are told that, if they feel unwell, they must attend A&E. As we all know, anyone who feels unwell does not want to spend a great deal of time there. A group of cancer patients and their carers came directly to us to discuss the issue. We are now working with the cancer unit to try to fast-track the process for those receiving chemotherapy by cutting out that trip to A&E and finding beds for them immediately.

Finally, I will outline some of the actions that we hope to take over the next 12 months. We will continue to look at innovative, including virtual, ways of engaging with patients, clients, carers and communities. It is not always a matter of sitting down with a group of 50 people; it can be about setting up a website or getting a Twitter page up and running. If we want to attract a younger population, we will to have to think a wee bit more innovatively.

We also want to develop advocacy services across Northern Ireland. Many services are currently offered, but we can do much to develop training guidelines and standards for advocacy, and we can also support people in doing that. We also want to develop further our work with priorities for action, by asking people, for example, what there priorities would be if they were the Minister of Health, Social Services and Public Safety. We want to select one major issue of concern and work on that with service providers over the next 12 months. It might be something to do with community care or domiciliary care, which is a big worry for people, or healthcare-acquired infections.

The Chairperson:
Thank you. I wanted to leave some time for members to ask questions, because the Committee and the council will have dealings with each other fairly regularly.

I view the Patient and Client Council as being like the Consumer Council for the health sector. The Consumer Council has quite effective powers: it can formally refer cases that require a departmental response. We, as MLAs, frequently receive complaints. There is not a week that goes by that we do not receive a complaint about some aspect of healthcare, which we then refer through the formal procedures. What powers does the Patient and Client Council have that are additional or different to those of an MP or MLA? Does the council have a similar level of authority, albeit in a rather different field, to the Consumer Council? In other words, beyond embarrassing and castigating people, what clout does the council have?

Mr Keanie:

First, the major difference between the new organisation and that which went before it is that the new organisation is embedded in the legislation that set up the new structures in the Health Service. All health and social care organisations are now required to consult and listen to the council. The legislation also affords the council the opportunity to gain entry to premises and to require organisations to hand over information that it needs in the pursuance of a complaint. The council has considerable powers that did not exist before. Chairperson, you asked specifically about what we have done. It would be interesting to read a detailed comparison of the difference between the powers of the Patient and Client Council and those of the Consumer Council. However, as we have not done made such a comparison, I cannot answer that question in any great detail.

The council has used its new legislative clout in some of its recent work. What I just said is all very well, but I predict that the next question would be whether the council has clout when it comes to the crunch. I am sure that the Committee does not want to hear details of particular cases in this forum. However, on one occasion, it was clear that our intervention reopened an issue that people thought was, or would have liked to have been, closed. In fact, the person who continued to make the complaints was re-engaged with at a high level and obtained some satisfaction. The body of work that we are building contains some genuine examples of how our position in the legislative arena is beginning to work.

The Chairperson:

You have the same inspection powers as the RQIA because you can demand entry to premises or hospitals, which is significant. When you find something that you feel is totally inappropriate, you can issue a report or complaint. Can you do anything more than that? Do you have the power to apply sanctions?

Mr Keanie:

No, we do not have specific sanctions. The responsibility for dealing with issues that we identify clearly lie elsewhere: it lies, for example, with the trusts, and, ultimately, with the Minister. One of the other differences lies in the set of relationships that we will be able to build. Previously, the health and social care councils around Northern Ireland had no point of contact or overarching body. In contrast, the Patient and Client Council has a central body with a board, which identifies cross-cutting issues and which, through me as chairperson, has pretty good access to the Minister.

I would like to be asked the same question again in a year's time because, as everyone around this table knows, the proof will be in the results. I would like to build up a body of work and results and to answer your question about effectiveness more fully at a later date.

Mrs O'Neill:
You are both very welcome, and it is nice to see you again. The voices of patients, carers and the community must be heard as we plan our Health Service, and, therefore, you play a key role. I want to ask about how you publicise your work and let people know where you are. I accept that the organisation is relatively new and is still establishing itself. However, how would the council work for me if, for example, I had a disagreement with a doctor about how my child was being treated in hospital and I did not know where to go? I would call you, but what would happen then?

Mrs Hully:
The fact that you called us would be a good sign because you knew that we were available. There is almost a step before that, in that the public must know that we exist and that we offer that service. That is part of the work that we need to get stuck into now. We must start working on our relationship with the public, so that people are signposted in our direction and told to talk to the Patient and Client Council. To date, many people have come to us through referrals.

We also need to build productive relationships with the health and social care trusts so that they also signpost people to us. Furthermore, we need to raise our profile, so that people are aware of us before they have a problem. We are examining how we communicate our message to ensure that people know how to access us. We need to improve our communication through our website, leaflets and information. However, it is essential that we carry out a specific piece of work, so that people immediately think of coming to the Patient and Client Council because they know what we do, who we are and how we can help them.

Mr Keanie:
Maeve is at an advanced stage of that work. The communication plan, for example, is just about ready to be activated.

Mrs O'Neill:

People are reluctant to complain, especially if, for example, a member of their family is in hospital at the time. They are almost afraid to complain in case it interferes with the care of their relative. We need to educate people on how to complain and what organisation to approach for advice. If, for example, I had a complaint about the trust, you would not contact the trust for me, but you would tell me how to go about it: is that right?

Mrs Hully:

Not necessarily. It depends on what you need. Some people do not even know where to start, and we will walk them through the process, whereas other people may wish us to make a phone call or help them to write a letter. We also follow up on cases to make sure that the person achieves some kind of resolution. Once people begin the complaints process, we will support them until they feel satisfied that their complaint has been dealt with appropriately. That is determined by the individual needs of the person who comes to us for help.

Quite often, after holding a session with a group — for example, at the moment we are working with priorities for action — people wait behind to tell us what happened to them and ask for help to make a complaint. There is a snowball effect; the more our organisation is out there, the more people understand what we do and the more they think that we are the people to whom they need to speak. We have to get out there on the ground, because we have a responsibility to let people know what we do and how we do it.

Mr Keanie:

In answer to Michelle's question, we hold our board meetings in different venues around the country every month, and they are open to the public. Right from the start, we took the approach that the public should be allowed to speak at those meetings. Although formally and officially they are meetings held in public, as opposed to public meetings, we involve any members of the public who attend. We have had some great input from that source. It is a matter of building up a body of work. That process is ongoing, but it will not happen overnight. We are making every effort to get out there to let people see who we are and what we can do for them.

Mrs O'Neill:

I am sure that the Chairperson will agree with me that we will be particularly interested in any work that you do on domiciliary care, because the Committee has been considering looking into that area, but it is difficult to fit everything in. Keep us informed, because we too are interested in the rights of the patient.

Mr Easton:
Thank you for your presentation. When following up on cases, do you get to find out the outcome of every complaint?

Mrs Hully:
Yes. That is exactly what we do as part of the process. We stay alongside people until they feel that their complaint has been adequately heard and responded to. That will not always mean that people hear what they want to hear, but it is about achieving resolution and the trust or service provider taking on board what has been said. That has an added advantage, because we want the trusts to learn from the complaints. If we see a number of complaints about the same issue being made in the same area, we approach the relevant trust. We inform the trust that the problem seems to be recurring, and we ask what is going on. As a regional organisation, we are able to adopt a regional perspective.

One element of our work is to support the individual the whole way through the complaints process, and a knock-on effect of that is that the trust can learn from the complaints made against it. We take responsibility for making sure that the trust takes that learning on board.

Mr Easton:
I have a couple more questions; do not worry, they are easy. Will you remind me of the structure of the Patient and Client Council? How many people in that organisation are lay people, how many are councillors, and how many are from the trade unions. I cannot remember the exact breakdown.

Your organisation has five local offices — one in every trust area — and your regional office will move out of Belfast. Would it not have made sense to keep the regional office in Belfast along with the local office? Would that not have saved a bit of money?

Mr Keanie:
There are some elements over which we had control and others that were handed to us as givens. The movement of the regional office to Antrim was part of the overall thrust to try to take some

government jobs, albeit a small number in this case, out of Belfast.

The Chairperson:

The world does not end at Glengormley. I applaud the move to Antrim. You can spot the member who lives in the Belfast area, Mr Keanie.

Mr Keanie:

I am trying to be as unpartisan as I can. Before we arrived on the scene, the decision was taken to move the office to Antrim. We have been doing everything we can to identify premises in Antrim, and that is way things sit at the minute, Alex.

As to your question about the make-up of the council, there are five lay people, five councillors, five from the voluntary and community sector and one trade union representative. Every one of those people went through the public appointments process, as did I and the elected members. We ended up with a board composed of people who had to go through that process and are genuinely interested in being there, and it looks as though it is shaping up pretty well.

Mrs McGill:

You are both welcome, and thank you for the briefing. I want to draw out some further information from you on questions raised by the Deputy Chairperson, Michelle O’Neill. Your organisation has the potential to effect change, particularly for those in the community who need to have a voice. I hope that all of the various structures will not eventually get in the way of the intended purpose of the Patient and Client Council. I need repeated assurance that that will not happen.

With respect to engaging with communities, John mentioned that the board meetings take place in public. Is it your view that those who attend A&E at Altnagelvin, for example, should attend those meetings? The Committee and I have raised the issue of the waiting times at Altnagelvin over a considerable time, and we are all working on that issue. The problem has been brought to my attention as an elected member. Should a patient who has to wait for five or six hours in A&E at Altnagelvin be encouraged to attend a board meeting? Maeve mentioned that some patients may be receiving chemotherapy and that others may be in pain. Would such people even be aware of the board meeting? I am not convinced that they would. Is that kind of community engagement really what we want to aim for? We need something much more substantial. It is important to have public engagement, John and Maeve with your work on specific issues. I would welcome a critical piece of work on waiting times in A&E and on the environment that patients experience when they have to wait there for five hours. I would like to hear your views on that.

On another point, you said that over 3,000 people have contacted the council, which may contradict the point I have just made. That seems a substantial number of people in a relatively short period. How did they contact you, and what was the upshot of their making contact?

Michelle O'Neill and Alex Easton raised one further point about meeting communities. MLAs could arrange for you to come into their constituency offices, and so forth, which would be a great opportunity for you. I wish you well in your work, and I thank you for your efforts.

The Chairperson:
Claire raised quite a few points.

Mr Keanie:
Let me have a stab at the first question, Claire. We want to hear from people who have suffered the kind of experience that you described. At the heart of everything we do is the question: what has been the person's experience? One may talk about health matters at a high policy level and work down through strategies and action plans. However, we really want to know about the essence of the process and what it has delivered for individuals or groups. Therefore, the answer to your question is that the Patient and Client Council wants to hear from the individual who has had a particular experience, such as the one that you described.

Maeve mentioned a specific group of people who receive chemotherapy and yet have to go through that sometimes uncomfortable process of sitting in A&E before being seen. However, you also referred to a wider issue, Claire.

The implied second part of you question —correct me if I am wrong — was about what the Patient and Client Council does to get out into the community to hear from people. The council has done a great deal to make itself known to people, and, if it was not getting through somehow, 3,000 people would not have been in contact. However, as Maeve described earlier, much work remains to be done, and we must create a much greater public awareness of what the Patient and

Client Council is about and how it can help. That can be done through simple measures such as the promotion of its single phone number point of contact.

Mrs McGill:
How did those 3,000 people contact the council?

Mrs Hully:
They did so through a combination of methods. When the council was created, it absorbed some legacy organisations. Therefore, some people were already in the system and required continued support when the council was created. The council also supports a great many people through its complaints advocacy work. Others made contact with the council through its engagement exercises — for example, the consultation exercise that the council conducted in connection with priorities for action. Other methods of contact include phone calls and through websites.

Above all else, the general public is interested in health and social care. Many of the contacts the council has received concerned people looking for dentists, and so forth. Therefore, in addition to specific complaints about the Health Service, many of the contacts concerned patients who needed to be directed to other parts of the Health Service. That provides some evidence of the spectrum of work in which we are involved.

Mr Keanie:
Claire, I think that the final part of your question, which focused on how the council engages with communities, was more of an offer. The council is happy to receive any help that it can get in engaging with communities and would be delighted to take up any such offers. Maeve and her team have visited all of the district councils and made our offer known to them, but we would be happy to hear any further suggestions.

Mrs McGill:
I suggested that I would welcome the council undertaking an investigation into A&E waiting times, particularly in the west, where there is not the same level of hospital provision as exists elsewhere. There has been a reduction in the numbers of hospitals in the west, and the new hospital in Enniskillen is not yet open. Therefore, it is important to examine what is happening with A&E waiting times in Altnagelvin Hospital.

The Chairperson:

The world does not end at Drumahoe. *[Laughter]* We are getting close to becoming parochial.

Mrs McGill:

I make no apologies for that, Chair.

Mrs Hully:

The undertaking of a piece of work on a particular issue, such as the one that exists in the west, is the essence of what the council does. You may leave that one with me.

Mrs McGill:

That work should lie with the council. Thank you.

The Chairperson:

If I missed any of that, no doubt I will see it in the 'Strabane Chronicle' next week. The next member to ask a question is Sue Ramsey, who, I am sure, will not be parochial.

Ms S Ramsey:

I will not be parochial. I thank the witnesses for their presentation, and I have a couple of questions.

I am not sure whether I need to declare an interest, but given the week that we are in, I will do so anyway. A family member, who previously approached the former Eastern Health and Social Care Council, is now being assisted by the Patient and Client Council. The help, support and guidance that she has received over the past few years has been great, particularly given the complexity of the issues involved. Unfortunately, the problems that she experienced resulted in the death of her child, but I do not want to go into that. The way in which the former council and your organisation have helped and guided people through such experiences cannot be ignored. You deal with individual complaints and issues, and the support that you provide is immeasurable. Congratulations on that.

Both Maeve and John mentioned the structure of the Patient and Client Council, and I know that they are public appointments. That allows the Minister to make appointments to the body based on the people who apply. My difficulty with public appointments is that for years the same people were always being appointed. Many of the same people sat on the boards of various bodies.

You are talking about conducting extensive research and selling yourselves to the community. How people can get onto the body, and how the concept of public appointments can be sold to the community, are key concerns. It is OK to say that lay people, local councillors and representatives of the community and voluntary sector are involved, but we need to make the process relevant to people on the ground. We need to change mindsets and let people know that public appointments are open to everyone.

Do you hold information about complaints centrally and use it to analyse whether there are any patterns? Someone who has attended a hospital and wants to make a complaint will usually fill in a hospital complaint form. Regardless of whether the matter is dealt with internally or whether the person making the complaint wants to forget about it after being discharged, does your organisation receive a copy of the complaint? For example, during the outbreaks of hospital-acquired infections, people were coming to us to complain that hospitals were dirty and wards were stinking. I am sure that some of those people made complaints; do such complaints reach you? There is a need to be proactive so that you can analyse the complaints coming through and, subsequently, implement a strategy for dealing with them.

Mr Keanie:

You touched on an important issue regarding public appointments. Across the public appointments process, but particularly for the Patient and Client Council given its name, we would not have much hope of being effective if it was simply a matter of the usual suspects sitting on a board. The process that established our board was pretty fresh, and most of its members do not hold other public appointments. Indeed, one of the board members Dr Sheila Kelly is seated behind us, and I do not think that she holds any other public appointment. Many new people have come onto our board, and we are expanding the opportunities for people to be involved.

Maeve described the set-up of the local advisory committees, which have enabled a large number of people from around Northern Ireland, who would not otherwise have had the opportunity, to become involved in the process. That is a structured opportunity, because whatever people say at the local advisory committees will be fed to our central body and will, therefore, have a better chance of having an impact.

There is also an opportunity to co-opt people to the board for a specified period. If a particular issue arises, someone who has a relevant set of experiences and expertise can be co-opted. We are expanding the opportunity to enable people with interest, knowledge and experience, who have never been able to get involved before, to be a part of the process of making changes. You have hit on a point that is vital to us as an organisation, and it is one that we are trying to do something about.

Mrs Hully:
The first question was on holding information, and the second was on whether we seek information on complaints from the trusts. To answer the second question first, we access information about patients who come to us. If someone comes to us to make a complaint about any of the trusts, we will work, with the agreement of the complainant, with the complaints people in that trust to retrieve the relevant information on the original complaint.

As the legacy organisations were four individual organisations, they held information only on their respective areas. We are working with the Department and trusts to obtain that information regionally, so that we can determine where the major complaints are, whether one trust receives more complaints than another and what the main issues are. We have not yet had the opportunity to do that. The end of this quarter will be the first quarter for which that information will be available to us. That information will be important in helping us to identify the key issues and determine where the major complaints are being made. We will have the opportunity to see whether one area receives no complaints while another area receives many.

Ms S Ramsey:
That is useful to know, and it is important. However, if 10 people made a complaint about a hospital today, there is a possibility that those complaints could be dealt with internally, unless one of them were to be directed to you.

Mrs Hully:
Yes, or we could receive the information retrospectively.

Ms S Ramsey:

If the complaint is about cleanliness, it could remain internal to that hospital.

Mrs Hully:

Yes, that is correct.

The Chairperson:

We have a few minutes left, and John McCallister is the last member to ask a question.

Mr McCallister:

At least I am allowed to be parochial, because the Chairperson and I are from the same constituency. *[Laughter.]* Leading off on that, why was the southern area office not based in Rathfriland? *[Laughter.]*

The Chairperson:

Is one not based in Broughshane?

Mr McCallister:

That hub of activity? *[Laughter.]*

I apologise for missing the start of your presentation. I support the work that you have been doing. Following on from what Claire said, the key is to get your message out to as many people as possible. Have you thought about using some of the newer technologies, Assembly Members' constituency offices or councils? Do you have any ideas on that? Have you considered internet websites, such as Facebook?

Have you had much contact with professionals across the health and social care arena to persuade them to buy-in to the idea? What contact have you had with the Royal Colleges, for example, in trying to broaden the scope of your message? Have you sent out the message that your purpose is to find a way through problems and not to find scapegoats? That would ensure that everyone buys into your organisation on one level, supports it and recognises that it exists for the common good. As you rightly pointed out, the key person throughout is the user.

Mrs Hully:

To answer the second part of your question, you are right that the staff are key. When we sat down to examine the role of the organisation and consider its values, we thought about how to build relationships, so that, if someone were to come to a hospital or to a member of staff with a concern or complaint, the relationships would already be in place, and that would make any complaints procedures easier to negotiate.

We spent quite a lot of time building up relationships, specifically with individual trusts, and, as part of that, with various members of staff. The complaints that are submitted are devastating to staff too, particularly in areas in which staff feel that they have been working extremely hard. Therefore, it is important that the staff are part of the process.

Earlier, I talked about trusts learning from complaints and engaging staff in discovering what happened, how it happened and ensuring that it will not happen again. There is great deal of work going on in that area.

Another point to make about staff is that, potentially, they will all be users of the services, so they will already have some interest in the Patient and Client Council. Indeed, our trade union representative is a member of the Royal College of Nursing. Our engagement with the Royal Colleges is important. It is a question of ensuring that we get our message across at all levels and that we tailor that message so that it can be understood and absorbed in each of the various arenas in which we operate.

Mr Keanie:

The fact that Maeve and I are increasingly being asked to attend many professional bodies' events is a small anecdotal indication of the interest that we are generating among them, so awareness of the council is growing.

John, with respect to contacting people and getting our message out, a major part of what we want to do over the next few months is to develop more innovative ways of getting in touch with people. The offices that we inherited are as much about facilitating contact with people as anything else, so that aspect of our set-up, as well as every other way in which we contact people, is up for constant review.

As for our use of technology, at present we have only a rudimentary website that comprises just a page or two of links to the old council-operated sites. Next week, we will evaluate tenders for a brand new website, which we intend to be as interactive as possible. I have a great interest and a little background in that subject, so I want to ensure that we develop a website that is relevant, as interactive as possible and gives people what they need. We are attempting to be as innovative as we can be, and it is one area in which we really must score highly. As I said to the Chairperson earlier, ask me the question again in a few months' or a year's time, John.

The Chairperson:

Thank you. We are spot on for time, which is good news. The Committee has made several attempts to address the issue of social care in a much more meaningful way. However, we have been deflected by some media crises, such as A&E and hygiene. Nevertheless, we are interested in finding out about what you do, because, although it is an extremely important aspect of the Department's work, it has been much neglected. Furthermore, given what you outlined, it is important that we do not reinvent the wheel. Your work could complement that of the Committee and vice versa. Therefore, if you were to carry out major research into a particular issue, there would, perhaps, be no need for us to replicate that work, because both bodies are independent and work at the behest of the Department and the trusts.

Your evidence was extremely helpful and provided a good introduction to the Patient and Client Council's work, and, in the coming years, we expect to liaise with you quite a bit. Thank you for your presentation.