



Department of  
**Health, Social Services  
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydënter Heisin  
an Fowk Siccar**

## **HEALTH AND SOCIAL CARE REFORM**

### **DHSSPS**

#### **Modernisation and Improvement Programme Board (MIPB)**

#### **PCC - Strategic Relationship between**

#### **PCC and HSC bodies**

**JANUARY 2009**

**MIPB 07/09**

This paper has been developed by the Work Plan workstream of the Patient and Client Council project. It describes the key relationships between the PCC and the rest of the Health and Social Care family of organisations and the key relationships that the PCC will need to establish and maintain outside HSC organisations. It has been approved by the Modernisation and Improvement Programme Board and is now free for circulation to HSC staff and other relevant stakeholders. A copy of the paper will be placed on the Health and Social Care Reform section of the departmental website - [www.dhsspsni.gov.uk/index/hss/rpa-home.htm](http://www.dhsspsni.gov.uk/index/hss/rpa-home.htm)

The paper is summarised below;

Part 1 of the paper sets out the context of the PCC strategic relationships including:

- The five statutory functions and powers underpinning their relationships
- The organisational qualities of independence.
- Representation and statutory empowerment

Part 2 sets out the strategic relationships between the PCC, and:

- The Department
- RHSCB
- RAPHSW
- HSC Trusts
- Special Agencies
- RBSO
- RQIA.

Further information on this document or the PCC Project may be obtained from Ray Martin, Project Director, [ray.martin@dhsspsni.gov.uk](mailto:ray.martin@dhsspsni.gov.uk), 02890523398.

## **Introduction**

This paper has been developed by the Work Plan workstream of the Patient and Client Council project. It describes the key relationships between the PCC and the rest of the Health and Social Care family of organisations and the key relationships that the PCC will need to establish and maintain outside HSC organisations. The paper is summarised below.

Part 1 of the paper sets out the context of the strategic relationships. The five statutory functions and powers underpinning the relationships and the organisational qualities of independence, representation and statutory empowerment are described. Alliances will need to be formed with, for example, NHS Centre for Involvement, the Social Care Institute for Excellence, the Picker Institute, RQIA and specialists in the voluntary and community sector if the PCC is to fulfil its functions.

Part 2 sets out the strategic relationships between the PCC, and the Department and HSC bodies including RHSCB, RAPHSW, HSC Trusts, Special Agencies, RBSO and RQIA. The Department functions in relation to the PCC and the PCC functions in relation to the Department are detailed. The paper identifies five aspects of the PCC's relationship with four separate groupings (RHSCB, RAPHSW, HSC Trusts and Special Agencies), namely, that of client organisation to the PCC, organisations accountable to the PCC, organisations that work together, organisations challenged by the PCC and organisations responding to complaints. The functions of the four groupings in relation to the PCC and the PCC functions in relation to the four groupings are set out. The functional relationship with the RBSO is also described. The relationship between the PCC and the RQIA is set out, for example, to ensure that when exercising their functions, each body is aware of the others' work plans and priorities. Finally, the PCC's informal involvement is described with three other key stakeholders, namely, the general public, local government and the voluntary and community sector groups.

**PCC Project Board**  
**Workstream C Sub Group**

**Paper:** *The relationship of the Patient and Client Council to other HSC Organisations and Key Stakeholders*

**1. Purpose of the Report**

- 1.1** The report has been compiled as part of the work of the Patient Client Council (PCC) Project Team. Its purpose is to describe the key relationships between the PCC and the rest of the Health and Social Care (HSC) family of organisations. It describes also key relationships that the PCC as part of its function will need to establish and maintain outside HSC organisations.

**PART 1 - CONTEXT**

**2. Context**

- 2.1** The PCC will be established in April 2009 with the following key functions contained within current draft legislation:
- i. To represent the interests of the public by:
    - consulting the public about matters relating to health and social care
    - reporting the views of those consulted to DHSSPS/HSC
    - publishing reports
  - ii. To promote Personal and Public Involvement by:
    - undertaking research and conducting investigations into the best methods and practices
    - providing advice regarding those methods and practices to HSC bodies
  - iii. To provide assistance to individuals making or intending to make a complaint by:
    - meeting all reasonable requirements
  - iv. To promote the provision of advice and information to the public by HSC bodies about design, commissioning and delivery of health and social care
  - v. Such other functions as may be prescribed
- 2.2** The draft legislation gives the following powers to the PCC to enable it to fulfil this range of functions and duties:
- i. HSC bodies must co-operate with the PCC
  - ii. HSC bodies must consult with the PCC
  - iii. HSC bodies must provide information to the PCC

- iv. HSC bodies must “have due regard” to the advice provided by the PCC
- v. Power of entry to HSC facilities (including primary care)
- vi. DHSSPS may, after consultation with PCC, approve a Consultation Scheme

**2.3** These functions and powers inform the following paragraphs on the necessary relationships the PCC will need to maintain, their purpose and their nature. In addition, the following paragraphs are informed by stakeholder input, a report on which appears at **Appendix A** of this document.

### **3. Qualities**

**3.1** The legislation does not make reference to values or to a mission for the PCC. However, there are organisational qualities implicit within the legislation that are relevant to describing the nature of the strategic relationships that the PCC will develop:

- Independence
- Representation
- Statutory Empowerment

**3.2** These organisational qualities might suggest the following characteristics and potentials for working relationships within HSC and beyond:

- The PCC is positioned uniquely to contribute to the public/HSC dialogue in a way that is non-aligned. All other bodies will be undertaking engagement towards a specific agenda – seeking to incorporate the outcomes of public involvement into the constraints within which they operate.
- The PCC has significant freedom – and the statutory underpinning – to ask difficult questions or address issues that are not being addressed elsewhere.
- The PCC is positioned uniquely to offer an objective critique of decisions and actions by HSC that is free of vested interest.
- The PCC – if it is to have any real credibility and authority notwithstanding its statutory powers - must be visibly, firmly and effectively rooted in communities of all types and kinds throughout Northern Ireland
- The PCC has a responsibility to support and enable effective engagement with an informed public by the HSC as a whole. In discharging this function, therefore, it has a responsibility both to the HSC organisations and to the public.

- The powers given to the PCC in legislation allow it to challenge HSC and ensure inclusive engagement. These are significant powers – it has access to key decision-makers as of right – and it will need to exercise these powers responsibly - and with demonstrable authority arising from its own engagement with the public. It may possibly favour those groups who otherwise lack the capacity or influence to advocate for themselves at high level.

#### **4. Alliances necessary for the fulfilment of PCC functions**

- 4.1** The resources likely to be available to the PCC have an impact on the types of relationships it will require to fulfil its functions. For example, the PCC is expected to be a resource for PPI and to carry out research on best practice. It will not have the capacity to do this alone. It will need to establish effective partnerships to fully deliver this function – for example, with the NHS Centre for Involvement, the Social Care Institute for Excellence and the Picker Institute – all of which are fully resourced as research organisations focussed on public involvement in health. Public involvement and consultation remains the lead responsibility of organisations commissioning and delivering health and social care.
- 4.2** The PCC - in appraising the quality and delivery of PPI across the system – as part of its role in advising DHSSPS on consultation schemes of HSC organisations prior to their approval – will not have the remit to undertaking monitoring, albeit that it will have a watching brief on activity in this area by HSC organisations. The monitoring function will be delivered therefore by agreement with RQIA. The PCC will, in this area, support and enable RQIA in its role as regulator.
- 4.3** The PCC as a complaints support organisation will not itself be capable of recruiting and retaining specialist staff for all the patient groups and service areas who seek this type of assistance. It will be likely to need to operate in some sort of alliance with specialists in the voluntary and community sector - for example, advocates for children and young people.

## **PART 2 – STRATEGIC RELATIONSHIPS**

### **5. Department of Health, Social Services and Public Safety**

#### **5.1 Nature of the Relationship**

The Department – and, through the Department, the Minister and Assembly – is the only part of the HSC structure to which the PCC is accountable. In all other organisations, the PCC is an independent body with a right of relationship. It is a Non Departmental Public Body.

- 5.2** However, the PCC is charged by the legislation with delivering on its functions with DHSSPS as with all other HSC organisations. Its accountability, therefore, will be in the context of an organisation that asserts its independence and its right to challenge the Department within the limitations of the function of the PCC.
- 5.3** It is to be understood, therefore, that the PCC will define and deliver its own priorities and objectives. However, such objectives and priorities will need to be part of an annual business plan agreed with the Minister/Department for which the PCC will remain accountable.
- 5.4** In addition, the PCC is fully accountable to the Department for the delivery of all of the functions with which it is charged and fully accountable to the Department for all matters of governance and statutory obligation.
- 5.5 Functions of the Department in relation to the PCC:**

The Department will:

- Appoint Members of the Council
- Provide a budget for the Council
- Ensure the submission of Annual Accounts to the Assembly
- Ensure the submission of the Report of the Comptroller and Auditor General to the Assembly
- Ensure the submission of the Annual Report to the Assembly
- Monitor and hold to account the Patient & Client Council
- Direct the Patient & Client Council when appropriate
- Ensure the congruence of PCC activities with the Framework Document
- Consult with the Patient & Client Council on HSC Consultation Schemes

**5.6 Functions of the PCC in relation to the Department**

The PCC will:

- Produce Annual Accounts for submission to the Department and to the Comptroller and Auditor General
- Produce an Annual Report for submission to the Department and for publication
- Be accountable to the Department for all of its functions
- Provide advice to the Department on policy and priorities
- Agree and deliver on an annual business plan with the Department
- Provide advice to the Department on Consultation Schemes
- Provide advice on policy and priorities
- Provide an independent challenge function to the Department on behalf of patients and the public

## **6. Regional Health and Social Care Board; Regional Agency for Public Health and Social Well-being; HSC Trusts; Special Agencies**

### **6.1 Nature of the Relationships**

These organisations are grouped under a single heading as – although their specific functions are different one from another – the essential characteristics of the relationship with the PCC are the same.

**6.2** Taken together, these organisations (i.e. the Board, Agency and Trusts) are one half of a dialogue, the other half of which comprises patients, clients and the public.

**6.3** The relationship with the PCC has five aspects:

- *As client organisations to the PCC*

The PCC must - to an extent to be agreed – act as a resource centre for PPI

- *As organisations accountable to the PCC*

Any formal accountability comes through the Department or the Regional Health and Social Care Board and Regional Agency for Public Health and Social Well-being. However, these organisations must engage with the PCC. The PCC has a right to expect their co-operation and to be consulted by them.

- *As organisations that work together*

Aspects of the PCC operation and those of these organisations will require joint working or collaboration. It may be that a Trust, for example, looks to the PCC as an “honest broker” in undertaking public engagement on a controversial topic. It may be that the PCC looks to a Trust for support in engaging with a specific patient group – for example, a survey of hospital inpatients.

- *As organisations challenged by the PCC*

It is a core function of the PCC to provide an informed and independent critique of the actions of HSC bodies on behalf of patient, clients and the general public

- *As organisations responding to complaints*

It is a core function of the PCC to provide complaints support to clients where HSC bodies will always be the party that is complained against

**6.4** The functions and nature of the PCC as set out in preceding paragraphs places certain key parameters around the working relationship with these HSC organisations:

- The PCC will not provide the PPI functions for any of these organisations. Each organisation is expected to undertake its own robust involvement and consultation.
- The PCC will assert its independence in its dealings with each of these organisations. Its involvement will not imply the endorsement or opposition of the PCC to any of the actions that they take. When the PCC wishes to state its endorsement or opposition to any action, it will do so explicitly.
- The PCC will assert its independence in the setting of its own agenda and priorities as part of an annual business plan agreed with the Minister/Department. It will not, therefore, be obliged by any of these organisations to undertake any activity with the exception of the PPI resource centre element of its functions.
- The PCC will scrutinise and comment upon the actions and decisions of HSC bodies. Challenge, therefore, will need to be an accepted part of any relationship with the PCC.
- The PCC when undertaking its complaints support function will act always in what it regards as the best interests of the individual client - notwithstanding any other corporate relationship to any HSC body

**6.5** The PCC is not itself accountable to any of these organisations. These organisations, as stated above, are informally accountable to the PCC. In the event of any serious dispute or disagreement on the manner in which either is discharging its functions to the other, this would be resolved by the DHSSPS – to which the PCC is fully accountable.

**6.6 Functions of the Regional Health and Social Care Board, Regional Agency for Public Health and Social Well-being, HSC Trusts and Special Agencies in relation to the PCC**

These HSC organisations will:

- Consult the PCC on the actions they take or propose to take
- Provide information that the PCC requests
- Generally co-operate with the PCC
- Provide access to premises when necessary

## **6.7 Functions of the PCC in relation to the Regional Health and Social Care Board, Regional Agency for Public Health and Social Well-being, HSC Trusts and Special Agencies:**

The PCC will:

- Respond to consultations in which the PCC has a specific interest
- Collaborate on specific work where appropriate in its view
- Provide insight on public and patient opinion arising from its work
- Support the development of PPI
- Seek to co-operate generally and constructively
- Provide a challenge and critique of activity based on its work
- Provide advocacy for complainants against any or all of these organisations

## **7. Regional Business Services Organisation**

### **7.1 Nature of the Relationship**

The relationship between the PCC and the Regional Business Services Organisation is purely functional. The RBSO does not deliver functions that require involvement and engagement with patients and the public except through the functions it carries out on behalf of organisations with which it has a contractual relationship who themselves remain responsible. The RBSO is not required to involve the public in the same way as the other HSC organisations.

**7.2** The relationship with the PCC is that of a client and a provider commissioned by it to deliver core corporate and organisational functions. However, the PCC will need to develop and maintain the capacity to specify, procure and quality assure the services it commissions from RBSO through the management of appropriate service level agreements.

### **7.3 Functions of the RBSO in relation to the PCC**

The RBSO will provide:

- Administrative support, advice and assistance
- Financial services
- Human resources, personnel and corporate services
- Training
- Management and maintenance of buildings, equipment and land
- Information technology and information management
- Procurement of goods and services
- Legal, medical and other technical services as required
- Internal audit and compliances

## **7.4 Functions of the PCC in relation to the RBSO**

The PCC will maintain sufficient management capacity to:

- Enable the effective delivery of RBSO support
- Meet all necessary statutory obligations
- Manage human resources for its operations
- Manage finance for its operations
- Report as necessary in accordance with RBSO requirements

## **8. RQIA**

### **8.1 Nature of the Relationship**

The PCC and RQIA are both Non Departmental Public Bodies accountable only to the DHSSPS. Neither is accountable to the other. Neither is required to discharge its functions in relation to the other. The relationship between the PCC and RQIA, therefore, will be by agreement and mutual and advisory in nature.

In the event that either organisation has a serious issue one with the other, the decision point will be at Departmental level. For this – and to maximise the benefit of the mutual functions of both organisations, it is preferable that they are placed under the same sponsor branch of the department.

### **8.2 Functions of the PCC and RQIA in relation to each other**

#### **8.2.1. Patient and Public Involvement – Internal**

The PCC will act in an advisory capacity to RQIA by agreement on the manner in which RQIA involves patients, clients, carers and the public in the fulfilment of its own functions.

#### **8.2.2. Patient and Public Involvement – External**

RQIA will incorporate inspection against standards of Personal and Public Involvement into their programmes of review and inspection. The PCC will act in a general advisory capacity and may enter into joint working and partnership arrangements for aspects of the review and inspection programmes.

Both RQIA and the PCC are autonomous in deciding how, and when, they will work together and will do so in accordance with their own priorities.

#### **8.2.3. Complaints Advocacy**

Actual advocacy on individual complaints will be regarded as a discrete area of work where the PCC is advocating on behalf of the complainant notwithstanding any other joint working or partnership arrangement.

There are three current key areas where the PCC may act as an advocate in relation to RQIA:

- Complaints made against RQIA itself
- Where RQIA is the second stage in a complaints process – in registered homes, for example
- Where a complaint is made relevant to the work of the Mental Health Commission

#### **8.2.4. General**

It is advisable that the two organisations meet regularly to discuss themes and issues arising from the exercise of their functions. These may inform priorities and work planning for both organisations.

The Department will be involved in the joint working arrangements of both organisations to the appropriate extent given the accountability of both of these organisations separately to the Department.

### **9. Other Stakeholders**

#### **9.1 Nature of the Relationships**

There are three key stakeholder groups essential to the successful delivery of PCC functions but outside the HSC family. Relationships are not formal, therefore – these stakeholders are under no obligation to work with the PCC. The PCC can usefully define, however, the type of relationship it would aspire to create with these bodies as a result of its effective function and shared interest.

#### **9.2 The three key stakeholder groups are:**

- The General Public
- Local Government
- The Voluntary and Community Sector

It will be noted that it is these three stakeholder groups that make up the members of the board of the Patient Client Council itself.

#### **9.3 It is in engagement with these stakeholders that the responsibility of the PCC comes to the fore:**

*“To promote the provision of advice and information to the public by HSC bodies about design, commissioning and delivery of health and social care”*

The expert knowledge of the PCC combined with its independence and its statutorily assured position within HSC are the things it can offer to these stakeholders. What it seeks in return is insight into agendas

outside HSC but nevertheless affecting it and engagement with the public that supports, enables and augments its own activities. .

#### **9.4 General Public**

The establishment of effective links with users, carers and wider communities outside organisational structures is a key task of the PCC. In order for it to be effective and to speak with authority, the PCC must base its agenda, its priorities and its critique on a knowledge and understanding of the views of the general public.

The PCC can offer the general public knowledge and insight into HSC operations and structures and, through its functions and status within those structures, access to influence. In addition, it can safeguard and promote meaningful involvement through its role in PPI development.

Finally, the PCC has a specific and substantial responsibility to the general public to provide access to a complaints support service for those with specific concerns about services that they have received from HSC.

#### **9.5 Local Government**

The increasing role of local government in the coming years and, in particular, its role in community planning make necessary a firmly established collaborative relationship between local government and the PCC.

The PCC will be in a position to offer local government independent knowledge and insight into the varying HSC agendas and operations and a direct contribution to the development of community planning.

Local government will be in a position to offer knowledge and insight into action on relevant agendas outside HSC but affecting it - agendas including neighbourhood renewal, housing and environmental initiatives.

It must be recognised, however, that where local government is working in partnership with the HSC to commission and/or deliver services, the PCC must maintain an appropriate critical detachment.

#### **9.6 The Voluntary and Community Sector**

The voluntary and community sectors can provide a depth of insight into specific issues within communities and groups on a local and regional level as well as access to service users and the general public.

The PCC can offer not only expertise in the HSC agenda but also its processes and culture.

The PCC would not in any way replace direct engagement with the community and voluntary sector by HSC organisations. It would underpin and augment these relationships by its functions and statutory position, particularly by:

- Its role in supporting engagement across HSC organisations and challenging these organisations where there are deficiencies
- Its statutory position and access as of right to HSC decision making structures – which can be employed to strengthen as necessary the voice of the voluntary and community sector within HSC

In addition to these strategic relationships, the Voluntary and Community sector can offer specific operational support to the delivery of a complaints support service, advising and participating in the delivery of this service on the basis of expertise in specific issues and conditions – for example, the needs of people with dementia.

**Feedback Report**

**1.0 Purpose of the Report**

**1.1** Feedback was sought from key stakeholders\* on the role of the Patient and Client Council by means of a questionnaire (attached at **Appendix B**). The purpose of this exercise was to inform two papers to be produced by the Workstream C Sub Group of the PCC Project Board -: the PCC Section of the DHSSPS Framework Document and a paper on the strategic relationships of the PCC.

**2.0 DHSSPS, Board and Trust Feedback**

**2.1** These organisations saw the PCC as providing a joint support and challenge function with the purpose of ensuring that patient and public views influenced policy, planning, decision-making and service delivery.

**2.2** These functions could be achieved through providing support and advice on patient and public engagement and also independent critique of HSC action on involvement. It was understood that the PCC would not carry out PPI on behalf of HSC. Each organisation was responsible for its own engagement.

**3.0 Voluntary and Community Sector Feedback**

**3.1** These organisations saw the PCC as a champion for the **quality** of patient and public involvement by ensuring that HSC engagement went beyond superficial consultations into dialogues of greater range and depth.

**3.2** There was concern that the PCC should not be seen in any sense as a gatekeeper for the relationship between the voluntary and community sector and HSC organisations.

**3.3** There was a desire to see the PCC as an expert body on HSC matters taking a lead on raising public awareness of HSC processes and structures. There was, in addition, a desire to see the PCC assert its independence not through campaigning so much as by maintaining an objective informed stance that would augment debate.

**4.0 Local Government**

**4.1** Local Government saw a relationship with the PCC as mutually supportive and strengthening. Councils foresaw a developing role in community planning towards which the PCC could make a specific and expert contribution from the HSC standpoint. In return, Councils would be in a position to provide the PCC with insight into public views and

opinion and to the wider community planning agenda on matters outside, but affecting, the HSC agenda.

## **5.0 RQIA**

**5.1** RQIA saw the need for clarity of respective function and mutual interest between the PCC and it. The importance of PPI in all aspects of HSC operations was noted and input from the PCC would need to be sought for RQIA to address this agenda within its function. However, RQIA would wish for it to be clear that evidence based and professional review work remained the remit of RQIA - notwithstanding work that would be undertaken by the PCC to deliver patient and public feedback to the HSC on its operations.

\* *The stakeholders engaged were:*

- *DHSSPS#*
- *Western Health and Social Care Trust#*
- *Eastern Health and Social Services Board#*
- *Community Development and Health Network*
- *Long Term Conditions Alliance*
- *Regulation and Quality Improvement Authority*
- *NI Local Government Association#*
- *Northern Ireland Council for Voluntary Action#*
- *Royal College of Nursing*

# *Denotes PCC Project Board Members*

**QUESTIONNAIRE FOR STAKEHOLDERS**

You have been asked to complete this questionnaire as a representative of one of the key stakeholders with which the new Patient and Client Council will require a strategic relationship. Its purpose is to produce, on behalf of the Patient and Client Council Project Board, a paper for the incoming senior management team that will contribute to the development of their agenda for establishing the organisation within the HSC family and among other stakeholders.

The term “your organisation” is used throughout. You should, where relevant, consider these questions in the light of plans for any successor body to your own.

1. What do you think the Patient and Client Council should exist to do and why?
  
2. In what ways would you think the Patient and Client Council should have an impact on the work of your organisation?
  
3. What (if any) areas of mutual interest, crossover or shared function should or might exist between the work of your organisation and that of the Patient and Client Council?
  
4. What (if any) areas of potential conflict or of duplication should or might exist between the work of your organisation and that of the Patient and Client Council?
  
5. In what ways should the Patient and Client Council relate to your organisation?

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**This document required the following approvals**

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