MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Meadhbha Monaghan
Date: 4 March 2024

I, Meadhbha Monaghan, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry: -

1. This statement is made on behalf of the PCC in response to the M1: Patient Advocacy and Representation Request for a witness statement, dated 6 February 2024, received from the Inquiry Team.

2. This is my first statement to the inquiry. A previous statement to the Inquiry was provided by Ms Vivian McConvey, who was then the Chief Executive of the Patient and Client Council, on 27 January 2023.

Qualifications and positions

3. I have been the Chief Executive Officer of the Patient and Client Council (‘the PCC’) since 13 March 2023. Prior to my appointment as Chief Executive Officer, I was the Head of Operations in the PCC from 15 May 2020 to 13 March 2023.

4. My primary degree is in Philosophy, a BA Hons from the University of Cambridge. I also hold an interdisciplinary Masters in Refugee and Forced Migration Studies from the University of Oxford.

Advocacy and representation

5. The effectiveness of arrangements to ensure that the views, wishes, concerns and complaints of service users and their families are appropriately addressed, within the Health and Social Care system, are dependent on effective systems of Governance.

6. The report by a review team entitled '*A Review of Leadership and Governance at Muckamore Abbey Hospital'* *Review of Leadership & Governance MAH 2020* published on 31 July 2020 provides a comprehensive description of statutory requirements, systems, standards, guidance, organisations and roles and responsibilities within the system of Clinical and Social Care Governance in Health and Social Care in Northern Ireland. The report covers Corporate, Clinical and Social Care, and Professional Governance. Amongst other things the report highlights the importance of training; having the right culture in place; and data including at times with specific reference to the provision of advocacy services, complaints handling, dealing with Serious Adverse Incidents (SAIs) and involving service users and carers. In theory these systems and these elements were in place with respect to Muckamore. However, they failed to operate as intended to safeguard patients and to ensure the quality of services.

7. Although the PCC has a broad range functions in relation to HSC, competing functions need to be balanced against an increasingly constrained budget. In real terms, the budget of the PCC currently, which sits at just under 2 million, represents a 40% decrease from whenever the organisation was set up in real terms. Therefore, in the overall health budget we have the second smallest budget in total, sitting at just under 2 million. The ability and the extent to which we are able to meet our statutory functions is impacted by resource. The numbers of complaints have remained fairly static over the last five years, though PCC have noted that the complexity of concerns and complaints has increased at a time when the health service is facing severe pressures and challenges.

8. PCC have developed, since 2020, a practice model that sets out, within the resource that we have, structures that we seek to engage the public directly through on a number of different programmes of care, largely determined by what the public have told us are important to them or which align to key policy and programme directives at a departmental level. That would include mental health, learning disability, care of older people, adult protection, SAIs.

9. The PCC has specific roles in relation to representing the interests of service users including providing them with support in raising issues and concerns and in making complaints. This role is largely discharged through the advocacy services we provide. These services include providing advice and support to service users and families in how to navigate their way through the health and social care system in general, even when they don’t have a specific issue or complaint, as well as supporting them in relation to specific processes such as Complaints, SAIs. The PCC does not currently have a role in Lookback Exercises and would welcome an amendment to current guidance. In particular, PCC would ask that consideration for the need to engage with families takes place at a much earlier stage in the Lookback Exercise. PCC would be an organisation which could be resourced to provide advice in relation to that engagement.

10. Some of these ‘system’ processes such as those in relation to child protection, looked after children, mental health, disability and safeguarding are underpinned by statutory provisions and professional practice which may be extremely difficult for those outside the health and social care system to navigate without this advocacy support. Associated with this is a significant information imbalance with service users and families at a significant disadvantage. Our experience is that they don’t have available to them accessible information, which enables them to navigate their way through these systems.

11. From a PCC perspective we view measures which broaden, strengthen and better resource advocacy services as important in their own right to ensure and improve the experience of individual service users and families as well as ensuring and

improving the quality of services they receive and outcomes for them. The availability and accessibility of advocacy services fundamentally supports access to social justice.

12. The PCC also considers that utilising the data generated as a by-product of providing these advocacy services can be an effective component part of clinical and social care governance in ensuring the safety and quality of services provided to the population as a whole.

13. It is however, in the PCC's view, very important that data and information being generated and shared with the different levels of management and Board members in organisations providing services is not solely generated from systems controlled by the organisation themselves and not solely based on reports generated by the organisations themselves. Organisations such as the RQIA play a role in providing reports external to HSC service provider organisations. There is a need to provide a parallel stream of information to ensure that data and reports reflecting the experience of service users and families are also generated independently of service provider organisations. This should allow management and Board members to consider this data and these reports alongside the data and reports generated internally within their organisation. This suggested approach is covered in more detail in paragraphs 58 to 62 below.

14. With regard to advocacy services, it is insufficient for advocacy services to just exist. It is how the advocacy services are received and viewed by the public and how they are integrated and embraced by the overall HSC system which is critically important.

15. There are issues with the culture within the HSC and with both the complaints and SAIs systems. These are already subject to a number of recommendations made by the Report of the Inquiry into Hyponatraemia Related Deaths (IHRD) published in 2019 and the Report of the Neurology Inquiry published in 2022. In particular, the IHRD report included a number of recommendations in relation to Candour, including a Statutory Duty of Candour, and on the reform of the SAI system to include for

example a fully funded independent advocacy service. The Neurology Inquiry included recommendations on the reform of the HSC complaints system. Many of these recommendations have yet to be fully implemented. The culture changes required take time to embed and remain in their infancy, whilst the provision of a fully funded patient advocacy service for SAIs has not been designed or consulted upon.

Statutory Powers of PCC

16. Articles 17 to 20 of the 2009 Reform Act specify the functions and other matters related to the PCC's discharge of those functions. Whilst over the past several years resourcing has been an issue for the PCC as it has been for other HSC Bodies it is important to understand the limitations of the legislation and the parameters within which the PCC discharges its functions. The articles are as follows:

    - Article 17 – Functions of the Patient and Client Council;
    - Article 18 – Duty to co-operate with the Patient and Client Council;
    - Article 19 – Public involvement and consultation; and
    - Article 20 – Public involvement: consultation schemes.

    The 'bodies' which come within the remit of Articles 18, 19 and 20 includes both the Department of Health and HSC Trusts.

17. Article 17 specifies a range of functions of the PCC which in addition to supporting clients who wish to make a complaint about Health and Social Care services also includes:

    (a) representing the interests of the public;

    (b) promoting involvement of the public;

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

18. Article 18 requires these bodies to co-operate with the PCC in the discharge of its functions. Whilst this article requires these bodies to consult the PCC, this is only in respect of matters and on such occasions as these bodies ***'consider appropriate'***. Similarly, whilst the PCC can essentially require these bodies to provide the PCC with information which the PCC requires in line with the PCC's functions, the information provided is **subject to whatever conditions** the providing body decides upon. This Article also gives the PCC Council a power of entry to premises controlled by any of these bodies. However, this power applies to members of the Council i.e. the PCC Board and does not extend to PCC staff and can only be exercised in connection with the PCC's functions. Finally, under Article 18 these bodies *must pay 'due regard'* to the views of the PCC but are *essentially free to ignore* those views if they so wish.

19. Article 19 places requirements on these bodies to take steps with regard to public involvement and consultation but it is for the **bodies themselves to decide what steps are appropriate**. The same article required these bodies, at the time the legislation was commenced, to prepare a consultation scheme for the Department to approve. Although this would be after consultation by the Department with the PCC it does not require that the PCC's views must be taken account of.

20. Article 20 requires that the consultation scheme must make it clear how it will involve and consult the PCC (amongst others) in regard to planning services etc. and must pay due regard to the views of the PCC (amongst others).

21. There is no statutory requirement for these bodies to update or resubmit these consultation schemes for approval even though the engagement and consultation

landscape has changed significantly since 2009, particularly in terms of public confidence in the HSC system and public expectations that they will be engaged and consulted with.

22. A ‘Framework’ document, first published by the Department around 2010, sets out in paragraph 2.47 “*The PCC’s relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to discharge its statutory functions efficiently and effectively on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC*”.

23. Paragraph 2.47 of the Framework Document summarises the constructive tension at the heart of the PCC’s functions – balancing on the one hand, remaining independent to be able to exercise a challenge function on behalf of the public, whilst on the other hand retaining constructive relationships with the wider HSC which, in the absence of stronger statutory powers, is critical in enabling the PCC to maintain influence.

24. This demonstrates how the PCC has statutory powers which limit the ways in which it can directly influence decisions on the provision of Health and Social Care Services. Therefore, the PCC is partly dependent on building constructive and productive relationships and arrangements with service providers and the third sector, as well as with those statutory bodies who have powers to investigate and take enforcement action where there are problems with the quality and availability of health and social care services. The PCC escalates and shares information about issues around individual cases to Trusts, RQIA, CoPNI, NICCY, the Ombudsman and professional regulatory bodies.

25. The approach of establishing partnerships and building relationships with others

does mean that the PCC is able to exercise a positive influence on the sector, despite these limitations, albeit via soft skills such as mediation and collaboration rather than though hard statutory obligation. However, this approach requires a significant commitment of time and resources for a small organisation like PCC and can take longer to reach a point when results are being achieved.

23. The limitations of the PCC's statutory powers coupled with the PCC's size and budgetary constraints means that the PCC can lack the desired leverage when seeking to achieve positive change. Potential opportunities to maximise influence on behalf of the public are compromised as a result.

Advocacy in the Health and Social Care context

24. Access to advocacy plays a fundamental role in governance and assurance. Supporting advocacy services provides a level of assurance that Trusts are committed to being learning organisations, committed to meeting their statutory duty of quality and are appropriately invested in the duty of candour and a culture of openness and transparency.

25. Advocacy support can and is provided through a range of models, that is independent advocacy, peer advocacy, self-advocacy and family advocates. The successful promotion of patient and family engagement with advocacy services is to a large degree determined by the Trust's commitment to and investment in advocacy. Listening to and hearing people's experience is the first line of defence when safeguarding vulnerable people.

26. The PCC believe that ultimately advocacy has the potential to improve the quality of services provided within the HSC and to lower system costs, as potential problems with services could be addressed early and possibly more constructively to the benefit of patient safety and experience. Trusts engaging more proactively with

advocacy providers and understanding user experience could provide an opportunity to be alerted to emerging trends before they become costly scandals and cause significant harm to patients. This is of overall benefit to the public and to service providers.

27. Understanding that advocacy provision may not be able to fully prevent a crisis, it can certainly help to deal with it at an earlier stage through improved patient engagement and contribution to system-wide trend spotting. PCC believe that consideration needs to be given to how lessons learned from complaints, SAIs and safeguarding incidents are communicated regionally/cross-sectorally/cross-organisationally.

Statutory Duty of Quality

28. HSC Trusts are subject to a Statutory Duty of Quality introduced in 2003 by the Quality Improvement and Regulation Order (Northern Ireland) (2003). The statutory duty placed the requirements for governance around the safety and quality of services on an equal footing with the requirements for financial governance.

29. The responsibility for having effective systems in place to deal with complaints and to investigate incidents sits with the service provider. Thus, the current complaints system places the onus on the service provider to address and resolve fairly the complaint. The PCC believes that this is the correct approach.

30. The Department’s guidance issued in April 2009 and subsequent updates including the most recent version issued in April 2023 include a set of complaints standards which service providers, including Health and Social Care Trusts, are expected to adhere to. The guidance places an emphasis on seeking early and fair local resolution of complaints. The Department’s guidance states that the complaints system: *“is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The*

HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs."

31. Consistent with the requirements imposed by the statutory duty of quality the guidance and standards issued by the Department places the responsibility for establishing and operating this complaints procedure on the organisations providing the service. In the case of HSC Trusts, the Chief Executive is accountable for the handling and consideration of complaints. It is the responsibility of the organisation providing the service to ensure that all of their staff are familiar with the HSC complaints process.

32. The Department guidance and standards place the onus on the organisation providing services to provide support to the complainant during the complaints process. It is not expected within the complaints process that all complainants will need or want to enlist the support of the PCC to fairly resolve their complaint. If that was to happen it would most likely indicate one or more of - a failure to operate an effective complaints procedure; a significant failure of internal control divergences and risk management within the organisations system of governance; a failure to comply with the Department's Direction and guidance on complaints; a failure to meet the requirements of the statutory duty of quality.

33. To meet this statutory duty requires that intelligence gleaned from complaints and incidents will form part of a service provider's systems to identify quality and safety issues thereby managing and mitigating risks to service user safety and ensuring the provision of quality services.

34. HSC Trusts as the first point of contact when things go wrong, and a complaint or SAI has commenced, are expected to inform and direct the public to the support

available from PCC and other sources of advocacy support available.

35. The PCC has a statutory function to assist people making or wishing to make a complaint through representation or otherwise about health and social care services, (Article 17 of the 2009 Reform Act). PCC have developed a practice model since 2019 (as set out in para 11 to 12 and 70 to 79 of Muckamore Abbey Hospital Inquiry, Witness Statement, Vivian McConvey, Date: 27 January 2023) which interprets this role as advocacy. The PCC thus provide a ***universal advocacy services*** into the health and social care system to service users and the public. The feedback from those to whom we provide this advocacy support is positive. The PCC has pursued a range of initiatives designed to increase our footprint in the community and to expand the range of opportunities available to the general public and service users to access our support.

36. The majority of the public who seek support from the PCC describe a negative and often distressing engagement experience when trying to find a resolution to their issues and complaints with the statutory body. Whilst this may not be true for all service users, it is for many of those who have availed of the PCC advocacy service. In some cases, those who contact the PCC have experienced harm resulting from the service received from statutory providers. In some cases, further harm has been reported by patients and families in how they have experienced the complaints resolution process or SAI review process. This harm relates to distress resulting from how the resolution process was undertaken and the relationship that they experienced with the HSC Trust staff.

37. The landscape within which service users and families access advocacy support has changed significantly in the past ten to fifteen years. Scandals involving health care, both in Northern Ireland and in other jurisdictions, have shaken public confidence in service providers and in their openness and transparency when things do go wrong. Members of the public have a growing and greater understanding of their rights. This in part is a result of support available through the accessibility of a much more

diverse range of information online from multiple different sources and the work of the voluntary and community sector services.

38. The need to ensure that both serious adverse incident reviews and the complaints process are effective, open, honest and fair and for service users and families to be listened to within these systems has never been greater. Implementation of the recommendations from the Neurology Inquiry (2022) and the Inquiry into Hyponatraemia Related Deaths (2019) on Complaints; the statutory Duty of Candour, SAI process; SAIs involving deaths; Trust Governance; and Culture and Litigation would go a considerable way to restoring public confidence.

39. PCC support public engagement through policy advocacy, assisting the public to become involved in policy and service planning / development / improvement initiatives being progressed by the Department of Health and HSC Trusts. In this work, PCC assist the public and in particular, directly the service user, to engage in a process which may or will change the configuration of services, policies, practice, laws or rules that impact how someone lives their life and the services they receive and have access to. This can be targeted at local or national level policy advocacy. Policy advocacy is a process of negotiating and mediating a dialogue through which influential networks, opinion leaders, and ultimately, decision makers connect with the ideas, evidence, and proposals emerging from the user experience, and subsequently act upon them.

40. Policy advocacy relates to PCC's duties in representing the interests of the public and promoting the involvement of the public. The PCC does not join review groups established by the Department or HSC Trusts as a member, where membership includes having a decision-making role or function in relation to the planning, commissioning and delivery of health and social care services and is not party to decisions made by such groups reserving the right to highlight any concerns regarding decisions made. The PCC does work to try to ensure that the views of service users are heard within the work of such groups. However, the PCC believes

that it has to remain separate from and independent of the HSC system if it is to then represent the interests of service users or families etc. who may be adversely affected by services and policies developed by such Departmental or HSC groups or bodies.

Types of Advocacy

41. In May 2012 the Department of Health published "*Developing Advocacy Services - A Policy Guide for Commissioners*" (Exhibit 1). The Policy Guide was developed by a working group established by the Department in June 2010 and chaired by the then Chief Executive of the PCC. The policy guide included the following descriptions of what advocacy is:

    - *"Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people."* (Bamford Review Report on Human Rights and Equality of Opportunity);
    - "*Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and justice*." (Advocacy Charter produced by Action for Advocacy); and
    - "*Advocacy is the process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up for justice*." (The Scottish Independent Advocacy Alliance: Principles and Standards for Independent Advocacy).

42. The guide summarised these descriptions of advocacy stating that: "*In summary,* *therefore, advocacy is about taking action to help people to:*

- *Express their views and wishes*
- *Secure their rights*
- *Have their interests represented*
- *Access information and services*
- *Explore choices and interests"*

43. The guide identified the most common types or "models" of advocacy as:

- *Citizen advocacy;*
- *Group/self-advocacy;*
- *Issue-based (also known as individual or professional) advocacy;*
- *Non-instructed advocacy; and*
- *Peer advocacy.*

And each of these types of advocacy is defined at Appendix One to the guide.

Sources of Advocacy Support within the Health and Social Care Sector

44. In the present day the primary sources of advocacy support to service users and families within the Health and Social Care sector is provided by:

a) The Patient and Client Council whose statutory role and functions underpin its provision of advocacy support;

b) A number of voluntary and Community sector organisations which are commissioned by HSC Trusts to provide advocacy services; and
c) Independent advocacy services as noted in the RQIA Report on its "*Review of Advocacy Services for Children and Adults in Northern Ireland"* (Exhibit 4) commissioned by the HSCB/ SPPG

45. PCC advocacy is most typically provided in the context of service users and families raising issues and making complaints with the care received in HSC services and Serious Adverse Incident (SAI) reviews. Voluntary sector advocacy services tend to support specific vulnerable people or communities, enabling them to access services and ensuring fulfilment of their rights and entitlements.

46. In addition, there are a number of statutory bodies, which service users can approach for support both within and outside the area of Health and Social Care i.e.

- The Northern Ireland Public Services Ombudsman (NIPSO);
- Commissioner for Older People in Northern Ireland (CoPNI);
- Northern Ireland Commissioner for Children and Young People (NICCY); and
- Mental Health Champion for Northern Ireland.

Patient and Client Council ("PCC") – Roles, Duties and Responsibilities

47. The roles, functions and powers of PCC are described in the statement provided to the Inquiry by Vivian McConvey**.** In 2019 the PCC was subject to a major review which examined its structures and practice methodology leading to significant changes. Vivian McConvey's statement also describes:

a) PCC structures - 2009 to 2019 and for the period since 2019;

b) PCC Practice Model/Methodology 2009 to 2019 and for the period since 2019;

c) PCC's role in providing advocacy in the context of the Muckamore Abbey Hospital Public Inquiry; and

d) Such information as PCC has in relation to advocacy services provided in Muckamore Abbey Hospital by Voluntary and Community Sector organisations;

Potential Future Role of Advocacy

48. In this statement I will set out how a focus on the following would improve communication, safeguarding and patient safety, including:
    - Why the system needs to change or be improved;
    - Developing an advocacy model that meets individualised needs;
    - Facilitating a centralised coordination of advocacy services and their data, that is designed to spot trends and patterns in complaints and act on them or refer them for action;
    - Understanding the importance and urgency of safeguarding and delivering the same at pace; and
    - Improved training on and monitoring of complaints handling across the healthcare system.

49. The PCC would welcome changes to the system which provide more independent assurance that HSC Trusts are adhering to the requirements of the Department's Direction on complaints and Departmental guidance and standards on complaints as well as SPPG guidance on SAIs.

50. In dealing with complaints HSC Trusts are expected to have trained their staff so that they are aware of their adverse incident reporting system as well as the HSC complaints system and how to deal with complaints.

51. Trust's training for staff should include:

    - familiarity with the HSC complaints system and standards;
    - understanding the role of advocacy in safeguarding vulnerable people and the different models; be that independent advocacy, peer advocacy, self-advocacy and family advocates;
    - understanding how advocacy can be integrated into the different decision-making fora in the patient's journey whilst in their care; and
    - Joint training with Trust staff and advocacy providers with regard to safeguarding procedures for children and vulnerable adults, ensuring that patients and families are fully informed and guided through the process.

Advocacy and Governance

52. The HSC Trusts should also have governance systems in place so that at different levels of management, up to and including Board level, aggregated data on complaints and incidents and significant concerns raised by individual complaints and incidents are considered to identify quality and safety issues.

53. The PCC has an extremely limited role or contribution to make in respect of the governance of HSC Trusts as set out in Department of Health Circulars, guidance, and regulations.

54. Extensive data is gathered by HSC Trusts and presented through their governance processes to enable HSC Trusts to monitor quality and safety of the services that they provide. PCC believe that data systems providing real time feedback on the service user experience sourced from an independent provider could be improved. This is direct feedback from patients, carers and service users. Flows of information from patients and families can supplement, support or test the hard data being presented to Trust Management and Boards based on their internal systems.

55. The patient and client experience is recognised as a key element in the delivery of quality healthcare. In line with this, the Public Health Agency (PHA) is responsible for leading the Regional Patient Client Experience (PCE) Programme for Northern Ireland, with the aim of embedding a more patient and client-focused approach to feedback of services and shaping future healthcare in Northern Ireland. 10,000 More Voices is one of the key initiatives within the regional PCE Programme. It provides an opportunity for deeper exploration of the public's experiences of healthcare through bespoke surveys.

56. Northern Ireland officially launched Care Opinion, also based in the PHA, as the feedback platform of choice in August 2020. This enables service users, carers and families to share their experiences of health and social care across Northern Ireland.

57. It would be helpful if the above functions could be more closely aligned with those of the PCC.

58. The PCC would also propose a change to the governance requirements placed by the Department on HSC Trusts by requiring them to report to their Boards on a regular basis, hard data and service user feedback / evidence benchmarked against the requirements of complaints guidance and standards and the Complaints Direction including also reporting on the Training of HSC Trust staff on complaints systems/advocacy and the monitoring of contractual arrangements with organisations commissioned to provide services on behalf of a Trust.

59. This proposed amendment would have the twin benefits of providing the Boards with assurance on the operation of the complaints procedure within their Trusts whilst reasserting the primary responsibility of Trusts to address the concerns raised by complainants. Action taken by Trust Board's to review the data would enhance their ability to monitor the quality and safety of the services they provide.

60. The PCC believes that it would be more helpful to the Boards of HSC Trusts if the PCC had a role in contributing to, for example annual quality reports, so that Board members were receiving more information directly from an independent source. However, the essence of the statutory duty of quality is that the Trusts must themselves establish effective systems of Governance, with the objective that it would never be the case that the PCC or any other external body are raising issues with a Trust Board that have not already been flagged up to them through their internal governance arrangements.

61. One proactive measure would be to include within the Department's guidance on governance a requirement for the PCC to provide direct feedback e.g. on an annual basis to Trust Boards based on the experience of service users gathered from the PCC's role in SAIs, complaints etc. Whilst this might be a useful addition to Trust governance arrangements, ***the PCC does not currently have the resources or budget to provide such a service****.* Therefore, the ability for the PCC to meet this requirement could only be achieved through the provision of a dedicated resource to provide an independent review of the Trust Quality Reports.

62. In response to the Hyponatraemia Inquiry the Department of Health developed extremely detailed guidance for Board members of ALBs. As yet, new training centred on this new guidance has not been developed although this has to be understood in the context of the COVID pandemic when understandably the Department's resources were heavily focussed on the pandemic response. The PCC would welcome the development of such a training course for Board members. Through the engagement of patients and service users providing a direct input to this training course, 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 participate in the development and delivery of this training.

- Patient experience is a key deliverable by the healthcare system;
- Improvements to complaints data pathways to HSC Boards is required;
- Greater assurance of complaints mechanism by HSC Boards would be welcome; and
- Improved feedback pathways between PCC and HSC Boards mandated by Department policy facilitate greater Board oversight.

A Confusing system

63. When supporting patients and families with addressing their concerns and complaints, PCC have experienced that initial complaints may actually have been safeguarding matters that require a clear process and rapid response to address, which is different from the complaints process. Advocacy services need to respond to safeguarding in a way that assists patients and families to navigate the complexity of safeguarding investigations. Families and patients require an understanding of the safeguarding process with a plain English leaflet and clear map of:

- Advocacy supports available;
- how to raise a concern and who to contact;
- what action should be taken by whom and when;
- the routine monitoring of complaints handling;
- how to escalate concerns if they feel that they are not being addressed appropriately; and
- an appointed independent senior designated officer within the Trust who the family or advocate can contact if they experience challenges or concerns with the safeguarding investigation

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

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

66. The PCC estimates that around 9 to 10% of the public who make a complaint related to HSC services access the PCC for support in making a complaint. This is because overwhelmingly Trusts are expected through their systems to support complainants and to respond to complaints without the need for service users and families to access support from the PCC or other organisations which provide advocacy services.

67. The current complaints system is underpinned by a combination of legislation, and Department of Health guidance and standards.

68. Serious Adverse Incident Reviews are governed by Department of Health (SPPG – formerly HSCB) guidance.

69. Lookback reviews are governed by Department of Health policy and standards.

70. Under the complaints system Trusts must advise complainants of the availability of support to complainants from the PCC. The PCC do not know the extent to which the

level of Trust staff's awareness of the PCC, and their Trust's responsibility to inform those wishing to make a complaint about the support available, may have on the number of people seeking support from the PCC.

71. PCC would suggest that there should be a report to the Trust Board on their compliance with complaints standards and guidance.

72. Trusts can commission their own advocacy services from voluntary and community sector organisations and can also advise complainants of the availability of advocacy support from these organisations. These organisations possess considerable levels of expertise in providing advocacy services.

73. The PCC believes however that the current arrangements for commissioning these services could be improved upon. The PCC believes that arrangements for advocacy provision as part of SAI reviews and Lookback exercises could also be strengthened.

- Reductions in complexity of the complaints system required;
- Increase in clarity of complaints pathways needed; and
- Fully resourced advocacy provision as set out in the IHRD recommendations for SAI reviews should be implemented.

Positive Passporting

74. In April 2023 the PCC launched its **'Positive Passporting Initiative'** which it has developed in partnership with a range of statutory bodies and with third sector partners. The initiative is intended to meet the needs of service users engaging with the PCC, who may require services that PCC may not provide. Given the issues with the existing complaints and advocacy mechanisms, the Positive Passporting Initiative will help provide the public with more single points of contact to access PCC and other services.

75. The PCC's goals in establishing this initiative are to:

   a. Explain PCC's role supporting the public in independent advocacy and engagement, underpinned by a ***'network of networks'*** approach;
   b. Gain a better understanding of the role and function of our partner organisations/ network;
   c. Explore the merit of developing a referral pathway with each partner organisation, with the goal of establishing a working agreement setting out the partnership; and
   d. Create an N. Ireland wide framework for collaborative working.

76. The range of partner organisations involved in this initiative includes the Information Commissioner's Office; Children's Commissioner; Commissioner for Older People; the Law Centre; VOYPIC, (Voice of Young People in Care), Children's Law Centre; Ulster University Law Clinic; Advice NI; the Homeless Prevention Forum; a group of 19 organisations working around homelessness and housing rights who offer a range of supports related to housing issues within N. Ireland including a prisoner support program; Disability Action; British Deaf Association; Migrant Help; Macmillan; SANDS etc.

77. Whilst not exhaustive, the focus began with these organisations, to ensure that all service users have access to support in their first point of contact with PCC. The aim would be to expand these issue-specific areas of support to allied agencies, statutory and non-statutory agencies, public and private sector and charitable organisations, to establish a working agreement which breaks down barriers to accessing support and reach more individuals within N. Ireland.

78. Whilst the principles and practice of advocacy can be applied to all casework, the breadth of service provision across health and social care is enormous thus the knowledge required to provide individualised support a challenge. A number of these organisations have specialist expertise related to specific conditions and

experiences. Thus, PCC can ensure that members of the public who contact PCC for support have access to expert advice for their specific issue. This is particularly valuable when an individual may need support or accompaniment to a particular appointment. PCC will endeavour to link in with the relevant partner organisation to ensure the individual has additional support.

79. Through this process of relationship building with external agencies and providers, PCC aims to connect advocacy service provision across the region. Working in partnership, works to the strengths of each advocacy provider, thereby creating a more inclusive environment for individuals accessing HSC services. The goal; expand positive experiences through positive outcomes for those individuals. The hope is that PCC may contribute to building a lasting framework of support for people that exists beyond HSC and improves access to services, service development and user experience within N. Ireland. The arrangements which the PCC is establishing with these partner organisations are reciprocal meaning that over time more individuals will be aware of PCC services and may also be passported to the PCC by these partner organisations.

- The Positive Passport Initiative will help by making it easier for the public to understand their right to complain and the support available; and
- The Positive Passporting Initiative will also foster collaboration across the voluntary and statutory sectors and reduce fragmentation.

Voluntary and Community Sector Commissioned Advocacy Services

80. The PCC, since it was established, has engaged with the third sector around a wide range of issues including individual complaints, SAIs, public consultations and involvement. Third sector organisations are a reservoir of expertise and experts (often by experience) in a wide range of areas where Trusts provide health and social care

services. Given the breadth of the PCC remit across health and social care, it is critical that within our individual and group advocacy work we take account of any networks, complementing the role of other professionals or advocates working within a case, particularly where they might have a specialist or expert role in an area.

81. A number of the larger third sector organisations can link into National resources in terms of intelligence and research. Many third sector organisations are able to maintain their own policy resource in NI either individually or by acting collaboratively through networks such as NICVA, CO3 and Children in Northern Ireland.

82. Key to added value the PCC brings to this network is our independence and the statutory functions and powers of the PCC. The PCC believes that the public expectation is that advocacy service providers will be independent of the HSC service provider. In its statutory role the PCC has and will escalate issues around individual cases to:

a) The PSNI;
b) Ombudsman;
c) RQIA;
d) CoPNI;
e) NICCY;
f) SPPG / DOH
g) The Service provider itself – Trusts, Care Homes etc.

83. The PCC recognises the valuable contribution which advocacy services provided by third sector organisations make to meeting the needs of service users. The PCC knows that meeting the needs of service users for advocacy support sometimes

requires an understanding of complex legislation, professional practice, Trust structures and Trust policies, procedures and administrative procedures. There are third sector organisations which have specialist knowledge and expertise in a range of different areas and which the PCC itself utilises in providing advocacy services to some service users.

84. The role of the third sector in providing advocacy services predates the establishment of the PCC in 2009. However, post 2009 there have been reviews and developments in how these services are provided within the HSC by third sector organisations.

- The Third Sector is a fount of valuable expertise and experience; and
- the Third Sector complements and works in conjunction with other professionals and advocates.

The necessity for structural independence

85. In March 2012 the RQIA published its review report entitled "*Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland*" (Exhibit 2) which described the context for the provision of advocacy services at that time and specifically detailed the various voluntary and community sector organisations providing advocacy services in each Trust area for Mental Health and Learning Disability services.

86. Subsequently new guidance for HSC Trust commissioning of advocacy services was described in Department of Health guidance, published in May 2012 (Exhibit 1).

87. In June 2014 the Advocacy Network for Northern Ireland, (ANNI) supported by the Health and Social Care Board, published a "*Code of Practice for Independent Advocates*" (Exhibit 3).

88. In January 2016 the RQIA published its report on its *“Review of Advocacy Services for Children and Adults in Northern Ireland”* (Exhibit 4). The report highlights a number of issues and recommendations for improvements in the service. A stand out point in the report set out in Table 1, page16 and 17 shows that only five of the advocacy services commissioned from voluntary and community sector organisations are commissioned as regional services by the HSCB. The PCC believes that this is still the case.

89. In May 2019 an Assembly researcher produced a Background Research Paper “*Advocacy in Health and Social Care in Northern Ireland: Mapping current roles and responsibilities”* (Exhibit 6) in relation to IHRD recommendation 37(iv). This provides the most extensive recent analysis of advocacy provision in Northern Ireland.

90. Principle 2 of the advocacy commissioning standards published by the Department in May 2012 (Exhibit 1) states “*Commissioning Principle 2 – Independence - Advocacy services are commissioned* ***that are structurally independent*** *from all statutory organisations and preferably from service providers.*” The PCC does not believe that the current arrangements for commissioning advocacy services can comply with this principle.

91. Independence is at the core of the effectiveness and efficacy of advocacy. This is of particular relevance to the third sector providers. It may be helpful for the Inquiry to note the Scottish Independent Advocacy Alliance (SIAA) /www.siaa.org.uk (Exhibit 5). Their aim is to ensure that independent advocacy is available to anyone in Scotland. A similar body does not exist in NI. It is funded by the Scottish government planning division. The principles and standards adopted by the SIAA ensure that advocacy is of the highest possible standard. The SIAA define ‘Independent advocacy’ as being ***structurally, financially and psychologically separate*** from service providers and other services, which means it is a separate organisation in its own right, has its own funding and is true to the principles of independent advocacy as described below:

- **Structural**; an independent advocacy organisation is a separate organisation in its own right. For example, it is registered as a charity or company and has its own Management Committee or Board of Directors.

  Everyone in the organisation recognises that it is separate and different from other organisations and services;
- **Financial**; an independent advocacy organisation has its own sources of funding that does not cause any conflict of interest and does not compromise the work it does; and
- **Psychological**; everyone in the organisation knows that they are only limited in what they do by the principles of independent advocacy, resources and the law. It is important to recognise that although there may be conflicts of interest present, psychological independence is vital.

As stated by the SIAA Principles and Standards; 'Psychological Independence, independence of mind is equally as important as structural or financial'.

92. There are many positives to the PCC's relationships with the third sector. The PCC also recognises that there is a tension arising from the fact that many of the same third sector organisations can be commissioned by Trusts to provide direct care services, particularly, but by no means exclusively, social care services. The PCC's concern would relate to structural, financial and psychological independence of the voluntary sector provider given the Trust pay for the advocacy service.

93. Trusts are to be commended for finding and dedicating resources within a difficult funding climate to fund advocacy services from third sector organisations. However, the PCC believes that such services should not only be independent of the commissioner and service provider they should demonstrably be so.

- PCC provides independent advocacy support; and
- Advocacy services need to be "*structurally, financially and psychologically separate*".

Inefficiencies of a fragmented system

94. The commissioning of advocacy services by individual Trusts also results in fragmentation and a lack of co-ordination of the advocacy services provided by voluntary and community sector organisations and the PCC. Different organisations are commissioned by different Trusts even to the point that in shared facilities several different third sector organisations can be commissioned to provide advocacy services by the different Trusts in a single facility.

95. In Muckamore Abbey Hospital it appears that three separate organisations were employed by the five HSC Trusts to provide advocacy services. From the perspective of effective governance, the PCC do not have clarity on what arrangements were in place to ensure that the management team in Muckamore Hospital had access to data from the different advocacy providers aggregated to give them an overall picture of any issues.

96. This can present as a confusing landscape for the families and patients and requires co-ordination and facilitation of an independent forum, which is connected directly into each Health and Social Care Trust governance structures. Going forward the PCC would propose improvements through the following;

    - Collaboration with the existing advocacy service providers and to support them in their work with patients and families agreeing through a Memorandum of Understanding with each advocacy service provider how this collaboration will operate to the benefit of patients
    - Hold regular meetings with Trust management on all aspects of the advocacy

work, guaranteeing the timely and sustained reporting of any and all issues, concerns, compliments and complaints received by advocates in the course of their work

97. Voice and Choice. Patients and families require clear information about the advocacy services available, an introduction to the service and must be given space and time to choose how and which service they wish to avail of.

98. The PCC has no detail on the content of the contractual agreements underpinning the use of these service providers in Muckamore Abbey Hospital including:

   a) Was the same service commissioned from each provider?
   b) Was each service provider providing identical data individually to their commissioning Trust?
   c) Did the Muckamore management team have access to information being generated by all three service providers on the issues they were dealing with either by collecting it themselves or being provided with reports by each of the three advocacy service providers?
   d) Were clients able to self-refer to advocates or did they need to be referred by Trust staff?
   e) Were the advocacy service providers free to escalate issues outside the Trust and did they know how and to whom they should escalate?
   f) What was in place to ensure that patients and families were aware of these advocacy services and how to access them?
   g) Were staff in Muckamore Abbey made aware of the details of the services being provided by these three organisations?

99. The PCC believes that commissioned advocacy services should be commissioned against a common set of standards which deal with each of these issues. The PCC also believes that these advocacy services should be commissioned independently of the HSC Trusts.

100. PCC is not seeking to position itself, nor would it be possible for PCC to be involved in every complaint.

101. PCC recognises the expertise and contribution of a wide range of voluntary sector organisations which provide advocacy services and the PCC itself avails of those services. The PCC is not seeking to displace or replace those providers. Under the current arrangements, alongside the services provided by PCC, Trusts are able to commission their own advocacy services from voluntary and community providers.

102. The PCC expects, and we believe the public expect, **that organisations providing advocacy services should be independent of service providers i.e. structurally, financially and psychologically independent**. The PCC does not believe that we can be assured that the current arrangements can deliver that independence.

103. Thus, the PCC suggests three other possible changes:

    - Changes to the commissioning of advocacy services so that they are all commissioned regionally and independently of Trusts. The PCC does not wish to become a commissioning body but would like to be involved and resourced to play a role in the specification of contracts for regional advocacy services, given PCC’s statutory functions.
    - Advocacy services require an independent regional body / organisation to support the development of advocacy policy, practice, training and standards. The PCC model of ‘*network of networks’* is a first step in the development of a regional approach to the co-ordination of advocacy services.
    - The decisions on which advocacy organisation is identified to provide support to a service user or service users as part of the complaints; SAI and Lookback reviews should be made independently of Trusts and advocacy service providers accountability arrangements should be independent of Trusts.

- The current advocacy service continuum is fragmented and uncoordinated, which can increase confusion and disorientation amongst families and patients; and
- Advocacy services should be commissioned at a regional level and independently from service providers.

The need for a statutory foundation

104. The PCC as a statutory body escalates cases as appropriate to and within HSC Trusts; to the RQIA; to the PSNI; to the Ombudsman; to NICCY and CoPNI. The PCC would look to design and assist in the development of a similar model across a network of advocacy services across the breadth of advocacy services provided by the voluntary and community sector.

105. The PCC believes that specialised areas of advocacy should be placed on a statutory basis. This includes the provision of advocacy services recommended by the Hyponatraemia Inquiry (recommendation 37iv).

106. The PCC has recently responded to a Department of Health initial consultation on the outcome of an Independent Review of Children’s Social Care Services. The final review report includes two recommendations for the development of Independent Advocacy Services for children and families. The PCC response included the following which we believe should underpin the provision of advocacy services within the Health and Social Care system by advocacy service providers in relation to complaints, SAI reviews, Lookback Exercises and Inquiries:

    - *Advocacy services should be commissioned as regional services and provided independently of HSC Trusts;*
    - *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 providers performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts.*
- *Access to these advocacy services should be client led and not solely dependent on a referral by HSC Trust.*
- *The PCC also believe that part of the role of advocacy service providers for advocacy services should include the development of information packs for clients and potential clients which explain to them roles and responsibilities, their rights and identify to service users other bodies where they can access support.*
- *It is also the view of PCC that the Department should ultimately place any specialist or targeted advocacy services (e.g. as part of the SAI process) on a statutory footing at the earliest possible opportunity either through amendment to the PCC's primary legislation functions or elsewhere if it is not determined that the PCC should lead on the provision and/or commissioning of these services.*

- Advocacy services should be placed on a statutory footing. They should be subject to some form of memoranda of understanding; or agency agreements between organisations to ensure consistency and coordination.

Serious Adverse Incidents

107. The PCC believe that there are specific issues with the SAI process under the current guidance. The Department of Health is currently reviewing the SAI system in response to IHRD recommendations.

108. Whilst the PCC does its best to try to support families through the SAI process, SAI cases in particular can consume a considerable amount of time and resource against competing priorities and finite resources. The PCC is only able to support even this small number of cases because the senior management team including myself as Chief Executive act as the advocate in the complex casework.

109. The demand for independent advocacy support from the PCC in Serious Adverse Incidents has increased year on year. The number of families seeking assistance with the SAI process from PCC has increased sharply in the last four years. As reported in the Accounts & Annual Report 2022/23, a total of 33 new SAIs were referred to the PCC in 2022-23. The IHRD recommended fully funded advocacy services, the PCC is not fully resourced to provide this service. The upward trend is as follows:

Number of new SAI's				
2018/19	2019/20	2020/21	2021/22	2022/23
16	26	31	25	33

110. PCC has in a small number of cases provided ongoing support to families engaged in the SAI process for up to five years, given the complexity of the support required, during and post the actual review.

111. In cases where a SAI has been initiated in response to serious incidents which may have caused death or serious harm to a patient or service user, the timeframes taken

to complete a SAI are an indication of the weakness of the current system.

112. In some of these SAIs where the PCC are supporting families, the initial advocacy support related to a complaint which, subsequently through PCC intervention, had been escalated to a SAI. Others are cases which were notified and reviewed as SAIs without a complaint being made or in place of a complaint. In other cases, which may have been through one or more failed SAI review the relationship between the Trust and patients/families has become so fractured that the Trust has approached the PCC to ask for our help in supporting the patients and families.

113. In reviewing the cases of families receiving advocacy support from the PCC in SAI's, just under half (48%) of all SAIs in 2022-23 were Level 3 SAIs compared to 4% in 2021-22. The nature of support to families navigating the SAI process is such that one case can involve support to multiple members of a family. Of the 33 new SAIs in 2022-23, this represented 63 individuals seeking support from the PCC. There continues to be an increasing demand for advocacy and support to families involved in SAIs.

114. In 2020, PCC appointed for a short period a dedicated SAI Senior Practitioner to commence the development of a new model of advocacy practice for families.

115. Learning from our previous experience, we decided that in 2022-23 the allocation of support to families in a SAI process should be provided by a specific group of Senior Practitioners within the PCC who have the experience required, and knowledge of the SAI process, to support the families involved.

116. The PCC's continued development, in 2022-23, of working relationships with colleagues in the five HSC Trusts has served to improve the support to families and indeed to having case issues escalated to Senior Managers in Trusts if the SAI

process is not running to the satisfaction of the families involved. Complex case meetings chaired by a Service Manager in the PCC allowed Senior Practitioners an opportunity to discuss these particular cases, seek advice and peer support as well as seek escalation both within the PCC and within Trusts if they were encountering challenges.

117. While there continues to be a waiting time for support from PCC, any SAI cases with a time constraint are allocated immediately. At year end, 2022/23, eight SAI cases were awaiting allocation as soon as resources were available. In all cases the families had been in contact with the PCC, had a conversation with a PCC practitioner and were aware that they would be supported once the resource was available. At the time of writing my statement all cases had been allocated.

118. There is a fundamental issue with the SAI process that the emphasis on the review process's purpose of identifying learning can sometimes be at the expense of an emphasis on describing the facts of what happened in clear and unambiguous terms. In reporting SAIs to SPPG and in the reports of SAI reviews, the families have stated that the Trusts can be reluctant to use clear and unambiguous language and to be completely forthright in describing service failures. This clarity, the use of unambiguous statements to describe the facts of what happened is the one thing that families consistently want. It is obvious that without a detailed factual understanding of what happened it is problematic to identify all of the learning that should be identified.

119. There are also questions about the level of resourcing of SAIs within Trusts both in having a pool of trained potential SAI panel members available and in providing protected time, administrative support, analytical and other expert staff to support SAI reviews. The PCC believes that implementation of the Hyponatraemia recommendations will go some way to addressing the current weaknesses of the SAI system.

120. Over the last 3 years the PCC has been continually engaging with the HSCB / SPPG and the PHA with regard to:

- Escalating individual advocacy casework with regard to SAIs in which the advocate has experienced challenges. The Chief Executive and Head of Operations have escalated the individual cases and met with lead staff in HSCB/SPPG and PHA to address concerns.
- The development of the PCC new practice model. The PCC have facilitated round table discussions with DOH, DOH Sponsor Branch, HSCB / SPPG, the PHA and HSC Trust governance leads to present the developing PCC SAI advocacy model, build working relationships, understanding the key roles of each DOH policy branch, the HSCB and PHA.
- Learning from SAIs, the central concern for the PCC was the lack of a safety framework that seeks to triangulate SAIs, incidents and other feedback from public to indicate a problem. This requires the development of a dashboard evidencing trends and patterns which sets out strategic actions and outcomes to address, and track implementation.

- SAI cases are resource intensive and the PCC have seen a circa 100% increase since 2019 in requests for support from patients and families; and
- Families want SAI reviews to establish the facts of what happened in clear and unambiguous language.

Conclusion

121. The PCC believes the changes outlined above will:

a. support Trusts and HSC bodies to improve their complaints and review processes;

b. increase public trust in complaints management;

c. support Trusts to take "ownership" of complaints management at the Board level;

d. increase cooperation and collaboration in the provision of advocacy services in the statutory and non-statutory sector and reduce the current fragmentation, thus increasing the efficacy of advocacy and representation;

e. increase system wide benefits by reducing inefficiency and duplication; and

f. most importantly, improve the experience of families and patients of the health and social care system including when they raise issues and concerns about the quality of services that they receive.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

M. Monaghan

Signed: ________________________________

Date:______4 March 2024__________________

List of Exhibits (Meadhbha Monaghan)

Exhibit 1 DHSSPS Developing Advocacy Services Guide for Commissioners – May 2012

Exhibit 2 RQIA Report of a review of the Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland – March 2012

Exhibit 3 Advocacy Network for Northern Ireland - Code of Practice for Independent Advocates – June 2014

Exhibit 4 RQIA review report on its Review of Advocacy Services for Children and Adults in Northern Ireland – January 2016

Exhibit 5 Scottish Independent Advocacy Alliance (SIAA) - Independent Advocacy Principles, Standards & Code of Best Practice - 2019

Exhibit 6 Background Assembly Research Paper - Advocacy in Health and Social Care in Northern Ireland: Mapping current roles and responsibilities – May 2019

Exhibit1

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

DEVELOPING ADVOCACY SERVICES

A POLICY GUIDE FOR COMMISSIONERS

DHSSPS
MAY 2012

Contents

Ministerial Foreword

I am delighted to publish this policy guide which aims to help commissioners better understand and develop advocacy services in Northern Ireland, in particular, by putting in place principles and standards for their future commissioning and delivery.

I recognise how vulnerable some people can feel for a variety of reasons particularly when they are facing decisions being made about their care, treatment or support. I also recognise that advocacy can make a real difference to people in their daily lives. It can give them a voice, help them access information and services and secure their rights.

While we have some distance to travel to catch up with other jurisdictions, there have been some important developments here in relation to advocacy in recent years, not least of which has been the Bamford Review report on Human Rights and Equality of Opportunity. Focusing on people with a mental health problem or a learning disability, that report explained the relevance of advocacy to our equality and human rights laws and standards. It also explained that people may need different types of advocacy at different times in their lives. There have, of course, been developments in human rights standards too since the Bamford Review, the most notable and relevant being the UN Convention on the Rights of Persons with Disabilities.

This Policy Guide seeks to build on these developments and provide practical guidance for commissioners to inform the future commissioning and delivery of advocacy services in a health and social care setting. It describes the common models of advocacy, referred to as a “continuum”, and highlights the importance of independence, one of a number of principles and standards set out in the Policy Guide.

Following the outcomes of the public consultation last year, it is intended that these principles and standards will underpin the future commissioning and delivery of all health and social care advocacy services. We recognise, however, that they may need to be tailored to meet the needs of specific client groups. This is addressed in the associated Action Plan which is being published alongside the Policy Guide and is geared towards helping the lead HSC organisations implement the Guide in a timely way as resources allow.

Implementing any new initiative can of course be challenging, particularly given the current difficult financial climate. But this should not mean that we stop seeking out ways of improving how we do things. In fact, the reverse is true in order to get the best from the resources that are available to us. This is exactly what this Policy Guide aims to help achieve in relation to advocacy services in recognition of the very real contribution they can make to the delivery of the vision and priorities I have set for the future of health and social care in Northern Ireland. However, advocacy is very much an evolving issue and I have no doubt that there is still more work to do as the Action Plan exemplifies.

Finally, I would like to acknowledge the contributions made by, and also thank, the many interested groups and individuals who have helped to inform and shape this Policy Guide. It has benefited greatly from the outcomes of the public consultation last year and I know that there will continue to be ongoing engagement with key stakeholders as the Action Plan is rolled out over the next couple of years and as we develop the detail of the new statutory right to an independent advocate in the proposed Mental Capacity Bill which my Department is also currently preparing.

Edwin Poots MLA
Minister of Health, Social Services & Public Safety

Executive summary

Background

This Policy Guide has been developed by a working group chaired by the PCC and aims to help commissioners better understand and develop advocacy services in a health and social care setting in Northern Ireland. Building on the Bamford Review report on Human Rights and Equality of Opportunity and the outcomes of a workshop held by the Advocacy NI Network in January 2010, it describes the different models of advocacy and sets out core principles and standards for the future commissioning and delivery of all advocacy services whilst recognising that these may need to be tailored to address the needs of specific client groups.

Overview

Section 1 – Introduction

Section 2 – Aims and Objectives

Section 3 – Context

Section 4 – Scope

This section sets out the scope of the Policy Guide which should inform the future commissioning and delivery of all health and social care advocacy services. It acknowledges, however, that aspects of the Guide, such as the core principles and standards, may need to be tailored to meet the needs of specific client groups.

Section 5 – Understanding what advocacy is and what it is not

This section is intended to help clarify what advocacy is and recognises that advocacy can be delivered in a variety of different ways depending on the needs of the person requiring this type of support. It refers to various models of advocacy (self/group, peer, citizen, issue-based, non-instructed) and describes them as part of a “continuum”. While acknowledging the important role that health and social care staff and professionals play in advocating for their patients and clients, this section also explains why people might need independent advocacy services and the benefits of investing in these services.

Section 6 – Understanding where advocacy fits in

This section explains how effective advocacy services have the potential to contribute to a number of strategic priorities for health and social care in Northern Ireland that ultimately promote wider equality and human right objectives. It also makes the link between advocacy and key themes in the recent HSC Review report “Transforming Your Care”.

Section 7 – Commissioning Advocacy Services

This section looks at the current commissioning arrangements and how they might be enhanced to achieve greater parity and consistency in relation to the commissioning of advocacy services in Northern Ireland. It proposes the setting up of a new regional Advocacy Commissioning Group to consider and identify opportunities for more collaborative working across the five LCGs areas and sets out principles for the future commissioning of advocacy services. It highlights, in particular, the importance of the principle of independence and explains what this means in relation to advocacy services. This section also provides some guidance on how to achieve personal and public involvement in the commissioning of advocacy services.

Section 8 – Supporting Advocacy Services

This section sets out some practical ways in which commissioners can support advocacy service providers and includes guidance on:

- The development of a model contractual agreement for advocacy services;
- Funding for advocacy service providers;
- Best Practice Fora for advocates;
- Raising Awareness of advocacy services;
- Training/Awareness raising for HSC staff; and
- Training for advocates.

Section 9 – Monitoring and Evaluation of advocacy service

This section sets out the core service delivery principles and standards that are intended to guide everything that all advocates and advocacy service providers do. These can be applied to all models of advocacy but may need to be tailored to meet the needs of specific client groups. This section also provides guidance to commissioners on how advocacy services can be monitored and evaluated, recognising the need to focus on processes as well as outcomes.

Section 10 – Implementation/Next Steps

This section refers to an Action Plan which has been developed to assist the implementation of this Policy Guide and will be taken forward by the HSCB in collaboration with key stakeholders including advocacy service providers, advocates and users and carers.

1. INTRODUCTION

1.1 This Policy Guide has been developed by a working group established by the Department in June 2010 and chaired by the Chief Executive of the PCC. The group was set up in light of the recommendations in the Bamford Review report on Human Rights and Equality of Opportunity in relation to advocacy[1] and following a workshop held by the Advocacy Network NI in January 2010 which focused on the future development of advocacy services in Northern Ireland.

1.2 The Policy Guide has been informed by the outcomes of a scoping study carried out in May 2010 [2] which gathered information on advocacy services commissioned or provided by the HSCB and HSC Trusts in Northern Ireland for people aged 16 and over with mental health conditions, learning disabilities, physical and sensory disabilities and older people (focusing on those with dementia).

1.3 In addition, evidence was gathered on advocacy services in the rest of the United Kingdom, the Republic of Ireland and internationally. Three workshops were also held during September and October 2010. The purpose of these workshops was to gather the views of key statutory and voluntary sector organisations as well as service users and carers on the key issues relating to the development of advocacy services in Northern Ireland.

1.4 A further series of workshops were held in May 2011 to test the key elements of the draft Policy Guide with stakeholders prior to consultation. The draft Policy Guide was subsequently subject to a four month public consultation from 27 June 2011 to 14 October 2011 and revised in light of the outcomes of that consultation.[3]

---

[1] www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf

[2] Scoping study, research and workshop summary papers can be viewed at http://www.dhsspsni.gov.uk/show_publications?txtid=47432

[3] Relevant consultation documents can be found at www.dhsspsni.gov.uk/showconsultations?txtid=50585

2. AIMS AND OBJECTIVES

2.1 The Policy Guide is primarily targeted at the commissioners of health and social care services in Northern Ireland i.e. the HSCB, the PHA, LCGs and the five HSC Trusts. LCGs are constituent parts/committees of the HSCB but have a distinct role and membership.

2.2 The Policy Guide aims to clarify and help improve understanding of what advocacy is and its role in the health and social care context (sections 5 and 6). It also aims to help commissioners develop advocacy services by providing some practical guidance on commissioning (section 7). In addition, guidance is provided on how advocacy services can be supported and monitored (sections 8 and 9), two key factors in ensuring the provision of high quality, effective advocacy services. Underpinning the guidance is a number of core principles and standards for both the commissioning and delivery of advocacy services in the future.

2.3 The Policy Guide will therefore be of interest not only to commissioners but also to existing advocacy service providers, users and their carers as well as advocates themselves, all of whom have a clear interest in how advocacy services in a health and social care setting are commissioned and delivered in the future.

3. CONTEXT

3.1 There are a number of factors driving the need for this Policy Guide. Firstly, there is a need for greater parity and consistency in relation to the commissioning and delivery of advocacy services in a health and social care setting in Northern Ireland. Currently, there is an array of advocacy services being provided by a range of mainly community and voluntary organisations and groups which receive funding from a variety of sources, including the statutory sector. As a result, a wealth of experience and skills has already been built up. However, in terms of what is commissioned by the statutory sector, existing provision is patchy with some HSC Trusts having more established arrangements in place than others. There is also evidence of some regional commissioning of advocacy services by the HSCB.

3.2 Going forward, it is also essential that commissioners are more aware of and understand the role that advocacy can play in helping to achieve the priorities that have been set for health and social care in Northern Ireland, and in supporting the proposed model for the future delivery of health and social care set out in the HSC Review report "Transforming Your Care".[4]

3.3 It is also important that the relevance of advocacy to the protection of the human rights of vulnerable people in society is better understood. The Bamford Review highlighted this in its report on Human Rights and Equality of Opportunity (hereafter the Bamford Review report). Focusing on people with a mental health problem or a learning disability, that report explained in particular the relevance of advocacy to our equality and human rights laws and standards which now also include the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which post-dated the Bamford Review.

3.4 Any future commissioning of advocacy services will also need to reflect the new commissioning arrangements for all health and social care services introduced in 2009 through the reform and modernisation agenda. Local commissioning, informed by the assessment and prioritisation of needs, is a key feature of these new arrangements and central to ensuring that informed decisions are taken in relation to all health and social care service provision, including the provision of advocacy services. These decisions will of course also be influenced by the challenges and pressures resulting from the current difficult financial climate which places an even greater emphasis than before on getting the best from available resources.

---

[4] www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

4. SCOPE

4.1 This Policy Guide is designed to inform the commissioning and provision of advocacy services in a health and social care setting for people who require this type of support. This could include people who are living with disabilities – physical, sensory, mental, learning or communication related. It could also include others such as carers, children and young people, older people, victims, prisoners.

4.2 Given the diverse range of potential client groups and users, it is recognised that aspects of the Guide, in particular, the commissioning and delivery principles and standards set out in sections 7 and 9, may need to be tailored to meet their specific needs. This is addressed in the associated Action Plan[5].

5. UNDERSTANDING WHAT ADVOCACY IS AND WHAT IT IS NOT

What is advocacy?

5.1 Advocacy can mean different things to different people in different contexts. However, the following descriptions would seem to capture the essence of what advocacy in a health and social care context is about.

“*Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people.”* ***(Bamford Review Report on Human Rights and Equality of Opportunity)***

“Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and justice.” ***(Advocacy Charter produced by Action for Advocacy)***

---

[5] See Section 10

> *"Advocacy is the process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up for justice." (**The Scottish Independent Advocacy Alliance: Principles and Standards for Independent Advocacy)***

5.2 There are common themes running through these descriptions one of which is that advocacy involves supporting people to say what they want and have their views heard. An important feature of advocacy is therefore listening to people who, for whatever reason, are experiencing difficulty in having their views heard in order to understand their position, inform them about their choices or options and then help them to take action to have their voice heard and secure their rights.

5.3 In other words, advocacy can empower people to speak up for themselves. It can also help people to become more aware of their rights, to exercise those rights and to be involved in and influence decisions that are being made about their care, treatment or support.

5.4 In some situations, however, people in need of support may, for whatever reason, be unable to clearly articulate or express their views. Such cases can be particularly challenging and highlight the vital role that advocacy can play in securing a person's rights, representing their interests and ensuring that decisions are taken with due regard to their preferences or perspectives. This type of advocacy is often referred to as non-instructed advocacy.

5.5 In summary, therefore, advocacy is about taking action to help people to :

- Express their views and wishes
- Secure their rights
- Have their interests represented
- Access information and services
- Explore choices and interests

5.6 Advocacy does not, however, in any way involve taking decisions on behalf of people being supported. Nor is it a mediation, counselling, befriending, lobbying or complaints service, although some of these may be useful skills for an advocate to have and advocacy may be used to support people through for example a complaints process. Advocacy is also not an advice service in the sense that it is not an advocate's role to tell someone what they should or should not do.

5.7 What is fundamental is that an advocate or advocacy service always acts for and in partnership with the people they support. This may, at times, involve challenging others, not in a way that seeks confrontation but, where possible, working in partnership and maintaining good relations with interested parties while remaining ultimately loyal and accountable to the people being supported.

5.8 The term "advocacy" has been used to cover a raft of services, such as those mentioned in paragraph 5.6, which would not be captured by this description of advocacy. This does not mean, however, that those services are any less valuable or necessary. Rather, they are part of what can be described as a "continuum" of services which supports people who require help with overcoming obstacles in accessing services and playing an active role in society.

5.9 It is important that it is made clear that the purpose of this policy Guide is not to devalue the other elements of that continuum but simply to help clarify what advocacy is and what it is not. This is important in the health and social care context so that commissioners, service providers, advocacy organisations, advocates, service users and carers can understand the boundaries and limitations of advocacy and when, for example, it might be appropriate to refer to another service or organisation.

What are the different types of advocacy?

5.10 It is widely accepted that advocacy can be delivered in a variety of ways depending on the needs of the person requiring this type of support. Different types of advocacy may also be needed by different people at different times in their lives and to respond to different circumstances.

5.11 The most common types or "models" of advocacy would appear to be:

- **Citizen advocacy;**
- **Group/self advocacy;**

- **Issue-based (also known as individual or professional) advocacy;**
- **Non-instructed advocacy; and**
- **Peer advocacy.**

5.12 Organisations providing advocacy services can and do offer more than one of these models of advocacy to their clients. Specialist advocacy services also exist that are geared specifically around the needs of a particular client group. Elder abuse advocacy is a good example of this. So, although it is helpful to identify and describe the various models, they should not be viewed in isolation. Indeed, the concept of a "continuum" is also applicable here in that each model can be viewed as a component part of a "continuum" of advocacy services. A person could benefit from more than one element of that continuum at any given time, or at different times, in their life.

5.13 The descriptions attached at Appendix 1 are intended to help clarify what some of the models mentioned above entail.[6]

Is advocacy not something we all do?

5.14 Many people turn to someone whom they trust to help or support them to express their views, have their views heard or respond to difficult questions being asked of them. That person could be a family member, a peer, a carer, health and social care professionals or staff. In this sense, advocacy is part of everyday life and something we can all do. Indeed, advocacy is an important part of many health and social care professional codes of conduct.

5.15 However, some people are more at risk of not being listened to or understood than others either because of other people's prejudice or their own vulnerability or both. The types of things that might put someone at risk of this are many and varied, for example; age, disability (physical, sensory, learning, mental, communication related), gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse, family breakdown. People who are regarded as lacking capacity to make decisions

---

[6] Descriptions sourced mainly from SIAA and Action for Advocacy publications

can be particularly vulnerable not least because of the extent of their reliance on others for help with many aspects of their care, treatment and support and the fact that they are least likely independently to exercise their right to make a complaint.

5.16 It may also be the case that the person who is vulnerable or at risk does not have any well-motivated or capable family members or friends to call upon or it may even be that family or friends have different views or wishes to that of the person needing support. In these circumstances, it is not difficult to see the potential for that person not having their views or wishes taken into account properly which is their basic right.

5.17 Difficulties also may arise where health and social care staff or professionals involved in a vulnerable person's care, treatment or support are of the opinion that what the person wants is not in their best interests. While nurses, doctors, social workers and other professionals clearly look out for and speak up for their patients or clients on a daily basis, conflicts of interest can arise and therefore there will be circumstances in which it may be more appropriate to refer to an independent advocacy service.

What are the benefits of investing in advocacy?

5.18 Investing in advocacy means that people who are vulnerable or at risk of exclusion or being discriminated against have a vehicle through which they can have their voice heard, gain access to information to help them make informed choices about their health and well-being and have their rights secured. Advocacy empowers people and can also help to safeguard people.

5.19 However, investing in advocacy services not only benefits the person needing support. It can also benefit commissioners and providers of health and social care services. For example, advocacy can help prevent crises arising in a person's life which otherwise may result in an intervention that has much greater resource implications. It can also enhance capacity building at a community and individual level which can ultimately serve to reduce dependency on other health and social care services.

5.20 By giving those most at risk a vehicle through which they can have their voice heard, advocacy can also help commissioners and service providers gain a better understanding of the needs of this important group. If engaged, they can act as a valuable channel for seeking ideas and views on how current health and social care services can be improved to better meet those needs and to inform planning for future needs and service re-design.

6. UNDERSTANDING WHERE ADVOCACY FITS IN

6.1 Effective advocacy services have the potential to contribute to a number of strategic priorities for health and social care that ultimately promote wider equality and human right objectives. The support that advocates provide can help people avail of opportunities and exercise rights to which they are entitled. This not only has the potential to enhance their daily lives but it can also help to build up their confidence and capacity to play an active role in society and secure greater equality in service provision generally.

Improving health and well-being

6.2 Advocacy can play a vital role in improving health and well-being by empowering people to take control of their lives and helping them (or where appropriate others) make better informed decisions about issues affecting their health and well-being. At a practical level, the support of an advocate can also help improve the effectiveness of treatment and, in some cases, help early intervention or prevent the need for treatment ensuring the best use of resources.

Reducing inequalities

6.3 In many ways, improving health and well-being for all is dependent on tackling inequalities in health provision. Advocacy can be an effective way of highlighting inequalities and can also help to address these by increasing awareness of services among those who need them most and bringing forward ideas as to how they might be improved to meet their needs.

Involving people

6.4 Investing in advocacy is also one of several ways in which commissioners and others can deliver their goals in relation to Personal and Public Involvement (PPI) which is about giving people the opportunity to influence the design, delivery and evaluation of health and social care services.

6.5 Advocacy services can offer support to those who may otherwise find it difficult to contribute to this process and can also act as a valuable channel or source of information and advice for commissioners and service providers seeking to find effective ways of engaging with vulnerable groups of people.

Safeguarding the vulnerable

6.8 As well as supporting people to have their views heard, advocacy can also play a valuable role in helping to safeguard those in society who, for whatever reason, are vulnerable or are at risk of harm or in need of protection. Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.

Transforming Your Care

6.9 The proposed future model for integrated health and social care in Northern Ireland set out in the HSC Review Report: "*Transforming Your Care*" is intended to put the individual at the centre and support them to care for themselves and make good health choices. As recognised in that Report, investing in advocacy has the potential to contribute at a practical level to the realisation of that vision.

7. COMMISSIONING ADVOCACY SERVICES

7.1 The rest of this Policy Guide aims to provide some practical guidance on the commissioning of advocacy services, including how they can be supported (section 8), monitored and evaluated (section 9). It is informed by preceding sections of the Guide and the new commissioning arrangements for all health and social care services.

7.2 The new commissioning arrangements were introduced by the Health and Social Care (Reform) Act (NI) 2009 (the 2009 Act) under which the HSCB is required, where appropriate, to devolve commissioning to LCGs, who must produce an annual commissioning plan for the population in the geographical area they cover. These LCGs are coterminous with the boundaries of the five HSC Trusts.

Annual LCG Commissioning Plans

7.3 As part of the annual commissioning process, LCGs should assess and prioritise the needs of their local population in relation to the full range of models/types of advocacy, informed by the scoping of existing provision (both statutory and non-statutory funded). Taking into account available resources and local priorities, priority unmet need should then be addressed in their annual commissioning plans.

7.4 To support this process and recognising the current role of the HSC Trusts in relation to the sub-commissioning of advocacy services, each LCG and HSC Trust should identify a named person to lead on the commissioning of advocacy services in their area.

Advocacy Commissioning Group

7.5 These LCG and HSC Trust Advocacy Leads should come together to form a regional Advocacy Commissioning Group. Terms of Reference should be developed for this Group but essentially its key role should be to ensure greater parity and consistency in the commissioning of advocacy services across the five LCG areas. This would, in particular, include considering and identifying opportunities for more collaborative working where appropriate.

7.6 A senior named person from the HSC Board/PHA should be identified to coordinate this Group.

7.7 The new Advocacy Commissioning Group should also consider the potential need for the regional commissioning of the advocacy services required to support the proposed new statutory right to an independent advocate under the Mental Capacity (Health, Welfare and Finance) Bill.

7.8 As a matter of good practice, this should include consideration of how existing effective advocacy provision can be built upon in preparation for this new statutory right so that, when introduced, the new right ideally complements rather than replaces existing effective advocacy provision. Separate guidance on this will be prepared for commissioners once the detail of this new right has been finalised. This is reflected in the Action Plan.[7]

Principles for commissioning of advocacy services

7.9 The *Commissioning Framework for Health and Social Care* sets out a number of principles governing the contractual relationship between commissioners and service providers. In addition to these, the following principles have been developed and should be adhered to when commissioning advocacy services in a health and social care setting. These principles are aimed at ensuring that commissioners choose only good quality advocacy services, and they apply regardless of the type or model of advocacy being commissioned.

---

[7] See section 10

Advocacy Commissioning Principles

Commissioning Principle 1 – Accountability

Advocacy services are commissioned that can clearly demonstrate that they are accountable to the people who use them.

Commissioning Principle 2 – Independence

Advocacy services are commissioned that are structurally independent from all statutory organisations and preferably from service providers.

Commissioning Principle 3- Empowerment and Enablement

Advocacy services are commissioned that are effective in empowering and enabling people who use them to have a voice and to be involved as fully as possible in decisions about their care, treatment or support.

Commissioning Principle 4 - Evidence based approach

Commissioners continually monitor and evaluate the advocacy services they commission with a view to achieving measurably better outcomes for people who use them in terms of increased independence, decision-making capacity and control over their own lives.

Commissioning Principle 5- Shared learning

Commissioners should make explicit in their commissioning arrangements their openness to learning from the experience of advocates and advocacy service providers.

Commissioning Principle 6 – Quality and Effectiveness

Advocacy services are commissioned that are well-managed and have an appropriate infrastructure to deliver high quality advocacy (as defined by the service delivery principles and standards in section 9).

Independence

7.10 It is important at this point to highlight, in particular, the principle of independence and to explain what it means in this context. There are three different types of independence that are relevant to all advocacy services, whether they be citizen, peer, self/group, issue-based, non-instructed or of a specialist nature. They are:

- Structural independence;
- Financial independence; and
- Psychological independence.

7.11 In Scotland, to be considered independent, an advocacy provider must be structurally, financially and psychologically separate from other service providers and other services i.e. a separate organisation in its own right with its own source of funding and true to the principles of independent advocacy.[8]

7.12 A less stringent approach is adopted in England and Wales. There, an advocacy scheme must be structurally independent from statutory organisations and *preferably* from all service provider agencies. However, crucially, it must be able to demonstrate that is as free from conflict of interest as possible both in design and operation, and actively seeking to reduce any conflicting interests.[9]

7.13 In practice, the England and Wales approach requires the advocacy arm of an organisation which also provides other services (such as day care or residential care services) to be as operationally independent of the rest of the organisation as possible. This would involve every step being taken to minimise potential conflicts of interest and to actively encourage psychological independence which, arguably, is the most important of the three types of independence described above. It would not, however, envisage an advocate employed by an organisation being assigned to a case involving an issue relating to another service provided by the same organisation. That said, there are some services which would be regarded as being complementary to advocacy, such as counselling, mediation or befriending, and therefore would not be seen

---

[8] SIAA: Principles and Standards for Independent Advocacy

[9] The Advocacy Charter - Action for Advocacy

as compromising the independence of the advocacy service if provided by the same organisation.

7.14 If adopted here, the Scottish approach to independence could present significant difficulties for many of the existing providers of advocacy services. As a result, it could potentially have a negative effect on the expertise that has already been developed as well as the availability of advocacy services to those who need them.

7.15 Therefore, while acknowledging that structural independence from service providers as well as all statutory organisations may be the ultimate goal as is currently the case in Scotland, it is considered that the approach described above that is applied in England and Wales is the more pragmatic one to adopt in Northern Ireland at this stage.

7.16 The England and Wales approach is therefore reflected in the relevant commissioning principle above and also in the equivalent service delivery principle and standards relating to independence in section 9.

Monitoring adherence to commissioning principles for advocacy services

7.17 As part of its role in assuring the quality and safety of commissioned health and social care services in Northern Ireland, the RQIA will be responsible for monitoring adherence to the principles outlined above to underpin the future commissioning of advocacy services. RQIA continues to develop a Human Rights framework for inspection activity and will monitor availability of advocacy services and make recommendations where indicated.

Personal and Public Involvement in commissioning advocacy services

7.18 The 2009 Act referred to in paragraph 7.2 above also places a legislative requirement on health and social care organisations to deliver meaningful involvement of key stakeholders in the planning of health and social care services through a programme called PPI. Therefore, the HSCB, the PHA, LCGs and HSC Trusts should ensure that those with an interest in advocacy services are involved in the key stages of the annual commissioning cycle.

7.19 Existing processes, structures, networks, fora and databases that have been established to facilitate stakeholder involvement in the commissioning process to date should therefore be reviewed in light of this policy guide to ensure that they take account of the need to include appropriate and adequate representation from the wide range of individuals and organisations that have an interest in advocacy service provision.

7.20 This will require consideration of the following :

- Who are the key stakeholders in relation to advocacy services?
- What is the purpose of involving them in the commissioning cycle?
- How should they be involved?
- When should they be involved?
- Do they have the time, commitment, energy and support to take part?

7.21 It will be important to make sure there is a range of ways that those interested in advocacy services can be involved and that the approach adopted reflects the diversity of the population who may need advocacy services and is as inclusive as possible. Whatever approach is decided upon, careful consideration needs to be given to practical issues such as venue, transport, provision of translation and interpreting services, etc.

7.22 It is also essential that there is access to accurate, fit for purpose information that provides stakeholders with a meaningful overview of the issues relating to advocacy in order that they can agree what actions need to be taken and identify individual stakeholder roles and responsibilities in bringing about improvements in advocacy provision.

8. SUPPORTING ADVOCACY SERVICES

8.1 As well as planning, negotiating and paying for services, commissioners also have a role to play in enabling and facilitating the work of service providers. This section sets out some practical ways in which commissioners can support advocacy service providers in line with the commissioning principles set out in section 7.

Contractual agreements between commissioners and non-statutory advocacy service providers

8.2 Commissioners should ensure that contractual agreements are developed in partnership with advocacy service providers and are in place at the start of the financial year so that both parties are clear from the beginning about what is expected of them.

8.3 Building on existing templates for contractual agreements between HSC commissioners and non-statutory organisations, it is recommended that contractual agreements with advocacy service providers should as a matter of good practice specify the following**:**

- Aim and purpose of the agreement;
- Type/model(s) of advocacy to be provided (drawing on the descriptions set out in Appendix 1);
- Location of the advocacy service provider;
- Statement explaining why the advocacy service(s) is needed;
- Statement that the advocacy service provider will work within an agreed set of principles and standards (see section 9);
- Statement of the commissioner’s responsibilities in relation to the contractual agreement;
- Objectives and targets for the advocacy service(s) i.e. service specification;
- Referral and access criteria for the advocacy service;
- Duration of the contractual agreement;
- Funding and payment arrangements including financial controls;
- Monitoring and performance evaluation arrangements (see section 9);

- Management and staffing issues including:
    - adherence to relevant policies, documents and legislative requirements relating to, for example, equality, human rights, health and safety, data protection, freedom of information;
    - training and sharing of best practice requirements;
- Complaints procedures;
- Contract Variation;
- Termination of contract; and
- Arbitration

8.4 Based on the outline provided above, a model contractual agreement for advocacy services should be developed that is capable of being adapted depending on the type/model of advocacy being commissioned and the target client group. This model should be made available to all HSC commissioners of advocacy services and will need to be reviewed to reflect any additional requirements that might apply to providers of the advocacy envisaged under the proposed Mental Capacity (Health, Welfare and Finance) Bill.

8.5 It will also be important to ensure that the model contractual agreement is clear in relation to any legal obligations being placed on the advocacy service provider, in particular, any arising under relevant equality or human rights legislation.

Funding for advocacy service providers

8.6 It should always be clear how much funding the advocacy service provider is receiving in return for the provision of advocacy services. This means that where a service provider is being funded for a range of services, one of which is advocacy, the proportion of the funding for advocacy should be clearly specified. This is essential to ensure the effective monitoring and evaluation of those services.

8.7 Best practice would suggest that, ideally, the contractual agreement should aim to outline funding for up to three to five years subject to quarterly monitoring and evaluation on a yearly basis. It is recognised, however, that this will be difficult to achieve in the current financial context.

Best Practice Fora for Advocates

8.8 Advocates benefit from exchanging ideas and information. Consideration should therefore be given to how existing local advocacy networks and fora can be supported and facilitated. For example, capacity for advocates to participate in these networks/fora could be recognised and facilitated in the contractual agreement between the commissioner and the advocacy service provider.

8.9 As far as practicable, these networks/fora should be self-supporting and it is considered important that, given the importance of independence, the facilitation role is undertaken by a body or organisation which is acceptable to those people/organisations involved in the forum. It is also considered important that the focus of the networks/fora should primarily be on the sharing of best practice. The use of on-line networks, possibly linked to the Advocacy Commissioning Group, referred to in paragraph 7.5, could also be examined.

Raising Awareness of advocacy services

8.10 There is a need for greater accessibility to, and information on, advocacy services in Northern Ireland. As resources allow, commissioners should give consideration to how the availability of advocacy services can be communicated more widely, for example via posters, leaflets, radio and media advertising and also through outreach activity recognising that face to face communication can sometimes be more effective in getting messages across and raising awareness more generally.

8.11 The setting up of an advocacy website and a central directory for advocacy services in the form of an electronic database has also been suggested. A list of advocacy services at all GP surgeries and all health and social care facilities would also help to raise awareness. Other ideas include an advocacy awareness week, an advocacy blog, the use of theatre/arts, targeting libraries, community centres, leisure centres etc, use of social networking media, provision of information in different formats and languages etc.

Training/Awareness raising for HSC Staff

8.12 Taking into account current levels of awareness and training, arrangements should be put in place to ensure that all health and social care staff who may come into contact with an advocate or people who may require advocacy receive an appropriate level of training or awareness raising in the role and benefits of advocacy, the different models of advocacy, how to access such services and the importance of independence. Consideration should also be given to providing initial and ongoing training for commissioners specifically to highlight where advocacy fits in and the wider benefits that advocacy can bring as well as the importance of independence. Any training or awareness raising should also cover the relevance of advocacy to equality and human rights laws and standards.

8.13 Decisions around the targeting of this training/awareness raising should be made in consultation with the LCGs, Trusts and advocacy service providers as well as service users and carers. These decisions should also take into account that further training may be required when guidance on the new statutory right to an independent advocate proposed under the Mental Capacity (Health, Welfare and Finance) Bill is issued.

Training for Advocates

8.14 Contractual agreements with advocacy service providers should specify the need for all advocates, including volunteers, to receive core induction training. This training should cover, in particular, the role of an advocate (including any legal obligations); the different models of advocacy and its relevance to equality and human rights laws and standards; the importance of independence and the service delivery principles and standards that all advocates will be expected to adhere to (see section 9). This training should be provided either in-house by the advocacy service provider or via an external provider. Either way, resources for this should be clearly identified in the contractual agreement. A core induction pack for all advocates should be developed to inform this training.

8.15 Advocacy service providers should also ensure that advocates have the opportunity to complete further training as necessary. Ongoing training requirements should be assessed by the advocacy service provider to ensure, where possible, that adequate resources are identified and set aside for this purpose during the development of the contractual agreement. This training should be competency based and subject to ongoing assessment.

8.16 To support this, a substantial piece of work is required to map current advocacy training in Northern Ireland to identify gaps in training provision and inform decisions on future training needs. This should include consideration of, and make recommendations on, the level of training and/or experience that independent advocates appointed for the purposes of the proposed Mental Capacity (Health, Welfare and Finance) Bill may be required to meet and, in particular, whether there is a need for a recognised formal qualification such as a certificate or diploma in independent advocacy along the lines of that currently available in England and Wales. Consideration should also be given to piloting any potential future accredited training for advocates in Northern Ireland.

8.17 In addition, consideration should be given to the development of a Code of Practice for all advocates based on the service delivery principles and standards set out in section 9. The purpose of this Code would be to describe what is and is not expected of an advocate in their day to day work, particularly in relation to compliance with any legal obligations, and would not only be of benefit to advocates but also commissioners, advocacy service providers generally and service users. It would also help to develop a better understanding of the training, supervision and support needs of advocates.

8.18 Related to this is the need to monitor developments in England and Wales and elsewhere in relation to the regulation of advocates, including the potential accreditation of organisations that hold voluntary registers (i.e. registers of people working in health and social care who are not required by law to be on a statutory register) as proposed in the Health and Social Care Bill 2011.

9. MONITORING AND EVALUATION OF ADVOCACY SERVICES

9.1 Everyone involved in the commissioning and provision of advocacy services has an interest in knowing that it is effective. While commissioners have a duty to ensure that public money is being used well, those providing the service should also recognise that they are accountable to the public for how they use this money.

9.2 It is therefore important that appropriate mechanisms are put in place to monitor and review the impact any investments being made in advocacy are having on the quality of service experienced by service users. These should be agreed between commissioners and the advocacy service providers during the development of the contractual agreement as reflected in section 8.

Defining Quality

9.3 The model contractual agreement described in section 8 should contain a statement that the advocacy service provider will work within an agreed set of principles and standards. These are set out below and essentially outline what advocacy service providers need to do to make sure that they provide good quality advocacy. They apply to all models of advocacy and are intended to guide everything that all advocates and advocacy service providers.

9.4 While commissioners may be entering into agreements with service providers for different model/types of advocacy, it is widely accepted that the same core principles and standards can apply to all types/models of advocacy. How adherence to these principles and standards is demonstrated will, however, differ and will require the development of separate performance indicators for each type/model of advocacy. They may also need to be tailored if an advocacy service is being commissioned for a particular client group. This should be borne in mind when finalising contractual agreements.

Principles and Standards for Advocacy Services

Principle 1- Clarity of purpose

Standard 1.1 - The advocacy service has clearly stated aims and objectives that communicate to users and other relevant stakeholders the scope and limitations of the service.

Principle 2 – Independence

Standard 2.1 - The advocacy service provider is structurally independent from statutory organisations and preferably from all other service providers.

Standard 2.2 - The advocacy service is as free from conflict of interest as possible both in design and operation, and actively seeks to reduce conflicting interests.

Standard 2.3 - Advocates always act for the individual while working in partnership, and maintaining good relations, with others involved in a person's care, treatment or support.

Principle 3 – Putting People First

Standard 3.1 - The advocacy service is directed by the needs, interests, views and wishes of the people who use it to enable them to have control over their lives and to be fully involved in decisions which affect them.

Standard 3.2 - The advocacy service values the people who use it and always treats people with dignity and respect.

Standard 3.3 - Advocates ensure that any information they receive concerning the people they advocate for is shared with them except in circumstances where it may cause them harm.

Standard 3.4 - Advocates represent the views of the person they are advocating for whether they agree with them or not.

Principle 4 – Empowerment and Enablement

Standard 4.1 - The advocacy service supports self-advocacy and empowerment through its work.

Standard 4.2 – Where a person is unable to communicate his/her views, ethical guidelines are used to inform decisions about advocacy activities.

Standard 4.3 - The advocacy service ensures that users of its service who want to, have a meaningful opportunity to shape the development and running of the service.

Principle 5 – Accessibility

Standard 5.1 – The advocacy service reaches out to the widest possible range of people who may require its services and

actively seeks out those that are most vulnerable or at risk of being excluded.
Standard 5.2 - The advocacy service aims to ensure that its premises, policies, procedures and publicity materials promote access for the whole community**.**

Principle 6 – Supporting advocates
Standard 6.1 – The advocacy service provider ensures that advocates, paid and volunteers, are prepared, trained and supported in their role/legal obligations and provided with opportunities to develop their skills and experience linked to the aims and objectives of the service.

Principle 7 – Accountability
Standard 7.1 - The advocacy service is accountable to the people who use it.
Standard 7.2 - The advocacy service is effectively managed and has in place systems for the effective monitoring and evaluation of its work.
Standard 7.3 – The advocacy service operates within the law at all times (including relevant equality and human rights laws and standards).

Principle 8 - Confidentiality
Standard 8.1- The advocacy service has a written policy on confidentiality which states that information known about a person using the service is confidential and any circumstances under which confidentiality might be breached.
Standard 8.2 – All client records are stored securely and in accordance with relevant data protection laws.

Principle 9 – Equality of Opportunity and Human Rights
Standard 9.1 – The advocacy service has a written Equal Opportunities and Human Rights policy which is freely available and is reviewed and updated annually.
Standard 9.2 – The advocacy service has systems to access community language/sign language interpreters and/or advocates.
Standard 9.3 - Equality of opportunity and human rights training is offered to all advocates.

Principle 10 – Complaints
Standard 10.1 – The advocacy service has a written complaints procedure which is freely available and reviewed annually.

Monitoring of advocacy services

9.5 Monitoring is the process of checking continuously how things are going. From the outset, advocacy service providers should set up systems for gathering the routine information they need so that they know how they are doing against agreed aims and objectives in the same way as any other service provider would do. This may, however, be somewhat more challenging for an advocacy service provider given the need to ensure that these systems do not compromise any of the principles outlined above.

9.6 In light of this, the assistance that commissioners can provide in supporting and advising advocacy service providers when developing or improving existing monitoring systems and deciding what information to collect should not be under-estimated. In particular, consideration should be given to what guidance is needed in relation to, where appropriate, the monitoring of any legal obligations placed on the advocacy service provider.

9.7 Advocacy service providers should see monitoring as primarily something which benefits them, not as a chore to please commissioners. It is therefore important that the process is not too burdensome and that the amount of information that needs to be collected is proportionate with the aims of the exercise.

Evaluation

9.8 Evaluation involves a planned process of gathering information, reaching conclusions and making recommendations. Any evaluation of an advocacy service should as a matter of good practice seek to take into account the perspectives of all stakeholders: people who need advocacy, paid and volunteer advocates, management and staff of the organisation providing the advocacy service, commissioners, referrers where appropriate.

9.9 Evaluation also involves making a judgement of how good something is, not just whether or not it has complied with the funding specification. It should focus on outcomes as well as activities, relevance as well as numbers, what could have been done as well as what was done.

9.10 However, evaluating any service is not a particularly easy exercise and, in relation to advocacy services, there is scope for it to be even more complicated. This should be borne in mind by commissioners during any evaluation process. It is likely for example that different views will be expressed depending on who is consulted so it is important to seek the views of as wide a group as possible. Also, those affected most by the service may often not be able to articulate their experiences as well as others and this should be taken into account when reaching conclusions and drawing up recommendations.

9.11 Some of the real achievements or successes of an advocacy service may also be difficult to identify because they are often around avoiding things happening or preventing the worst from happening. Similar issues arise where someone is supported to make a decision for themselves, but makes an unwise decision which results in an undesirable outcome for that individual. Therefore, looking at the history or steps leading up to an outcome can often be as important in the context of evaluating advocacy services as the outcome itself.

9.12 Finally, consideration should be given to the development of an evaluation framework for advocacy service providers that would include advice on processes and tools for gathering and analysing information on outcomes and for measuring this against the principles and standards set out above. This framework could be used for self-assessment and external evaluation purposes if deemed appropriate.

10. IMPLEMENTATION/NEXT STEPS

10.1 The HSCB has developed an Action Plan to assist with the implementation of this Policy Guide.[10] While lead responsibility for the majority of the actions rests with the HSCB, the Action Plan envisages stakeholder involvement/input and will be taken forward on a collaborative basis. The HSCB, together with the PCC, will jointly explore the options for how this can best be achieved.

---

[10] www.dhsspsni.gov.uk/Advocacy-Action-Plan.pdf

Appendix 1: Models of Advocacy

Citizen Advocacy

Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who might need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the organisation providing the advocacy service. The advocate supports their partner using their natural skills and talents rather than being trained in the role.

Self/Group advocacy

Self advocacy, speaking up for yourself, is the ultimate aim of most advocacy. Where self advocates come together, this is often referred to as group or collective. Group advocacy happens where a group of people who are all facing a common problem get together on a formal basis to support each other over specific issues. Individual members of the group may also support each other over specific issues. The group as a whole may campaign on an issue that affects them all. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual’s sense of isolation when raising a difficult issue.

Peer advocacy

Peer advocacy happens when individuals share significant life experiences. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and empathise with their advocacy partner. Peer advocacy works to increase self awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

Issue-based advocacy

Issue-based advocacy is also known as one-to-one, individual or professional advocacy. It is provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

Non-instructed advocacy

Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity e.g. comprehension or communication issues. An individual might be able to express what they want, e.g. to go home or a view of what they like or dislike, but may lack the capacity to instruct an advocate as to the action to take regarding a particular issue. The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.

Appendix 2: Glossary of Terms/Abbreviations

Bamford Review	The Bamford Review of Mental Health and Learning Disability Services in Northern Ireland
Department	Department of Health, Social Services and Public Safety (DHSSPS)
HSC	Health and Social Care
HSCB	Health and Social Care Board
LCG	Local Commissioning Group
PCC	Patient Client Council
PHA	Public Health Agency
PPI	Personal and Public Involvement
RQIA	Regulation and Quality Improvement Authority
SIAA	Scottish Independent Advocacy Alliance
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Exhibit 2

The Regulation and
Quality Improvement
Authority

Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland

31 March 2012

informing and improving health and social care
www.rqia.org.uk

Table of Contents

1.0 Introduction

1.1 The Legislative Framework

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, created the enabling legal framework for raising the quality of health and social care services in Northern Ireland. This Order, extended regulation and quality improvement to a wider range of services and in April 2005, RQIA was established as a non-departmental public body of the DHSSPS.

The Mental Health (Northern Ireland) Order 1986 (the Order) provides the legislative framework for the care, treatment and safeguards for people who require mental health and learning disability services. Article 85 of the Order established the former Mental Health Commission (the MHC) which had the duty "to keep under review the care and treatment of patients, including the exercise of the powers and the discharge of the duties conferred or imposed by this Order."

1.2 Transfer of former Mental Health Commission (MHC) functions to RQIA

The Health and Social Care Reform (Northern Ireland) Act 2009 transferred the functions of the former MHC to RQIA on 1 April 2009. As a consequence, the Mental Health and Learning Disability Programme of Care was established within RQIA to manage the functions outlined within the Order. These include making an inquiry into a case where there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage.

1.3 Application by RQIA of Human Rights Principles

The importance of applying a Human Rights Based approach and adhering to the principles set out in the Bamford Review, of justice, benefit, least harm and autonomy was stressed in the transfer of functions. This approach is integral to the process of engaging with service users and their representatives by the MHLD Directorate.

“Physical, cultural, social and attitudinal barriers exist which prevent people with disabilities from accessing the same rights as non-disabled people” (Disability Action) this applies particularly to mental health and learning disability service users.

Mental Health Officers in RQIA have used the Mental Health (Northern Ireland) Order 1986, the Human Rights Act 1998, the UN Convention on the Rights of Persons with a Disability (2008), and the DHSSPS Patient Experience Standards to create a range of expectation statements in the areas of:

- fairness
- respect
- autonomy
- dignity
- equality
- protection

With the help of advocates MHLD officers established a programme of patient experience reviews and a programme of thematic inspections.

By inspecting against these expectation statements RQIA ensures the fulfilment of the Bamford principles and the achievement of the RQIA core activities of:

- improving care
- informing the population
- safeguarding rights and
- influencing policy

1.4 The Role of Advocacy in Safeguarding Rights

There has been increased recognition from the government of the role of advocacy in safeguarding people‟s rights and in promoting increased choice and control over their own lives. The difficulties experienced by vulnerable people, particularly those with a mental disorder or learning disability in making their views known, have been well documented. Advocacy has been recognised internationally, as a key way of supporting people to access appropriate services and allow them to participate in decisions about their life.

2.0 What is Advocacy?

“Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice” (Action for Advocacy, 2010).

“Advocacy is the act of speaking up for people who are not being heard and supporting them to express their own views and ultimately, where possible, to make their own decisions and take control over their lives.” (Department of Health, Social Services and Public Safety, 2010)

The World Health Organisation in 2003 stated in its publication “Mental Health Policy and Service Guidance Package Advocacy in Mental Health” that,
“Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development.”

The concept of advocacy has now been broadened to include the needs and rights of persons with mild mental disorders and the mental health needs and rights of the general population. Advocacy is considered to be one of the essential eleven areas for action in any mental health policy because of the benefits that it produces for people with mental disorders and their families. The advocacy movement has substantially influenced mental health policy and legislation in some countries and is believed to be a major force behind the improvement of services in others (World Health Organization, 2001a).

The concept of mental health advocacy has therefore been developed in RQIA to promote the human rights of persons with mental disorders and to help reduce stigma and discrimination. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes.

3.0 International Perspective on Advocacy

In Northern Ireland the Irish Advocacy Network (IAN) is the only cross border organisation involved in mental health advocacy. The mental health advocacy movement is growing in Australia, Canada, Europe New Zealand, the USA and elsewhere. It comprises a diverse collection of organizations and people, many of whom join together to work in coalitions to achieve common goals.

In several other countries, advocacy initiatives are supported and, in some cases, carried out by governments, ministries of health, states and provinces.

In many developing countries, mental health advocacy groups have not yet been formed or are in their infancy. There is potential for rapid development, particularly because costs are relatively low, and because social support and solidarity are often highly valued in these countries. Development depends, to some extent, on technical assistance and financial support from both public and private sources. The World Health Organisation (WHO), through its Regional Offices and the Department of Mental Health and Substance Dependence, has played a significant role in supporting Ministries of Health all over the world in promoting Mental Health Advocacy. (WHO 2003)

3.1 UK Perspective

In England, primary care trusts have a statutory duty to provide independent mental health act advocacy (IMHA) services, (since April 2009) which help and support patients understand and exercise their legal rights

The Care Quality Commission‟s second annual report on the use of the Mental Health Act (MHA), from April 2010 to March 2011 concluded that,
"Although we saw some good examples of patient involvement during our visits, some staff have been found lacking in their knowledge of independent mental health advocacy (IMHA) and have failed to explain to patients how to access these services." They reported that "patients had regular IMHA access on only 65 per cent of wards, though 85 per cent of wards could provide IMHA when requested."

The Mental Health (Care and Treatment) (Scotland) Act 2003 recognises the importance of independent advocacy in supporting people to *"have their own voice heard in decisions made about their health and wellbeing".* It enshrines the right of access to independent advocacy for people with a „mental disorder‟ in law (section 259).

The Scottish Welfare Commission reported in its overview inspection report in 2010 that

- "there was very good evidence of advocacy provision although there was some evidence that access was more limited for people with dementia and acquired brain injury. "

The Scottish Welfare Commission has produced detailed guidance for commissioners and providers of advocacy services in respect of “Good practice Guidance for working with independent advocates” (February 2009).

Health Improvement Authority Wales (HIW) has not as yet reported on any findings relating to advocacy services in mental health or learning disability services.

3.2 Northern Ireland Perspective

Effective advocacy services have the potential to contribute to a number of strategic goals for health and social care that ultimately promote wider equality and human right objectives. These include:

- Social Inclusion and justice;
- Health improvement and well-being;
- Reducing inequalities in health and well-being;
- Personal and public involvement;
- Safeguarding adults; and
- Bamford Review/Modernising Mental Health and Learning Disability Services (including proposed Mental Capacity legislation).

Currently, there is an array of advocacy services being provided by a range of mainly community and voluntary organisations and groups across Northern Ireland, all of whom receive funding from a variety of sources, including the statutory sector. As a result, a wealth of experience and skills has already been built up in relation to advocacy services.

However, in terms of what is commissioned by the statutory sector, existing provision is patchy, with some HSC Trusts having more established arrangements in place than others e.g. Belfast and Northern HSC Trusts. There is also evidence of some regional commissioning of advocacy services by the DHSSPS and the HSC Board.

4.0 Types of Advocacy

Citizen Advocacy

Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who might need support in their Communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the advocacy organisation. The advocate supports their partner using their natural skills and talents rather than being trained in the role.

Group or Collective Advocacy

Collective advocacy happens where a group of people who are all facing a common problem get together on a formal basis to support each other over specific issues. Individual members of the group may also support each other over specific issues. The group as a whole may campaign on an issue that affects them all. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual‟s sense of isolation when raising a difficult issue.

Peer Advocacy

Peer advocacy happens when individuals share significant life experiences. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and empathise with their advocacy partner. Peer advocacy works to increase self awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

Professional (Individual) Advocacy

Professional advocacy is also known as one-to-one, individual or issue based advocacy. It is provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

Ultimately, self advocacy is what all the models of advocacy aim to achieve i.e. a means of building a person‟s confidence and knowledge to enable him/her to speak up for him/herself and have their voice heard. However, this may not always be possible, for example when a person lacks capacity. In these circumstances, the role of advocacy is considered to be particularly important and is often referred to as non-instructed advocacy.

Non-instructed Advocacy

Non-instructed advocacy could take the form of any of the models described above, and focuses on those who lack capacity to instruct an advocate. This type of advocacy will be central to the outworking of the new proposed statutory right to an independent advocate in the Mental Capacity (Health, Welfare and Finance) Bill, due in 2015/2016.

(“Developing Advocacy Services. A policy guide for commissioners” DHPSSNI May 2012)

5.0 Advocacy Forum - RQIA

RQIA in recognising the importance of this work in relation to mental health and learning disability in particular, set up an Advocacy Forum in 2009. A scoping exercise was conducted and all organisations providing advocacy services were visited by their designated Mental Health Officer (RQIA). Details of the provider organisations, its staff, and the volume and type of activity involved were established and recorded.

The establishment of a relationship with advocates has assisted officers in theming their inspection activity and embedded user involvement in the activity of the MHLD Programme of Care. The majority of people currently working as advocates have personal experience of mental health services either as a user or carer. The RQIA Advocacy Forum quality assured the inspection methods used by the MHLD team and provided comments on questionnaires used by the inspectors to determine the quality of care provided.

RQIA aims to establish a positive, reciprocal and enduring relationship with service users. The existence of the forum further evidences RQIA personal and public involvement activities. Meetings with advocates were held in February and July 2009 specifically to gauge their views on a proposed „Open Surgery „Review.

This resulted in advocates being invited to discuss how they could work with RQIA to maximise the uptake of interviews and agree the aims and objectives of the forum. Their participation in facilitating practical arrangements was discussed and their help was invaluable in targeting some of the wards visited by inspectors.

5.1 Facilitation of Advocacy Forum

The Advocacy Forum is comprised of a number of voluntary organisations including Praxis, Northern Ireland Association for Mental Health (NIAMH), MindWise, Irish Advocacy Network (IAN), Life After Mental Health Problems (LAMP), Foyle Advocates, CAUSE, Bryson House, MENCAP, Alzheimer‟s Society and Disability Action. This forum is facilitated by a nominated RQIA responsible mental health officer. The RQIA officer has a remit to develop Public and Personal Involvement within the Programme of Care and was involved in initial meetings and in the annual review of the effectiveness of the Forum. At the last review, advocates spoke of the noted improvement in their ability to gain information and acceptance from ward staff as a direct result of the positive working relationship with RQIA, and the recommendations made by Mental Health Officers following inspections of wards. RQIA is able to call on advocates directly in relation to specific patient issues. This provides an extra assurance that issues will be dealt with appropriately once RQIA leaves the site of inspection.

5.2 Outcomes to date

Outcomes to date have included sharing of best practice, sharing of RQIA‟s planned inspection activity, getting input to RQIA processes, discussion of individual concerns, and involvement in DHSSPS activities in relation to advocacy.

Given the importance of advocacy in advancing the human rights of service users, RQIA entered into dialogue with NITA, the National Institute for Trial Advocacy who provided Advanced Advocacy training through the Law Society and Institute of Professional legal Studies.

NITA agreed to philanthropically engage in the training course, given its importance in Northern Ireland, and with RQIA developed a training programme for 24 lay advocates in Belfast in May 2010.

From 1 October 2010 to 31 December 2011 RQIA completed 54 inspections of Mental Health wards and 23 inspections of Learning Disability wards focusing on the human rights theme of fairness. One of the expectation statements under this theme is that Advocacy Services are available to all patients. Findings from the inspections of Mental Health wards indicate that 87% of these facilities required recommendations made in respect of the need to consider the provision of advocacy services for patients. Of the Learning Disability wards inspected 87% had recommendations made in relation to the need for development of Advocacy Services. In cases where users were not fully capable of representing themselves effectively, inspectors recommended that an advocacy service is provided.

6.0 Provision of Advocacy Services by Trusts in Northern Ireland

6.1 Belfast Health and Social Care Trust

Mental Health Services

The Belfast trust is the only trust to have established a paid position for a service user advocacy consultant. The organisations commissioned by the BHSCT to provide advocacy services for those with mental health problems are as follows

- Praxis
- NIAMH
- MindWise
- IAN
- LAMP
- CAUSE
- Disability Action
- MENCAP
- Bryson House
- Alzheimer‟s Society

Praxis, the IAN, LAMP and CAUSE provide advocacy services in the community and in a hospital setting and NIAMH and MindWise provide services in a hospital setting only, both in Knockbracken and Shannon Unit. CAUSE is a registered charity which provides peer-led practical and emotional support to the carers and families of people with severe and enduring mental illness. It works with carers and family members over 18 years. NIAMH is a voluntary organisation which is normally not available to 16-17 year olds, unless they are in an acute ward and request to see an advocate. LAMP are a peer advocacy group working in the Mater Hospital and from a drop in centre in Rosemary Street, Belfast. An advocate from IAN works with the resettlement team.
Generally speaking only one provider organisation will work in any particular ward, i.e. patients cannot choose which organisation they use.

Learning Disability Services

The organisations commissioned by the BHSCT to provide advocacy services for those with a learning disability are:

- Bryson House – voluntary sector service for 18 years +Telling it like it is (TILII) supported by Association for Real Change (ARC) –voluntary service

Older People's Services

Advocacy services are provided for older people in the Trust area by the Alzheimer‟s Society.

Young People's Services

VOYPIC (Voice of young people in care) provide advocacy services to children and adolescents in Beechcroft Unit.

Representatives from all of the above organisations attend the RQIA Advocates Forum, which meets quarterly. One of the advocates from IAN, has assisted RQIA staff with Patient Experience Reviews in Knockbracken and participated in the RQIA MH&LD Expert Advisory Panel.

6.2 Southern Health and Social Care Trust

Mental Health Services

The SHSCT commissions CAUSE and NIAMH to provide advocacy services to people with mental health needs. Both organisations work in the community and hospital settings.

SHSCT also provides peer advocacy services through a Mental Health forum in the Newry and Mourne area. A network of Peer Advocates has been developed and a training programme devised to increase capacity. The trust supports a User and Carer Service Improvement Group, comprised of Advocates and service user and carer representatives. This group is consulted on changes to services.

Learning Disability Services

The SHSCT commissions Disability Action to provide independent advocacy services to adults with a learning disability. Longstone hospital residents have access to a full time advocate.

Older People Services

Advocacy services are provided for older people in the Trust area by the Alzheimer‟s Society

Representatives from all of the Southern Trust commissioned organisations attend the RQIA Advocates Forum and have assisted officers in meeting patients during inspections.

6.3 South Eastern Health and Social Care Trust

Mental Health Services

The organisations commissioned by the SEHSCT to provide advocacy services for those with mental health problems are:

- CAUSE
- MindWise

A Peer Advocate Co-ordinator is also commissioned by the Trust.

Learning Disability Services

The organisations commissioned by the SEHSCT to provide advocacy services for those with a learning disability are:

- Bryson House - voluntary sector service for adults
- Carer‟s forum – voluntary sector service for 16 years +
- 2 TILLI groups supported by ARC – voluntary sector service for adults

Older People Services

Alzheimer‟s Society Support group – voluntary sector service.

The CAUSE representatives attend the RQIA forum, as does one of the advocates from MindWise.

6.4 Western Health and Social Care Trust

Mental Health Services

The WHSCT commissions one organisation to provide advocacy services for those with mental health problems, namely Mind Yourself/Foyle Advocates, which is a voluntary service for adults and children admitted to adult psychiatric wards. The types of advocacy provided by Mind Yourself include group/self and peer advocacy.

Learning Disability Services

The organisations commissioned by the WHSCT to provide advocacy services for those with learning disability are:

- MENCAP - voluntary service for adults
- Independent Advocacy Service

Older People's Services

The WHSCT commissions the Alzheimer‟s Society to provide advocacy services for old people.

Representatives from the Western Trust advocacy groups rarely attend the Forum. This is primarily because of the distance and expense of travel. One of the advocates from Mind Yourself participated in the RQIA sponsored training course. Advocates have met with inspectors during visits to acute wards in Gransha hospital. This organisation is run predominantly by volunteers. There have also been changes of personnel since the RQIA forum was established. The organisation is sent minutes from the meetings and representatives have met with inspectors during inspections in Gransha and in the Tyrone and Fermanagh hospital.

6.5 Northern Health and Social Care Trust

Mental Health Services

The organisations commissioned by the NHSCT to provide advocacy services for those with mental health problems are:

- NIAMH - voluntary service for adults
- MindWise – voluntary service

The Northern Trust are the only Trust who do not contract services from CAUSE.

Learning Disability Services

The NHSCT commissions MENCAP to provide advocacy services for people with learning disabilities. This is a voluntary sector service for adults and children. The advocate is based in Muckamore Abbey Hospital and works part time.
Compass Advocacy Network also provides services to this group.

Older People's Services

Two organisations provide advocacy services for older people.

- Age NI First Connect
- Alzheimer‟s Society – voluntary service

The NIAMH advocates regularly attend the RQIA Forum and have assisted MHOs during inspection activity. Alzheimer‟s Society advocates have liaised with officers during inspections and assisted patients to complete questionnaires. The senior manager attends the Forum.

7.0 RQIA Inspection Findings and Recommendations in relation to Advocacy in hospital wards.

These are outlined in the attached appendices.

Recommendations in relation to advocacy were made following inspections by MHLD officers of all wards in MHLD hospitals on the theme of fairness. Almost all of the facilities visited required a recommendation regarding advocacy. The majority of these related to requiring that advocates attend the ward meetings on a regular basis and that wards proactively encourage visits from advocates.

Belfast HSC Trust

There were variations in the availability of advocacy across the Belfast Trust. The Shannon Regional Secure unit has an excellent service with a patient‟s advocate and a carer‟s advocate available.

In Muckamore Abbey Hospital (MAH) some patients attended the TILLI group and advocates were available in most of the admission wards. Advocates were involved in the resettlement plans for some patients. Long stay wards had limited access to advocacy services and patients from the Southern Trust in MAH had no advocacy provision.

Preliminary findings during Patient Experience Reviews indicate that the availability of advocacy is improving in many wards.

Southern HSC Trust

Recommendations were made in 1 of 7 wards inspected, this was the most notable exception to the Regional inspection findings. The four wards in the Bluestone Unit, Southern Trust, offered an exceptional service. The assessment and treatment unit in Longstone hospital also provided an excellent service.

South Eastern HSC Trust

Recommendations were made with respect to advocacy in all of the South Eastern Trust facilities inspected. Advocacy was available in the acute wards; however this was extremely limited in terms of allocated time available for each ward.

Northern HSC Trust

Recommendations were made in 9 out of the 10 inspections. Many of the recommendations have since been partially actioned. The Ross Thompson Unit in Causeway hospital now has an advocacy service.

Western HSC Trust

Recommendations were made in relation to the availability of Advocacy Services in all of the inspected wards. Advocacy services are available within the acute wards in Gransha Hospital and the dementia wards within Waterside. However the availability of advocacy services is limited within Tyrone and Fermanagh Hospital.

Progression towards achievement of Quality Improvement Plans will be examined during current inspections by MHLD Officers in 2012.

8.0 DHSSPS Advocacy Working Group Guidance

In 2010 in line with other UK health departments, the Department of health established a working group to help develop a policy on advocacy services in a health and social care setting. The RQIA mental health officer with responsibility for advocacy was invited to join this group. A draft document was agreed in June 2011 and went out for consultation. (DHSSPSNI draft advocacy policy document 2011). This document precedes the new proposed incapacity legislation, but will be used to support the role of the independent advocate. Information gleaned during the course of the work has informed this paper.

To inform this work, the Department also carried out a scoping study of advocacy services commissioned or provided by the five HSC Trusts, as well as research into advocacy provision in the rest of the UK, the Republic of Ireland and internationally (New Zealand and South Australia mainly). This, along with the outcomes of three workshops held in September and October 2010, has helped to inform the drafting of the policy. The purpose of the workshops was to engage, at an early stage, with interested groups (including statutory and voluntary sector organisations and service users and carers) to inform policy development. A key driver for this work is the proposed introduction of a new statutory right to an independent advocate in the Mental Capacity (Health, Welfare and Finance) Bill which the Department is currently preparing. This proposed new statutory right reflects the growing recognition of the value of advocacy services in protecting the human rights of the most vulnerable in our society as acknowledged in the Bamford Review report on Human Rights and Equality of Opportunity.

The DHSSPS “Developing Advocacy Services". A policy guide for commissioners” May 2012 also aims to pave the way for the proposed new statutory right by seeking to improve understanding of what advocacy is and how advocacy services in a health and social care setting are commissioned. It sets out key principles and standards for the future commissioning and delivery of advocacy services and addresses the issue of independence. Further guidance will be prepared on the proposed new statutory right, once the detail has been developed.

9.0 Future Monitoring Requirements by RQIA

The DHSSPS envisage that RQIA will have a significant role in monitoring, quality, availability and access to independent advocacy under the new legislation as a safeguard for patients who are deemed to lack capacity to consent to tier 3 interventions e.g. ECT or forced feeding. It is proposed that this may involve a similar process to that currently in place for appointment, registration and referral to Part 2 and Part 4 doctors under the existing Mental Health Order. (1986)

There is much current debate around the concept of “independence”. Most of the current advocacy providers are employed by organisations which also provide accommodation and care services to Trusts. The level of training varies greatly amongst advocates and it is vital to ensure that commissioners do not spend all of the available resources on the statutory advocates at the expense of peer led services.

The provision of advocacy services to those under the age of 16 is outwith the proposed new legislation.

10.0 Summary

There is a clear recognition of the importance of the continued provision of Advocacy Services in Northern Ireland. The anticipated new capacity legislation has reinforced the growth of the advocacy movement and government interest in this area. The Patient Client Council and the HSCB, as the commissioner, are both interested in setting standards for advocacy services and exploring the options available for delivery of services.

RQIA has been at the forefront of establishing mutually beneficial relationships with advocates and carers representatives. It is envisaged that we will continue to engage with advocates in designing and implementing our inspection programme and in ensuring that service user‟s benefit from the added protections that access to advocacy affords them.

The RQIA Advocacy Forum will continue to meet quarterly.

There is a significant amount of work to be done in the coming year in conjunction with DHSSPS, both with regard to on-going policy development relating to advocacy in implementing the processes involved in the administrative procedures required to support the independent advocate role and in signposting patients to the most appropriate Advocacy Service to best meet their needs. It is envisaged that the new legislation will be in place by 2016.

By continuing to develop relationships with advocates, RQIA can begin to explore options to involve service users and carers in our mainstream inspection programme. This helps to reinforce RQIAs commitment to PPI and raise the calibre of our inspection activity, putting the public and the service user at the heart of everything we do.

RQIA Mental Health Officers will continue to support patients and relatives access to Advocacy Services and will continue to see Advocates prior to, and during inspections of Mental Health and Learning Disability wards.

APPENDIX1

BELFAST HEALTH AND SOCIAL CARE TRUST

BEECHCROFT ADOLESCENT UNIT	It is recommended that an advocacy service is provided. It is recommended that information is made available to the young people and families about advocacy services such as CAUSE and VOYPIC.
KNOCKBRACKEN - RATHLIN	It is recommended that a formalised in reach system for patients is considered, as there may be inequity of accessibility to the service for patients on this ward, as other acute in-patient units in the Trust have established advocacy clinics. It is recommended that the advocate attends patients' meetings on a consistent basis.
KNOCKBRACKEN - MAINE	In view of the vulnerability of patients on the ward it is recommended that contracted advocacy input is resolved as a matter of urgency. It is recommended that “Have your say” meetings occur at least monthly and that the outcomes from these meetings are clearly documented and that advocacy input is facilitated.
MATER - WARD K	It is recommended that the patients' advocate attends the patients meeting.
MATER - WARD L	It is recommended that all patients are made aware of the advocacy service. It is recommended that the advocate attends patients‟ meetings to assist patients to discuss any issues of concern at this forum.

MUCKAMORE ABBEY - CRANFIELD FEMALE	It is recommended that all patients have equal access to patient advocacy and that advocates proactively seek the views of patients on admission and on an ongoing basis.
MUCKAMORE ABBEY - CRANFIELD ICU	It is recommended that the unit oversees the adequate provision of independent advocacy services for all patients.
MUCKAMORE ABBEY - DONEGORE	It is recommended that advocates are invited and facilitated to take an active part in patient forum meetings. It is recommended that staff discuss the role of the advocate on the ward and adopt a more flexible approach to collaborative working.
MUCKAMORE ABBEY - ENNIS	It is recommended that the Trust is proactive in the delivery of an independent advocacy service to the ward.
MUCKAMORE ABBEY - ERNE	It is recommended that the patient advocate attends the ward on a regular basis to improve access to this service for patients and relatives.
MUCKAMORE ABBEY - FINGLASS	It is recommended that the advocacy service is more accessible and that independent advocacy is available to all patients on a proactive basis. It is also recommended that the patients‟ advocate become involved in patients‟ forum meetings on the ward.
MUCKAMORE ABBEY - GREENAN	It is recommended that the hospital's advocacy service is developed to include an in-reaching service to patients in Greenan Ward.

MUCKAMORE ABBEY - KILLEAD	It is recommended that the independent advocacy service attend patients meetings on the ward.
M' ABBEY - SIX MILE ASSESSMENT CENTRE	It is recommended that advocates are invited to attend ward meetings.
MUCKAMORE ABBEY - RAHTMULLAN	It is recommended that advocates adopt a proactive approach and visit the ward on a regular basis, irrespective of actual requests and limitations in engagement.
M' ABBEY - SIX MILE TREATMENT CENTRE	It is recommended that an advocate attends all patient forum meetings.
WINDSOR HOUSE	It is recommended that the ward advocate attends the ward on a more regular basis to improve patients' awareness of the service.

APPENDIX 2

SOUTHERN HEALTH AND SOCIAL CARE TRUST

LONGSTONE - MOURNE HOUSE	It is recommended that the ward advocate is facilitated to meet with individual and small groups of patients to proactively identify any issues that require the advocacy service.
LONGSTONE - SPERRIN	It is recommended that the patients' advocate provides a proactive in-reaching service to patients in Sperrin. The establishment of a patient's forum with attendance from the advocate would also enhance patients' access to independent advocacy.
ST LUKE'S - GILLIS MEMORY CENTRE	It is recommended that there is a proactive, formalised, planned approach to the expansion of the advocacy service and engagement with these patients who have very specific requirements. It is recommended that this protocol is inclusive of the needs of those patients whose communication skills are severely impaired and that a forum for eliciting patient and carers views is considered.
LONGSTONE - CHERRY VILLA	It is recommended that advocacy services proactively engage with patients on the ward and that this is monitored in view of the heavy work load of the advocate. It is also recommended that efforts are made to enhance the information available to patients and carers about this service.

APPENDIX 3	
SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST	
DOWNE - ACUTE UNIT	It is recommended that the advocate attends the patients‟ meetings.
DOWNE - DEMENTIA UNIT	It is recommended that staff and patients have an awareness of the role of the advocate and the availability of advocacy services at the point of admission and that this is documented in the patients‟ notes.
DOWNSHIRE- WARD 27	It was recommended that the advocate should attend the patients' meetings to promote patient knowledge and understanding of the service and proactively engage with the patients.
DOWNSHIRE- WARD 28	It is recommended that the Patient Advocate continues to attend the patients meeting on a regular basis. It is recommended that the Patient Advocate is part of a communication strategy to inform relatives and patients of any developments regarding a reassignment or closure of Ward 28 in respect of various resettlement options available to the patient.
DOWNSHIRE- WARD 29	It is recommended that the Patient Advocate will attend the ward by request and on a regular basis. It is recommended that the Patient Advocate is part of a communication strategy to inform relatives and patients of any developments regarding Ward 29, and in respect of the various re-settlement options available to the patient.

LAGAN VALLEY - WARD 11	It is recommended that access to independent advocacy services is reviewed to ensure that this is not wholly dependant on referral from staff. It is recommended that the independent advocacy service should be available and proactive on the ward on a more regular basis. It is recommended that MindWise Advocacy Service is actively promoted on the ward with patients who have a functional mental illness.
LAGAN VALLEY - WARD 12	It is recommended that staff inform patients of the availability of advocacy services at the point of admission and that this is documented in the patients‟ notes.
ULSTER ACUTE UNIT	It is recommended that staff inform patients of the availability of advocacy services at the point of admission and that this is documented in the patients‟ notes.

APPENDIX 4	
WESTERN HEALTH AND SOCIAL CARE TRUST	
LAKEVIEW - CRANNOG (CHILDREN'S)	It is recommended that the arrangements for the provision of independent advocacy services are clearly published within the ward and that these are accessible to all patients. It is recommended that the 'looked after' children on the ward are advised of the services available from VOYPIC.
LAKEVIEW - STRULE LODGE	It is recommended that the Trust review the arrangements to enable all patients to access independent advocacy services.
GRANSHA- CLINIC A	It is recommended that advocates are involved in the facilitation of patients meetings.
GRANSHA- CLINIC B	Good practice recognised, it is recommended that the initiatives underway to complete leaflets and notices for advocacy services are finalised in a timely manner.
GRANSHA- CEDAR	It is recommended that advocates are encouraged to attend the monthly patient meetings and are proactive in engaging with patients.
TYRONE AND FERMANAGH - ASH WARD	It is recommended that independent advocacy services are available to all client groups and that advocates proactively engage with the staff and patients.
TYRONE AND FERMANAGH - BEECH VILLA	It is recommended that the Trust reviews that advocacy service provision to the ward to

	ensure it complies with the expectation statement.
TYRONE AND FERMANAGH - ELM WARD	It is recommended that all patients are made aware of the role and function of an Independent Advocate.
TYRONE AND FERMANAGH - LIME	Inspectors confirmed that there is a need to more robustly inform patients of the role and availability of advocacy services. It is recommended that this could be promoted through regular patient meetings. It is recommended that the gap of an independent service needs to be resolved.
TYRONE AND FERMANAGH - OAK	It is recommended that advocates attend the ward regularly and adopt a proactive approach to establish contact with patients.
TYRONE AND FERMANAGH - SPRUCE	Review provision of carer‟s advocacy and possible carers support group.
WATERSIDE WARDS 1 AND 3	It is recommended that the Trust make arrangements for independent advocacy services to engage proactively with patients. It is recommended that regular patient meetings should be facilitated with an advocate in attendance.

APPENDIX 5	
NORTHERN HEALTH AND SOCIAL CARE TRUST	
HOLYWELL - CARRICK 3	It is recommended that the input of the Advocate is reviewed and service provision is formally agreed.
HOLYWELL - CARRICK 4	It is recommended that the advocate is more proactively involved in Carrick 4 and attends patients‟ meetings and the ward regularly so that patients are familiarised with the service.
HOLYWELL - INVER 1 (PREV LISSAN 2)	It is recommended that the advocate attends the ward on a regular basis and attends patients‟ meetings.
HOLYWELL - INVER 4	It is recommended that negotiations to clarify the role of advocacy services on the ward are prioritised and that RQIA is advised of the outcome.
HOLYWELL - LISSAN 1	It is recommended that patients should have regular access to the Patient Advocate.
HOLYWELL - TARDREE	It is recommended that access to Advocacy is extended to include attendance on the ward on a more regular basis to identify issues which may require advocacy and be accessible to patients, independent of staff referral.
HOLYWELL - TOBERNAVEEN CENTRE	It is recommended that advocates should attend patient meetings.

HOLYWELL - TOBERNAVEEN LOWER	It is recommended that the Patient Advocate attends the patients meetings. It is recommended that the Advocate is informed of any patient who lacks capacity.
ROSS THOMPSON UNIT	It is recommended that advocacy services are available and accessible to patients in RTU.

Exhibit 3

Code of Practice for Independent Advocates

ANNI

Advocacy Network Northern Ireland

ANNI

Advocacy Network Northern Ireland

An easy read version of this booklet is currently being written

June 2014

Code of Practice for Independent Advocates

FOREWORD

On behalf of the Health and Social Care Board I am delighted to endorse this Code of Practice for Independent Advocates produced by the Advocacy Network Northern Ireland.

Independent Advocacy can support people who use health and social care services to articulate their views and wishes; secure their rights; have their interests represented and influence the services they receive to reflect their own interests and preferences.

The organisations and practitioners in the field have worked hard to develop this comprehensive guide to individual practice and conduct for independent advocates, whether paid or working in a voluntary capacity.

The development of this Code of Practice is an important step in raising the standards, profile and professionalism of Independent Advocacy in Northern Ireland.

Fionnuala McAndrew
Interim Chief Executive
Health and Social Care Board
28 May 2014

Contents

ANNI

INTRODUCTION

The Advocacy Network Northern Ireland, ANNI, came into being in August 2012 with the aim of providing opportunities for independent advocacy organisations to:

- **Share expertise, best practice and experience**
- **Provide shared training and development opportunities**
- **Promote independent advocacy**
- **Identify and follow up opportunities to develop the advocacy services sector**

The Northern Ireland Health and Social Care Board linked in with ANNI from its inaugural meeting, as a means of engaging with the advocacy sector. This relationship led to ANNI being commissioned to develop this Code of Practice for Independent Advocates, along with a Standards Framework and a Core Induction Checklist. The Health and Social Care Board provided funding and a Project Manager was appointed to co-ordinate the work of ANNI.

The overall aim is to raise the quality of experience for those who engage with advocacy services and to provide clarity around the roles and expectations for all those who come into contact with independent advocacy services in Northern Ireland.

In developing the Code, ANNI has sought the engagement of the wide range of advocacy practitioners throughout Northern Ireland, whether or not their organisations are members of ANNI. Engagement has been through workshops, email and one-to-one visits. This Code of Practice is a product of this work. Members of the Steering Group are delighted to commend this Code of Practice to the advocacy sector. It is expected that advocacy organisations will require their advocates to sign up to and adhere to the Code.

Paul McFall
Chair
Advocacy Network Northern Ireland

ANNI

“As an Independent Advocate, I agree to….”

Be open, fair and trustworthy

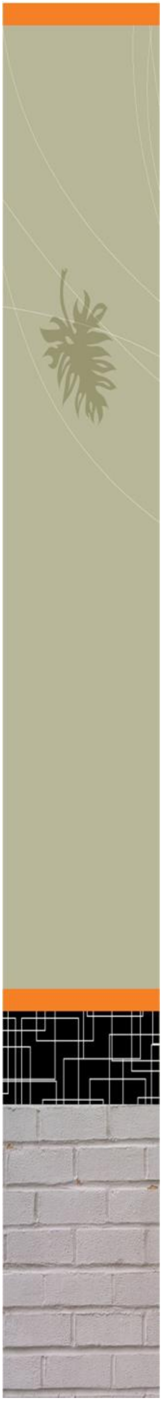
- ✓ I will work in a way that is open, honest and reliable;
- ✓ I will establish appropriate boundaries for my role with the person I am supporting as an advocate and work within these;
- ✓ I will act within the limits of my knowledge and skills.

Put the views of people for whom I advocate first

- I will support and encourage people for whom I advocate to speak for themselves if they are able and wish to do so;
- I will represent the views and wishes of the people for whom I advocate;
- I will represent the views and wishes of people for whom I advocate, whether I agree with them or not;
- I will not seek to influence or direct the views of the people for whom I advocate;
- I will do everything I reasonably can to obtain the views and wishes of the people for whom I advocate.

Help people with whom I work to participate as fully as possible when decisions are made about their lives

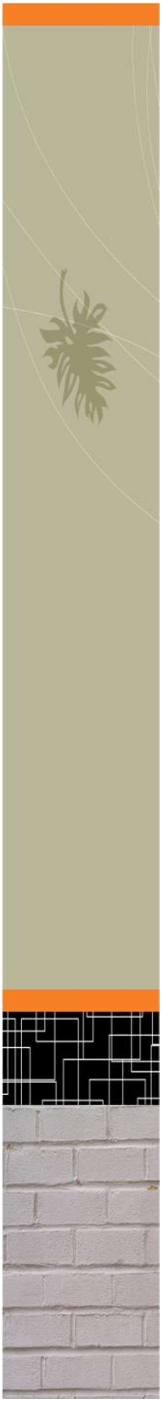
- ✓ I will provide people for whom I advocate with the information they need to make informed choices;
- ✓ I will support the people for whom I advocate to explore the implications of the options they are considering;
- ✓ I will do everything possible to ensure that the people for whom I advocate have time and opportunities to consider their options and make choices.



Work with the agreement of the people for whom I advocate

- I will ensure that the people for whom I advocate understand my role, what I am planning to say on their behalf and to whom I will say this. I will not proceed with this unless I am sure that this is what they wish me to do;
- I will do everything possible to ensure that the people for whom I advocate are aware of implications of me passing on their views;
- I will recognise that the people for whom I advocate have a right to change their minds and will ensure that the wishes and views that I communicate on their behalf are current;
- I will seek to gain the agreement of the people for whom I am advocating in whatever way is most suitable for them. Where agreement cannot be made in writing, I will record the details of how their agreement was and is communicated.

Respect boundaries of confidentiality



- ✓ I will not pass on information about the people for whom I advocate unless they want me to, except where there is a legal requirement or justification for me to do so;
- ✓ I will regard confidentiality as being between the people for whom I advocate and the organisation providing the advocacy service, and will share information with my manager where appropriate in order to facilitate safe and reflective practice;
- ✓ I will pass on concerns about the safety of vulnerable adults and children and young people in accordance with the law and with the policy requirements of the organisation with whom I am working;
- ✓ I will explain the limits of confidentiality to the people for whom I advocate.

Be accountable and seek support

- I will be accountable to the people for whom I advocate in relation to any action I take on their behalf and any wishes and views I communicate to others;
- I will actively participate in supervision and support offered by the advocacy organisation for whom I am working in order to achieve the best possible outcomes for the people for whom I advocate;
- I will be accountable to the advocacy organisation for whom I work in relation to the advocacy work that I do;
- If people for whom I am advocating need support that is beyond the boundaries of my role I will signpost them appropriately and establish links with further support if that is what they want;
- I will keep case records as required by the advocacy organisation with whom I work and statistical records as required by or for those who fund the work.

Challenge others

- I will challenge others to ensure that the wishes and views of the people for whom I advocate are heard and considered;
- I will challenge in a constructive manner, recognising and respecting the roles and views of others.

Respect and promote the Human Rights of those with whom I work

- ✓ I will ensure I have current knowledge and understanding of Human Rights and equality legislation, policy and service frameworks and developments;
- ✓ I will respect the Human Rights, dignity, diversity and autonomy of people for whom I advocate;
- ✓ I will promote the Human Rights of those with whom I work to others with whom they come into contact;
- ✓ I will challenge others when I become aware that someone's Human Rights are not being respected.

Show respect for others

- I will treat the people for whom I advocate with respect and dignity at all times;
- I will uphold the principle that advocacy should be made available to those who would benefit irrespective of their history and circumstances;
- I will treat all other professionals, carers and family members in the life of the people for whom I advocate with respect and will value the differences between their role and mine.

Practice self-care

- I will seek appropriate support and ensure that I avail of support opportunities offered;
- I will use supervision opportunities to reflect on my advocacy case work;
- I will not accept advocacy work that is beyond my competence as an advocate.

Continue my professional development

- I will keep up to date with developments in advocacy and other areas that may impact on the people for whom I advocate;
- I will avail of learning and development opportunities relevant to my role that are offered to me;
- I will identify my own learning needs in relation to my role and seek to address these in conjunction with my manager.

Sample Individual statement of commitment

As an Independent Advocate I agree to follow the **Code of Practice for Independent Advocates**.

Name: ______________________________

Organisation: ______________________________

Signed:__________________________Date:____________________

ACKNOWLEDGEMENTS

It would not have been possible to produce this Code of Practice without the help of a number of people.

Firstly, I want to thank all the independent advocates and advocacy managers who fed into the production of this Code. Thank you for all the support, challenges and affirmation. This is your Code of Practice and it would not have worked without you. I am also grateful to the organisations for which you work for generously allowing your time to contribute to the project.

I also wish to thank ANNI for taking on this work, and the members of ANNI Steering Group for all their help and contributions. In particular, a sub-group comprising of Paul McFall, Jennifer-ruth Mcanlis, Elizabeth Gracey and Paschal McKeown kept me on the right tracks and preserved my sanity (well, almost).

Colin Harper and Martin Coyle have also supported me as unofficial mentors in this work. Thank you, both. Martin generously allowed me to use some of his former work with Action for Advocacy as a starting point.

I want to thank Alzheimer's Society for housing the project and supporting me throughout the work, and Geraldine Nolan for her efficient admin support.

Last, but by no means least, I want to thank the Health and Social Care Board, and in particular Valerie McConnell, for not only funding the work but for her continuing interest in its progress.

Marian Cinnamond
Project Manager
Advocacy Network Northern Ireland

Acknowledgements

- Action Ability Belfast (USDT)
- Advice NI
- Age Concern
- Alzheimer’s Society
- ARC NI (Association for Real Change)
- BIEF (Ballymena Inter-ethnic Forum)
- BDA (British Deaf Association)
- Bryson Care
- Cause
- CAN (Compass Advocacy Network)
- Derg Valley Care
- Disability Action
- Humanitas
- Irish Advocacy Network
- Lamp Group
- Leonard Cheshire NI
- Mencap
- MindWise
- Mind Yourself
- NAPA
- Niamh
- NICEM

Acknowledgements (Cont'd)

- Patient and Client Council
- Positive Futures
- Positive Life
- South East Trust
- The Rainbow Project
- Third Age National Advocacy Programme
- True Voice Trust
- Victim Support NI
- VOCAL
- VOYPIC

ANNI Steering Group

- Action Ability Belfast (USDT)
- Alzheimer’s Society
- Bryson Care
- Cause
- CAN (Compass Advocacy Network)
- Derg Valley Care
- Disability Action
- Irish Advocacy Network
- Leonard Cheshire NI
- Mencap
- MindWise
- Niamh
- Positive Life
- VOYPIC

ANNI

Advocacy Network Northern Ireland

Published
June 2014

Advocacy Network Northern Ireland

Social Care & Children’s Directorate
Health & Social Care Board
12-22 Linenhall Street
Belfast BT2 8BS

0300 555 0115
http://www.hscboard.hscni.net

Funded by:

Health and Social Care Board

Host organisation:

Alzheimer’s Society
Leading the fight against dementia

Code of Practice for Independent Advocates

Exhibit 4

The Regulation and
Quality Improvement
Authority

Review of Advocacy Services for Children and Adults in Northern Ireland

January 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting on three key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?

These stakeholder outcomes are aligned with Quality 2020,[1] and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

This review was carried out by Dr David Stewart (RQIA Medical Director, and Director of Reviews), and Ronan Strain (RQIA Project Manager).

RQIA wishes to thank all those people who facilitated this review through participating in discussions, attending the regional summit event, or providing relevant information.

We would particularly like to thank the Health and Social Care Board (HSC Board), the Health and Social Care trusts (HSC trusts) and independent advocacy providers for providing information to underpin the review process.

---

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

Table of Content

Executive Summary

In May 2012, a guide for commissioners (Developing Advocacy Services) and an associated action plan were published by the Department of Health, Social Services and Public Safety (DHSSPS), to help commissioners better understand and develop advocacy services in Northern Ireland.[2]

The guide introduced principles and standards to underpin the future commissioning and delivery of all health and social care (HSC) advocacy services. It recognised these may need to be tailored to meet the needs of specific client groups.

As part of its 2015-18 review programme, RQIA was commissioned by DHSSPS to conduct a review of the commissioning arrangements for the provision of Advocacy Services for Children and Adults in Northern Ireland. The review examined the commissioning systems and processes to consider if they were in keeping with the principles and standards set out within the DHSSPS policy guide.

The Health and Social Care Board (HSC Board) is responsible for identifying the need for advocacy services for children and adults, and commissions some services directly through regional contracts. Health and Social Care trusts (HSC trusts) commission advocacy services from providers for their local populations.

RQIA found that the HSC Board and trusts have clear commissioning arrangements in place. Contracts reflect the principles and standards set out in the DHSSPS guide. The commissioning process adheres to relevant procurement of goods and services legislation. Feedback from independent advocacy providers highlighted that the process was considered to be consistent, fair and equitable.

RQIA was provided with examples which demonstrated that HSC organisations value the importance of independent advocacy services. Advocacy is now regarded as a core element of provision for some services, and is recognised to be valuable when service changes are being considered or implemented.

Following the publication of the guide and action plan, an implementation process was established by the HSC Board. The Advocacy Network for Northern Ireland (ANNI) facilitated the development of specific documents to support the implementation process.

---

[2] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

RQIA identified a number of constraints that impact on the optimal delivery of advocacy services in Northern Ireland:

- At present there is no clear statutory duty or strategic framework to provide independent advocacy services in Northern Ireland.
- A lack of resources has impacted on investing in advocacy services across all programmes of care.
- There is no process for regulation of providers of advocacy services or for individuals undertaking advocacy.

RQIA found that the provision of advocacy services varies across geographical areas and HSC trust programmes of care (PoC). Most advocacy services are provided for mental health, learning disability, and family and children's services. In most HSC trusts, there is limited investment in advocacy for individuals in other PoC.

It is recognised by both commissioners and providers that the current contract arrangements for advocacy focus mainly on outputs in relation to how much activity is provided, rather than on outcomes. The contracting process does not fully reflect the complexities of the work of advocacy. The time spent on working with someone in a challenging situation where they need advocacy can be substantial. Each case is different and may require contact with a range of organisations.

RQIA was advised that it is anticipated that the future direction of advocacy services will be impacted by the new mental capacity legislation and potential new European procurement legislation, and this will need to be assessed.

RQIA makes eight recommendations for improvements in the commissioning process and quality of advocacy services for children and adults in Northern Ireland.

The recommendations have been prioritised in relation to the timescales in which they should be implemented:

- Priority 1 – to be completed within 6 months of publication of report
- Priority 2 – to be completed within 12 months of publication of report
- Priority 3 – to be completed within 18 months of publication of report

Chapter 1: Introduction

1.1 Introduction

The DHSSPS policy guide, Developing Advocacy Services[3] was developed by a working group, established in June 2010, and chaired by the Chief Executive of the Patient and Client Council (PCC). The group was established in response to recommendations in the Bamford Review report on Human Rights and Equality of Opportunity in relation to advocacy.[4]

The guide aims to inform the commissioning and provision of advocacy services in a HSC setting for people who require advocacy support. This includes people who are living with disabilities – physical, sensory, mental, learning or communication related. It may also include others such as carers, children and young people, older people, victims, and prisoners.

The guide was also informed by a scoping study carried out by the DHSSPS in May 2010.[5] The study gathered information on advocacy services, commissioned or provided by the HSC Board and trusts, for people aged 16 and over with mental health conditions; learning disabilities; physical and sensory disabilities; and older people (focusing on those with dementia).

A diverse range of client groups and users may require advocacy. It was recognised that aspects of the guide, in particular, the commissioning and delivery of the principles and standards, may require to be tailored to meet their specific needs.

Definition and Models of Independent Advocacy

Independent advocacy plays a crucial role for service users and carers. It can support people who use HSC services to: articulate their views and wishes; secure their rights; have their interests represented; and influence the services they receive to reflect their own interests and preferences.

Independent advocacy can mean different things to different people in different contexts. However, the following descriptions reflect the role of advocacy in a HSC context:

"Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people." (Bamford Review Report on Human Rights and Equality of Opportunity)[6]

---

[3] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

[4] www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf

[5] Scoping study, research and workshop summary papers can be viewed at http://www.dhsspsni.gov.uk/show_publications?txtid=47432

[6] http://www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf

"Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and justice." (Advocacy Charter produced by Action for Advocacy)[7]

"Advocacy is the process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up for justice." (The Scottish Independent Advocacy Alliance: Principles and Standards for Independent Advocacy)[8]

Advocacy can empower people to speak up for themselves. It can also help people to become more aware of their rights, to exercise those rights and to be involved in and influence decisions that are being made about their care, treatment or support.[9]

In certain situations, however, people in need of support may be unable to clearly articulate or express their views. Such cases can be particularly challenging, and highlight the vital role that advocacy can play in securing a person's rights, representing their interests and ensuring that decisions are taken with due regard to their preferences or perspectives. This type of advocacy is often referred to as non-instructed advocacy.[10]

The most common types or models of advocacy are:[11]

Citizen Advocacy

Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who may need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long-term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the organisation providing the advocacy service. The advocate supports their partner using their natural skills and talents, rather than being trained in the role.

Self/Group Advocacy

Self-advocacy, speaking up for yourself, is the ultimate aim of most advocacy. Where self-advocates come together, this is often referred to as group or collective. Group advocacy happens where a group of people who are all facing a common problem get together on a formal basis to support each other over specific issues. Individual members of the group may also support

---

[7] http://www.qualityadvocacy.org.uk/wp-content/uploads/2014/03/Code-of-Practice.pdf

[8] http://www.siaa.org.uk/wp-content/uploads/2013/11/siaa_principles_and_standards_2010.pdf

[9] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

[10] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

[11] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

each other over specific issues. The group as a whole may campaign on an issue that affects them all. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual's sense of isolation when raising a difficult issue.

Peer Advocacy

Peer advocacy happens when individuals share significant life experiences. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and empathise with their advocacy partner. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

Issue-based Advocacy

Issue-based advocacy is also known as one-to-one, individual or professional advocacy. It is provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

Non-instructed Advocacy

Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity, for example, comprehension or communication issues. An individual might be able to express what they want, for example, to go home or a view of what they like or dislike, but may lack the capacity to instruct an advocate as to the action to take regarding a particular issue. The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.

Going forward, it is essential that commissioners are aware of, and understand the role that advocacy can play in helping to achieve the priorities that have been set for HSC in Northern Ireland, and in supporting the proposed model for the future delivery set out in Transforming Your Care (TYC).[12]

---

[12] www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

1.2 Context of the Review

Advocacy services for both children and adults have been considered in recent reviews and strategies both in Northern Ireland and elsewhere in the United Kingdom.

Northern Ireland

The DHSSPS has published HSC service frameworks for key services including, mental health, learning disability, and older people.[13] Service frameworks set out, at high level, standards for services which patients and users should expect to receive. Each framework has high level standards in relation to advocacy which state:

"Service users and their carers should have access to independent advocacy as required".

Delivering the Bamford Vision action plan 2012-15 included the implementation of mental capacity legislation. The Mental Capacity Bill includes a consistent approach, with appropriate safeguards to decisions about care, treatment, property or assets, which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reasons.[14] In particular, the Bill will provide for the appointment of independent advocates. An independent advocate under the Bill will be a person who can speak on behalf of a person who lacks capacity and who will have knowledge of the procedures involved in relation to a proposed intervention, and of the person's rights under the Bill, in particular the person's right to seek review of any authorisation. The primary role of the independent advocate under the Bill is to support and represent the person who lacks capacity in the determination of whether a proposed act is in his or her best interest.

RQIA has published a number of reports which reflect the value and importance of advocacy services, and a key way of supporting people to access appropriate services and allow them to participate in decisions about their life.

In March 2012, RQIA published the report of a review of the Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland.[15] This review concluded that there was a significant amount of work to be done with regard to ongoing policy development relating to advocacy. This included implementing the administrative procedures required to support the independent advocate role and in signposting patients to the most appropriate advocacy service to best meet their needs.

---

[13] http://www.dhsspsni.gov.uk/sqsd-standards-service-frameworks

[14] https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

[15] http://rqia.org.uk/cms_resources/Advocacy_Report_final%20report.pdf

In October 2012, RQIA published the report of a review of the implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (May 2010).[16] The review provided evidence of positive developments by HSC trusts in relation to advocacy services.

In February 2013, RQIA published the report of a review of Safeguarding Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland.[17] This review recommended that HSC trusts should ensure that patients and relatives on all wards have access to advocacy services.

England and Wales

The Royal College of Psychiatrists (RCPsych) published a report in February 2012 on 'Independent advocacy for people with mental disorder'. This highlighted that in England and Wales there is an independent mental capacity advocacy service for those who lack the capacity to make decisions for themselves, a situation which is not uncommon in general hospitals. The report stated that staff in general hospitals will usually be less aware of the need for advocacy services and indeed of their role, and psychiatrists and other mental health staff had a part to play in addressing this.[18]

In March 2015, the Department of Health (DOH) published the 'Analysis of the use of the IMCA (Independent Mental Capacity Advocacy) Service in England from April 2013 to March 2014'. It identified patterns and trends in the use of independent mental capacity advocates, and where more can be done so that everyone entitled to advocacy has access to it.[19]

A review undertaken by the National Institute for Health Research (NIHR) concluded the lack of robust evidence leaves advocacy in a potentially vulnerable position, and the need for better quality, more widely quantified information on the outcomes of advocacy has never been greater.[20]

The National Institute for Health and Care Excellence (NICE) published specific standards in relation to advocacy services. NICE quality standard (QS30), states: "people with dementia are enabled, with the involvement of their carers, to access independent advocacy services".[21]

The Welsh Government in December 2011 published the 'Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Planners'. This reinforced the importance of certain

---

[16] http://www.rqia.org.uk/cms_resources/PQC%20Overview%20Report%20Final%20October%202012.pdf

[17] http://www.rqia.org.uk/cms_resources/Overview%20Report%20of%20Safeguarding%20in%20MHLD%20Hospitals%2014%20Feb%2013_ISBN.pdf

[18] http://www.mentalhealthlaw.co.uk/media/RCPsych_CR171_Independent_Advocacy.pdf

[19] https://www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-7th-annual-report

[20] http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SR7.pdf

[21] https://www.nice.org.uk/guidance/qs30/chapter/quality-statement-9-independent-advocacy

principles, and also the need for independent mental health advocacy services to recognise they are delivering a statutorily required function.[22]

Scotland

In 2013, Scotland published revised guidance for advocacy which aimed to capture developments since the publication of a Guide to Commissioners in 2001 by the then Scottish Executive Health Department. It sought to clarify commissioners' statutory responsibilities under the Mental Health (Care & Treatment) (Scotland) Act 2003.[23]

Existing Provision in Northern Ireland

Following the publication of the DHSSPS action plan, the HSC Board undertook a scoping exercise in 2012-13, which highlighted that most advocacy services do not fit neatly into programmes of care or across geographical structures.

In addition, there were a number of factors driving the need for this review. Firstly, there is a need for greater parity and consistency in relation to the commissioning and delivery of advocacy services in a HSC setting in Northern Ireland. Currently, there is an array of advocacy services being provided by a range of mainly community and voluntary organisations and groups, which receive funding from a variety of sources, including the statutory sector. As a result, a wealth of experience and skills has already been built up.

However, in terms of what is commissioned by the statutory sector, existing provision is patchy, with some HSC trusts having more established arrangements in place than others.

Investing in advocacy means that people who are vulnerable or at risk of exclusion or being discriminated against have a vehicle through which they can have their voice heard, gain access to information to help them make informed choices about their health and wellbeing and have their rights secured. Advocacy empowers people and can also help to safeguard people.[24]

Investing in advocacy services not only benefits the person needing support. It can also benefit commissioners and providers of HSC services. For example, advocacy can help prevent crises arising in a person's life which otherwise may result in an intervention that has much greater resource implications. It can also enhance capacity building at a community and individual level which can ultimately serve to reduce dependency on other HSC services.[25]

---

[22] https://www.rcpsych.ac.uk/pdf/Advocacy%20Guidance.pdf

[23] http://www.gov.scot/Publications/2013/12/7000

[24] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

[25] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

Effective advocacy services have the potential to contribute to a number of strategic priorities for HSC that ultimately promote wider equality and human rights objectives. The support that advocates provide can help people avail of opportunities and exercise rights to which they are entitled. This not only has the potential to enhance their daily lives but it can also help to build their confidence and capacity to play an active role in society and secure greater equality in service provision generally.[26]

As part of its 2015-18 review programme, RQIA was commissioned by the DHSSPS to carry out this review, to gain assurance as to the effectiveness of the existing commissioning processes undertaken by the HSC Board and trusts.

1.3 Background

Roles and Responsibilities

Health and Social Care Board

The HSC Board advised RQIA that its main role is to identify the needs of the Northern Ireland population and to commission HSC services to meet those needs, within the strategic priorities identified by the DHSSPS and the funding made available. Where independent advocacy is the most appropriate service to meet an identified need or strategic objective, and funds are available, the HSC Board will commission that type of service.

The HSC Board currently has a number of regional contracts to deliver independent advocacy across different programmes of care including, children services, people with hearing impairment, and children with disabilities. The HSC Board also commissions advocacy in relation to resettlement of learning disability patients from hospital.

In September 2012, the HSC Board established an Advocacy Commissioning Group which involved representatives from the five local commissioning groups (LCGs) and five HSC trusts. This group agreed terms of reference and operated until December 2013, when it was deemed that the major objectives of the group had been achieved.

The HSC Board also established an internal advocacy group, and currently employs four social care commissioning leads, responsible for taking forward the action plan associated with the DHSSPS policy guide. The role and remit of the group is to support the service improvements identified in the action plan as they apply to independent advocacy services for people with serious mental illness, learning disability, children's services, older people and physical disability.

---

[26] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

Health and Social Care Trusts

The five HSC trusts have responsibility for commissioning advocacy services from independent advocacy providers. These are commissioned through a tendering process, adhering to the DHSSPS policy guide and procurement legislation.

Advocacy services are commissioned across various programmes of care, primarily within:

- family and child care
- children and adult learning disability
- children and adult mental health
- adult physical disability

HSC trusts advised RQIA that specific advocacy services for conditions such as dementia and autism are commissioned on a short-term basis, as and when required.

Independent Advocacy Providers

Independent advocacy providers are responsible for the delivery of the advocacy services for which they have agreed contracts in place with either the HSC Board or trusts. Advocacy providers may focus on provision of services to individuals in a specific PoC, or across PoCs.

Independent advocacy providers are supported by the HSC Board and individual trusts to work in specific services and localities, engaging with patients, service users and carers in both acute and community settings.

Providers also engage with the HSC Board and individual trusts through attending regular management, policy, service delivery, and budgetary meetings.

The independence of the role of the advocacy providers is considered as key to delivering support to people who use HSC services to articulate their views and wishes; secure their rights; have their interests represented and influence the services they receive, to reflect their own interests and preferences.

Information about the delivery of advocacy services is provided to the contracting authority (HSC Board/HSC trust) via monthly monitoring return forms, which collect data in relation to the volumes of services being delivered. However, the monitoring arrangements do not capture the quality of the advocacy service provided or the outcomes of individual cases.

Throughout the year independent advocacy services provide feedback from their experiences and lessons learnt to the contracting authority.

The Northern Ireland Commissioner for Children and Young People (NICCY), and Commissioner for Older People (COPNI) are independent voices and champions for children, young people, and older people across Northern Ireland, standing up and speaking out on their behalf. They work to ensure that those who are vulnerable and at risk are kept safe and ensures that all children, young people, and older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services they need.

Advocacy Network for Northern Ireland

The Advocacy Network for Northern Ireland, ANNI, was established in August 2012, with the aim of providing opportunities for independent advocacy organisations to:

- share expertise, best practice and experience
- provide shared training and development opportunities
- promote independent advocacy
- identify and follow up opportunities to develop the advocacy services sector

The HSC Board has worked with ANNI from its inaugural meeting, as a means of engaging with the advocacy sector. This relationship led to ANNI being commissioned to develop a code of practice for independent advocates, along with a standards framework and a core induction checklist. The HSC Board provided funding and a project manager was appointed to coordinate the work of ANNI. The funding provided to ANNI was on a non-recurrent basis for a defined time period.

Advocacy Commissioning Structure / Process

The procurement of goods and services for the HSC Board and trusts is managed and delivered by the Procurement and Logistics Service (PaLS), which is accredited as a Centre of Procurement Expertise (CoPEs).

PaLS is part of the Business Services Organisation (BSO) which provides a broad range of regional business support functions and specialist professional services to the whole of the HSC sector in Northern Ireland.

During the commissioning process for independent advocacy services, the HSC Board and trusts adhere to the Northern Ireland Public Procurement Policy Handbook (June 2011),[27] and the European Union Treaty Principles. The HSC Board and trusts also adhere to DHSSPS Procurement Guidance Notes,[28] and 'Management of Purchasing and Supply' guidance (mini-code),[29] which allows for local competition at the lower level spend moving to European Union (EU) competition on the appropriate higher level spend.

---

[27] http://www.hscbusiness.hscni.net/pdf/ni-ppp-handbook-v3-june-2011.pdf

[28] http://www.dfpni.gov.uk/index/procurement-2/cpd/cpd-policy-and-legislation/content_- cpd policy procurement_guidance_notes/content_cpd_policy_pgn_05_14_collaborative_procurement/pgn_05_14_v2_-_collaborative_procurement.pdf

[29] http://www.dhsspsni.gov.uk/cas-purchasing.pdf

Fundamental principles from the EU Treaty which the HSC Board and HSC trust must adhere to include:

- transparency – contract procedures must be transparent and contract opportunities should generally be publicised
- equal treatment and non-discrimination – potential suppliers must be treated equally
- proportionality – procurement procedures and decisions must be proportionate
- mutual recognition – giving equal validity to qualifications and standards from other member states, where appropriate

The HSC Board and trusts receive advice and guidance from the Central Procurement Directorate within the Department of Finance and Personnel (DFP), and BSO Procurement Unit, when undertaking a tendering process.

A regional Social Care Procurement Group (SCPG) is in place and provides advice to the Regional Procurement Board on the direction of social care procurement. Members of the group are drawn from HSC trusts, HSC Board, Public Health Agency (PHA), and BSO. The SCPG is leading on development of proposals for an approach to social care procurement which will focus on increasing compliance in this sector.

A procurement strategy for HSC and arm's length bodies (ALBs) is currently being developed by the DHSSPS. This will set out key objectives and targets for continual improvement in the acquisition of goods, services and works. All bodies will be expected to implement all aspects of the strategy.

Currently, the HSC Board and trusts undergo tendering processes as contracts become due for renewal. Retendered contracts are generally for three years, with an option of an additional two year extension.

Appendix 1 sets out an example of the processes which the HSC Board and trusts follow when commissioning independent advocacy services for children and adults in Northern Ireland.

The Scoring System

The scoring system used by both the HSC Board and trusts when awarding contracts for the provision of independent advocacy services across Northern Ireland and Europe adhere to the follow two criteria.

1. Selection Criteria – This is scored on the historic and current information from the provider organisation in line with the DHSSPS policy guide. For example, is the provider organisation structurally independent? This information is scored pass or fail.

2. Award Criteria – This is weighted against four main areas. The first three areas are scored out of 60% and relate to the providers. The fourth area is price, and accounts for 40% of the overall scoring total of 100%:

1. Service delivery plan
2. Staff levels and training
3. Governance arrangements, policies and procedures, and service continuity plans
4. Price

RQIA found that most independent advocacy providers indicated that they are content with the current contract arrangements, and that the tendering process is consistent, fair and an appropriate quality method of commissioning.

1.4 Terms of Reference

The Terms of Reference of the Review:

1. To profile the current provision of advocacy services for all programmes of care across each HSC trust, and assess the impact of the guide on the range and quality of advocacy services currently available to service users and carers.

2. To assess the implementation of the policy guide and progress made in relation to its associated action plan (Developing Advocacy Services: A Policy Guide for Commissioners and its associated Action Plan, May 2012).

3. To evaluate the effectiveness of the processes HSC trusts have in place to gain assurance that the six commissioning principles are adhered to during their contract process.

4. To evaluate the effectiveness of the processes HSC trusts have in place to monitor the adherence of advocacy service providers to the proposed Principles and Standards.

5. To evaluate the effectiveness of the processes HSC trusts have in place to raise awareness of advocacy services, and the importance of independence, among health and social care professionals and service users and carers.

6. To consider the implications of the new mental capacity legislation on future provision of advocacy service in Northern Ireland.

7. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements in advocacy service provision in Northern Ireland.

1.5 Methodology

The review methodology was designed to gather information about the current processes and contracting arrangements in place to assure adherence to the DHSSPS policy guide and associated action plan for commissioners.

The methodology was as follows:

1. Literature search/review to determine relevant areas in relation to the provision of advocacy services for children and adults in Northern Ireland.
2. Discussions with the HSC Board, HSC trusts and Advocacy Network for Northern Ireland (ANNI).
3. Self-assessment questionnaire completed and returned by the HSC Board and HSC trusts.
4. Self-assessment questionnaire completed and returned by independent advocacy providers.
5. Meetings and telephone discussions with independent advocacy providers.
6. Regional summit event and group discussions involving all relevant stakeholders.
7. Publication of an overview report of the findings of the review.

Chapter 2: Findings

2.1 Profile of Advocacy Services for Children and Adults in Northern Ireland

Table 1 highlights the current profile of independent advocacy services commissioned by HSC services within Northern Ireland, on a local and regional level. It should be noted that some independent advocacy services are commissioned on a short-term, which are not reflected in the table.

Table 1: Current Profile of Independent Advocacy Services within Northern Ireland on a Local and Regional Level

Commissioning Organisation	Independent Advocacy Organisation	Programme of Care	Local or Regional Service
HSC Board	VOYPIC	Children and Young People, including CAMHS and Learning Disability	Regional
HSC Board	British Deaf Association	People with Hearing Problems	Regional
HSC Board	Barnardos	Children with Disabilities	Regional
HSC Board	Bryson Charitable Group	Learning Disability Resettlement	Regional
HSC Board	Mencap	Learning Disability Resettlement	Regional
Belfast Trust	Irish Advocacy Network	Adult Mental Health	Local
Belfast Trust	NIAMH	Adult Mental Health	Local
Belfast Trust	Mindwise	Adult Mental Health	Local
Belfast Trust	CAUSE	Adult Mental Health, Forensics, Carers	Local
Belfast Trust	Praxis	Adult Mental Health	Local
Belfast Trust	Bryson Charitable Group	Adult Learning Disability	Local
Belfast Trust	NIACRO	Children and Young People	Local
South Eastern Trust	NIACRO	Children and Young People	Local
South Eastern Trust	Mindwise	Adult Mental Health	Local
South Eastern Trust	CAUSE	Adult Mental Health	Local
South Eastern Trust	Telling It Like It Is (TILII Group)	Adult Learning Disability	Local
South Eastern Trust	Carers Forum Advocacy Group	Adult Learning Disability	Local

South Eastern Trust	Age NI	Older People	Local
South Eastern Trust	Alzheimer Society	Older People	Local
Western Trust	VOCAL	Adult Learning Disability	Local
Western Trust	Mind Yourself	Adult Mental Health	Local
Western Trust	Disability Action	Adult physical, sensory and autism services	Local
Southern Trust	NIAMH	Adult Mental Health (including older people and carers)	Local
Southern Trust	CAUSE	Adult Mental Health (including older people and carers)	Local
Southern Trust	Disability Action	Adult Learning Disability Resettlement	Local
Southern Trust	Disability Action	Adult physical, sensory and autism services	Local
Northern Trust	NIAMH	Adult Mental Health	Local
Northern Trust	Disability Action	Adult Learning Disability	Local
Northern Trust	Disability Action	Adult Physical Disability	Local

RQIA found that there is no regional information system in place to capture the full picture of the current profile of advocacy services in Northern Ireland. Workforce and workload varies across each independent advocacy organisation, which is heavily influenced by funding and type of contract.

RQIA was advised that the number of advocates employed by independent advocacy organisations ranges from 1 - 9 whole time equivalent (wte). Organisations advised that demand for advocacy services is increasing year on year.

Figures 1 and 2 show examples of increasing demand from two independent advocacy organisations.

Figure 1: VOYPIC - Children and Young People Advocacy Services

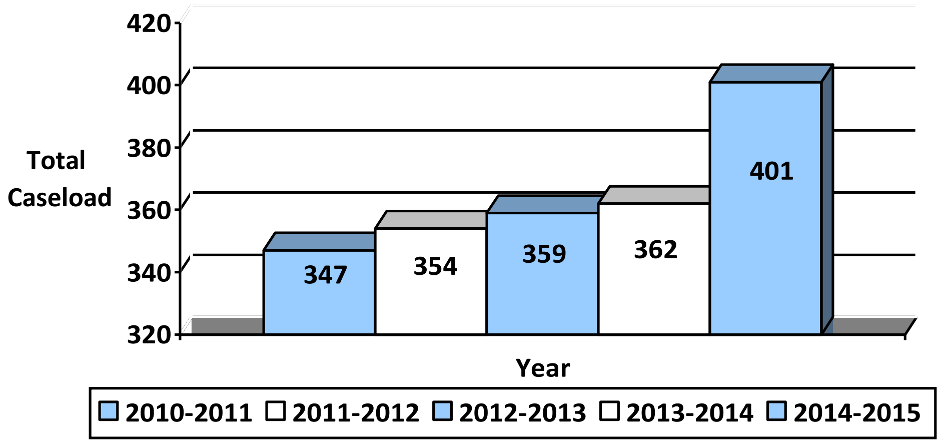
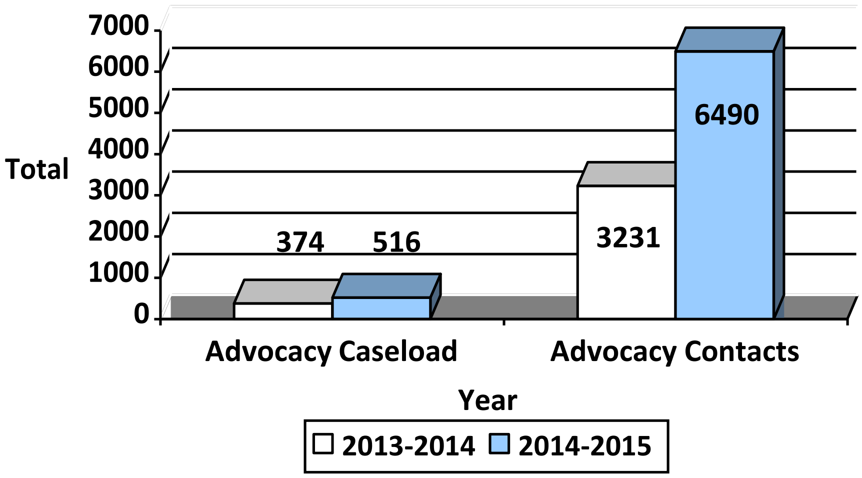


Figure 2: NIAMH - Adult Mental Health Advocacy Services



Information received from HSC organisations and independent advocacy providers highlighted that the current profile of advocacy services varies across geographical areas and across different PoC.

Information provided by HSC organisations indicated that most advocacy services are provided for individuals using adult mental health, adult learning disability, and family and children's services.

HSC trusts advised that they commission advocacy services for other programmes including adult physical disability, sensory impaired and older people; or for people with specific conditions including Alzheimer's disease, and autism. However, the pattern is not consistent across all HSC trusts.

On a regional level, the HSC Board directly commissions advocacy for children's services; children with disabilities; resettlement of patients from hospital with a learning disability; and people with hearing problems.

RQIA found that most funding is used for professional advocacy, although many of the professional advocacy organisations also facilitate self/group, and peer advocacy services within the relevant HSC trust.

RQIA was advised that the number of service users, and complexity of cases, varies considerably across providers and HSC trusts. The review found that some cases can be resolved quickly over the telephone or by a single visit from the advocate. However, other cases can be very complex and lengthy, taking more than six months to resolve, and requiring a multidisciplinary approach to the casework.

Due to a lack of regional information available, the review team would recommend a needs assessment to determine future requirements, and assist in the development plans for future demands on advocacy services. With evidence of increasing demand, along with complex cases, the review team recommends that the capacity of advocacy services is reviewed to improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.

Independent advocacy providers advised that some complex cases could require advocates to link with other sectors, including housing and education to assist their clients in resolving issues. RQIA was advised that there is no clear framework for this to occur.

During individual discussions with organisations and at the regional summit event, RQIA was advised that there is no regular forum through which learning about advocacy services is shared across the commissioners and providers of advocacy services. However, ANNI facilitates meetings for discussions between its member organisations.

Participants at the review summit event suggested other approaches such as newsletters or an annual regional event to share learning between providers and HSC organisations about the provision of advocacy services.

Recommendation 1	**Priority 3**
HSC trusts / Commissioners should carry out a needs assessment to determine future capacity requirements, and improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.	

Recommendation 2	**Priority 3**
HSC Board in partnership with relevant organisations should review and clarify arrangements for advocates to link with other sectors, including housing and education, when this is required in seeking to resolve cross-agency issues for their clients.	

Recommendation 3	**Priority 2**
HSC Board should work in partnership with HSC trusts and independent advocacy providers to consider other approaches such as newsletters or an annual event to share learning and experiences of advocacy services across organisations.	

2.2 Range and Quality of Advocacy Services since the Implementation of DHSSPS Policy Guide, May 2012

RQIA found that the range and quality of advocacy has improved in several areas since the implementation of the DHSSPS policy guide.

The review found that there is greater involvement and communication of advocates during the implementation of service changes, and HSC organisations now see advocacy as playing a key role in involving and supporting patients and clients in processes. For example, informing service policy and strategies such as the resettlement from long stay institutions.

The review also found improved continuity of care, with advocates enhancing their skill and expertise. For example, advocates undertaking accredited Open College Network (OCN) advocacy courses, such as Level 3 (Independent Advocacy Management) and Level 4 (Understanding Advocacy in a Capacity Context). Also, the DHSSPS Office of Social Services (OSS) has provided funding for training social care staff in the voluntary sector.

The review team was also provided with evidence of improved processes and mechanisms within HSC trusts and HSC Board to raise awareness, disseminate information, and evaluate advocacy services. For example, through the establishment of ANNI, the development of the code of practice, standards framework, and core induction checklist, was an important step in raising the standards, profile and professionalism of independent advocacy in Northern Ireland.

However, the review found that the range of provision of advocacy services has not substantially changed since the DHSSPS and the HSC Board completed scoping exercises in 2010-11 and 2012-13.

The provision of advocacy services continues to be predominately for mental health, learning disability and children’s services. There have been some developments for other programmes of care, however, RQIA was advised that these vary in nature and extent across different areas. There are recognised gaps, for example, in the provision of advocacy for people with particular conditions such as brain injury.

While recognising significant developments in relation to training of advocates, there is a lack of consistency in this training. RQIA was advised that there will be significant resource and training implications to prepare for the implementation of the new mental capacity legislation.

Recommendation 4	**Priority 3**
The resource and training implications for advocacy services should be included in the assessment of requirements to take forward the implementation of the new mental capacity legislation.	

2.3 Implementation of the Policy Guide and Progress Made in Relation to the Associated Action Plan

The review team found that, before the implementation of the DHSSPS policy guide in May 2012, HSC organisations already had arrangements and processes in place for the commissioning of independent advocacy services. However, HSC organisations welcomed this policy guide, as it has ensured a more structured commissioning process and increased awareness of independent advocacy services across HSC organisations.

The HSC Board advised the review team of the processes involved in taking forward the associated action plan, aligned to the DHSSPS policy guide. The HSC Board highlighted that the implementation of the policy guide, and its associated action plan, was introduced without any additional resource. Therefore, actions had to be achieved within existing resources, and, in the absence of any formal accreditation or regulatory framework for advocacy services.

The HSC Board established the Advocacy Commissioning Group in September 2012, which included senior leads from the five LCGs and HSC Trusts. RQIA was advised that nominated members of this group changed throughout its lifetime. This group developed and agreed terms of reference to take forward the DHSSPS policy guide and associated action plan. The group stood down in December 2013, when the HSC Board considered that the major objectives of the group had been achieved.

The terms of reference for the Advocacy Commissioning Group:

1. Review and update the advocacy services scoping exercise concluded in 2010 to identify currently commissioned services that are consistent with the definitions presented in the DHSSPS policy guide.
2. Ensure the implementation of the advocacy commissioning principles within HSC contracting/commissioning organisations.
3. Support currently commissioned services to meet the principles and standards for advocacy services.
4. Facilitate and support efforts to raise the awareness of clinical, professional and managerial staff of the benefits of independent advocacy.

The Advocacy Commissioning Group worked in partnership with independent advocacy providers through ANNI to develop and agree the following products:

1. Code of practice for independent advocates.
2. Standards framework.
3. Core induction checklist.

The process also provided support to independent advocacy providers to review their compliance with the principles and standards set out in the DHSSPS policy guide, and to begin the process of improvement planning through self-assessment and audit.

RQIA found that the work done by the Advocacy Commissioning Group to implement the action plan had delivered on its agreed terms of reference.

However, when the group stood down, there was no longer a regional forum to discuss advocacy issues across organisations.

2.4 The Commissioning Principles

The Commissioning Framework for Health and Social Care[30] sets out principles governing the contractual relationship between commissioners and service providers of advocacy services. The principles are aimed at ensuring that commissioners choose only good quality advocacy services. They apply regardless of the type or model of advocacy being commissioned.

RQIA found that the HSC Board and trusts have effective commissioning arrangements in place, and that the HSC Board and trusts seek to reflect the commissioning principles when awarding contracts.

The HSC Board and trusts highlighted that their commissioning processes are guided by experienced procurement officers, supporting senior managers to develop a service specification. Prospective independent advocacy providers are asked to submit proposals to provide services which can meet the requirements of the service specifications.

The service specifications set out clear quality standards which the HSC Board and trusts expect from independent advocacy providers. During the tendering process, the HSC Board and trusts use a scoring system which will reject applications if they cannot demonstrate that they can adhere to the six commissioning principles. For example, the tendering process dictates that only those who are structurally independent from all statutory organisations and preferably from service providers can compete for the tender.[31]

Feedback from independent advocacy providers identified a number of areas for improvement in the current commissioning process. The contract/service specifications focus primarily on outputs rather than outcomes of advocacy. Providers considered that the contract monitoring arrangements do not fully reflect the complexities of the work of advocacy. The time spent on working with someone in a challenging situation where they need advocacy can, in some cases be substantial.

Independent advocacy providers would welcome a more outcome based model in reporting on advocacy. Effective advocacy services can lead to a range of quality outcomes, such as supporting human rights, improved wellbeing, social inclusion and reducing inequalities.

---

[30] http://www.dhsspsni.gov.uk/mipb_-_09-09.pdf

[31] http://www.dhsspsni.gov.uk/Developing-Advocacy-Services-A-guide-for-Commissioners-May-2012.pdf

Advocates can also contribute to building effective links between organisations providing HSC services and groups representing the interests of particular client groups.

RQIA recommends that HSC organisations work with advocacy providers to develop outcome measures in service agreements for the provision of advocacy services.

Some advocacy providers considered that there were no safeguards to prevent an advocate being contracted in such situations who had no training in relation to the specific needs of that individual. HSC trusts advised that this would be an uncommon situation, and that they would seek to ensure that the principles for commissioning were followed.

Some independent advocacy providers raised concerns that they had experienced some difficulty in providing advocacy for a client if the service they are using is located in a different HSC trust area from where their place of residence is.

HSC trusts advised that arrangements for particular commissioned services vary. Some services are provided on a geographic basis for the HSC trust population. Others, including mental health services, will be commissioned to provide advocacy for anyone using the service provided by that HSC trust.

RQIA was provided with examples where advocates provide services across HSC trust boundaries, such as during resettlement programmes from long stay facilities.

RQIA recommends that HSC trusts review service agreements with advocacy providers to ensure clarity on the provision of services for clients across trust organisational boundaries.

Independent advocacy providers would welcome more clarity around structures and mechanisms that support the commissioning process. Independent advocacy providers highlighted that there is not always a clear source of guidance in relation to the contractual arrangements. They would welcome a dedicated point of contact with commissioners, who can provide advice and guidance, if required, where such arrangements are not already in place.

Recommendation 5	**Priority 2**
HSC organisations should work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning.	

Recommendation 6	**Priority 2**
HSC trusts should review service agreements with independent advocacy providers to ensure clarity as to the arrangements for provision of services for clients across trust organisational boundaries.	

Recommendation 7	**Priority 1**
HSC commissioning organisations should review their arrangements to ensure that there is a clear point of contact for service providers to provide advice and clarification in relation to service agreements.	

2.5 Monitoring adherence of Independent Advocacy Service Providers to the proposed Principles and Standards

RQIA found that the contractual agreements developed by the HSC Board and trusts contain statements that the independent advocacy service provider will work within an agreed set of principles and standards, as outlined within the DHSSPS policy guide.

The principles and standards outline what advocacy service providers need to do to ensure that they provide good quality advocacy. They apply to all models of advocacy and are intended to guide advocacy service providers.

RQIA found that the HSC Board and trusts have established processes to monitor the adherence of independent advocacy providers to the proposed principles and standards.

Monitoring and review of services delivered by independent advocacy providers is part of the agreed contract and service specification.

HSC commissioners have annual contract review meetings with each provider organisation. At these meetings documentation must be presented, including: ongoing monitoring forms; annual accounts; an annual report; and confirmation of insurance. Organisations are also asked to confirm that registration with Access NI is up to date for staff and volunteers. Relevant policies including: child protection, vulnerable adults, complaints and adverse incidents are expected to be up-to-date. Provider organisations can also be asked for minutes of relevant meetings, if required.

The contracts/service specifications set out robust reporting mechanisms and key performance indicators, which include quantitative and qualitative returns reported on a monthly, quarterly and annual basis. Management teams within the HSC trusts meet quarterly and annually with independent advocacy providers to ensure smooth delivery of services. The advocacy organisations are also required to produce end of year reports.

Service contracts set out requirements that the independent advocacy providers will ensure that advocates providing services have the required training and support to undertake the role. Training requirements include:

- Core induction training, which will cover the role of the advocate (including any legal obligations).
- The different models of advocacy and their relevance to equality and human rights laws and standards.
- Ongoing training requirements should be assessed by the advocacy provider to ensure, where possible, that adequate resources are identified and set aside for this purpose during the contractual period.

Training for advocates should be competency based and subject to ongoing assessment.

While systems are in place to ensure effective commissioning and monitoring of contracts for advocacy services, there is no requirement for organisations providing advocacy services, or for individual advocates, to be registered with any regulatory body.

RQIA was advised by some commissioning and providing organisations that they perceive the current lack of regulation as a significant gap in the provision of assurance of the quality of advocacy services. If not addressed this gap may widen in the context of the new mental capacity legislation with increased need for advocacy to be made available.

Recommendation 8	**Priority 3**
DHSSPS should review potential options for the introduction of regulation for advocacy services to determine if a regulatory framework should be established for organisations providing advocacy or for individual advocates	

2.6 Awareness of Advocacy Services, and the Importance of Independence, Among Health and Social Care Professionals and Service Users and Carers

The HSC Board and trusts advised RQIA of mechanisms in place to raise the awareness of advocacy services of HSC professionals and of service users and carers.

As part of the commissioning process and agreed contract service specification, the independent advocacy provider work within a range of key performance indicators (KPIs), which focus on activity delivered, for example:

- The delivery of two awareness sessions to HSC trust staff per year, with a minimum of 25 attendees at each session. This KPI is recorded and reported on a quarterly and annual basis.

The HSC Board and trusts also raise awareness through other processes including:

- HSC trusts publicise and promote advocacy services with relevant groups of staff and service users, outlining their responsibilities in promoting advocacy and providing information about services available in particular areas.
- HSC trusts involve advocates in staff inductions and invite them to present at staff meetings to share their experiences as independent advocates. Within children's services, HSC trusts provide a welcome pack, which includes information about independent advocacy services.
- Advocates have spoken at service forums, taken part in workshops for staff and participated in staff training.
- Advocates have also spoken at national and international conferences and shared their experiences of working within HSC trusts.
- HSC trusts have provided funding for training of peer advocates.

Independent advocacy providers highlighted that they raise awareness through a number of mechanisms including:

- Organising regional awareness raising events, conferences, and advocacy weeks.
- Training professionals in HSC trusts and students through working relationships with universities and professional bodies.
- Participating in a wide range of working groups, committees and alliances such as: ANNI; Helplines Network Northern Ireland; Mental Health and Learning Disability Alliance; a Royal College of Psychiatrists project; service user and carer improvement groups; HSC trust management groups; and the regional mental health services framework steering group.
- Placing leaflets and posters within the community at specific target points.
- Providing information online and through social media (Twitter and Facebook).
- Updating of HSC trust websites/intranet in partnership with their communications departments.

HSC Board informed RQIA that a lack of dedicated resource has prevented the development of a specific regional campaign to promote independent advocacy. Information has been shared about advocacy in regional service development and improvement activities where appropriate.

Some independent advocacy providers raised concerns that advocates do not always get invited to relevant meetings to support the person they advocate for. They also advised that some HSC professionals do not fully recognise the professional role of an independent advocate. They perceive that at times issues raised by advocates on behalf of their clients are regarded as complaints. They have found that there is still some resistance about working with advocates in services, but this is lessening as the advocacy sector develops.

2.7 Implications of the New Mental Capacity Legislation on Future Provision of Advocacy Service in Northern Ireland

The development of a single legislative framework for the reform of mental health legislation, and for the introduction of mental capacity legislation in Northern Ireland was recommended by the Bamford Review in its report, published in 2007: A Comprehensive Legislative Framework.[32]

The key recommendation in the 2007 report was: “There should be a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland”. The new framework would help reduce the stigma often associated with separate mental health legislation, and provide an opportunity to strengthen protections for people who lack capacity to make their own decisions. The vision was also of a framework that would apply to everyone in society, including those subject to the criminal justice system.

A new mental capacity legislation has now been drafted, and significant progress has been made in securing agreement to, and developing other aspects of the new framework.

The HSC Board, HSC trusts and advocacy providers acknowledged that the future direction of advocacy services will be greatly impacted by the new mental capacity legislation.

In 2014, during the consultation for the new Mental Capacity Legislation in Northern Ireland, approximately 45% of respondents received, commented on the inclusion of a statutory role for independent advocacy, that should be truly independent, commissioned regionally rather than directly by individual trust.

During the review, HSC organisations advised RQIA that there will be significant resource implications for implementation of the new capacity legislation. At present, it is not possible to fully assess the impact on provision of advocacy services, although this is likely to be substantial.

RQIA was advised that there may be additional complexity caused by the inclusion of 16 and 17 year olds in the proposed legislation. For a looked after child there may be tensions between different advocates, and, in some circumstances, between advocates and parents.

Legally, parents can make health and social welfare decisions on behalf of anyone under 18. There may be concerns if an advocate represents a child contrary to the wishes of a parent undermining parental responsibility. A

---

[32] http://www.dhsspsni.gov.uk/cl-framework

guardian ad litem also has a role to ensure the best interests of children. In child care proceedings it will be vital to understand the roles and responsibilities of advocates appointed under the new capacity legislation.

2.8 Independent Advocacy Provider Involvement

The HSC Board informed the review team that stakeholder involvement for the development and improvement of existing independent advocacy services is facilitated through consultation with ANNI. However, as an umbrella group for independent advocacy providers, it would represent a conflict of interest to involve this forum directly in commissioning processes.

Where a requirement for new independent advocacy services is identified as part of a regional strategy, the stakeholders associated with that strategy are consulted and involved as necessary.

In relation to independent advocacy for children services, the HSC Board has endorsed the Ask First Standards (Northern Ireland Standards for Children and Young People's Participation in Public Decision Making, 2010),[33] which are a key tenet within children's procurement specifications.

RQIA found that HSC trusts have several mechanisms in place, through which both advocates and service users are involved in shaping how services are developed and delivered.

HSC trusts have established service user forums, support groups and networks for service users, carers and advocates. They are encouraged to bring forward the views of service users and carers, using the opportunity to highlight good practice and areas for improvement. The chair of these groups is supported as an equal member of senior management groups, and is part of all senior management decisions taking account of service user and carer views.

In addition to this, the recovery strategies in HSC trusts have a number of work streams to develop services that are recovery orientated and in the case of the recovery college, are co-produced and co-delivered with service users. Advocates are also part of these work streams.

Other services such as mental health services have in place steering groups to progress work in reshaping services to reflect the domains of the regional care pathway. Service users and advocates are integral to all the associated work streams of the groups and are helping to reshape services to be compliant with the pathway.
The Belfast Health and Social Care Trust was one of the first trusts to give voting rights to service users and carers on the trust's interview panels. Service users and carers have been at the heart of the design for two new

---

[33] http://www.ci-ni.org.uk/DatabaseDocs/nav_3175978__ask_first.pdf

mental health facilities (Old See House and the inpatient facility being built at Belfast City Hospital).

Under the contractual agreement, independent advocacy providers must have policies and procedures in place to support service users and carers to achieve their personal goals. The advocates will work under their code of practice and other policies which include: vulnerable adults; managing challenging behaviour; human rights and equality legislation

Chapter 3: Conclusions

During this review, RQIA found that the implementation of the DHSSPS policy guide and associated action plan, May 2012, has helped HSC commissioning organisations better understand and develop independent advocacy services in Northern Ireland.

The guide has given commissioners key principles to ensure they commission independent advocacy services in a consistent, fair and equitable way. The guide also provides commissioners and providers with standards to assure independent advocacy providers are delivering a safe, effective and compassionate service.

RQIA found that the HSC Board and trusts have effective commissioning arrangements in place. Commissioners adhere to relevant procurement legislation, and contracts reflect the regional principles and standards within the DHSSPS policy guide.

Where independent advocacy is the most appropriate service to meet an identified need or strategic objective, and funds are available, HSC organisations have clear arrangements and processes in place to commission that type of service.

The HSC Board has responsibility for commissioning regional advocacy services, mainly for children services, people with hearing impairment, and children with disabilities. The HSC Board also commissions advocacy in relation to resettlement of learning disability patients from hospital.

HSC trusts have responsibility for commissioning local advocacy services, primarily for family and child care, adult learning disability, and adult mental health. However, the review highlighted that existing provision is variable across other services such as hospital emergency departments, older people, cancer services, and for specific conditions such as dementia, Alzheimer's disease and autism.

RQIA found that current contracts focus primarily on outputs rather than outcomes. RQIA recommends further work to ensure a more outcome based model in reporting on advocacy, as effective advocacy can improve quality outcomes.

The development of a code of practice for advocates and other guidance by ANNI has been a positive development. However, further work is required to take this forward.

At present, there is no regulatory framework for advocacy services. RQIA recommends that options are considered to determine whether a framework should be established.

RQIA found that HSC organisations have successfully engaged with advocacy providers during the implementation of service changes.

RQIA found strong commitment among the commissioners and providers of independent advocacy services to take forward the role of advocacy in Northern Ireland. This will provide an important foundation to take forward the development of services to meet the challenges of providing independent advocacy to meet the requirements of the new mental capacity legislation.

Chapter 4: Summary of Recommendations

The eight recommendations have been prioritised in relation to the timescales in which they should be implemented.

- Priority 1 – to be completed within 6 months of publication of report
- Priority 2 – to be completed within 12 months of publication of report
- Priority 3 – to be completed within 18 months of publication of report

Recommendation 1	**Priority 3**
HSC trusts / Commissioners should carry out a needs assessment to determine future capacity requirements, and improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation.	

Recommendation 2	**Priority 3**
HSC Board in partnership with relevant organisations should review and clarify arrangements for advocates to link with other sectors, including housing and education, when this is required in seeking to resolve cross-agency issues for their clients.	

Recommendation 3	**Priority 2**
HSC Board should work in partnership with HSC trusts and independent advocacy providers to consider other approaches such as newsletters or an annual event to share learning and experiences of advocacy services across organisations.	

Recommendation 4	**Priority 3**
The resource and training implications for advocacy services should be included in the assessment of requirements to take forward the implementation of the new mental capacity legislation.	

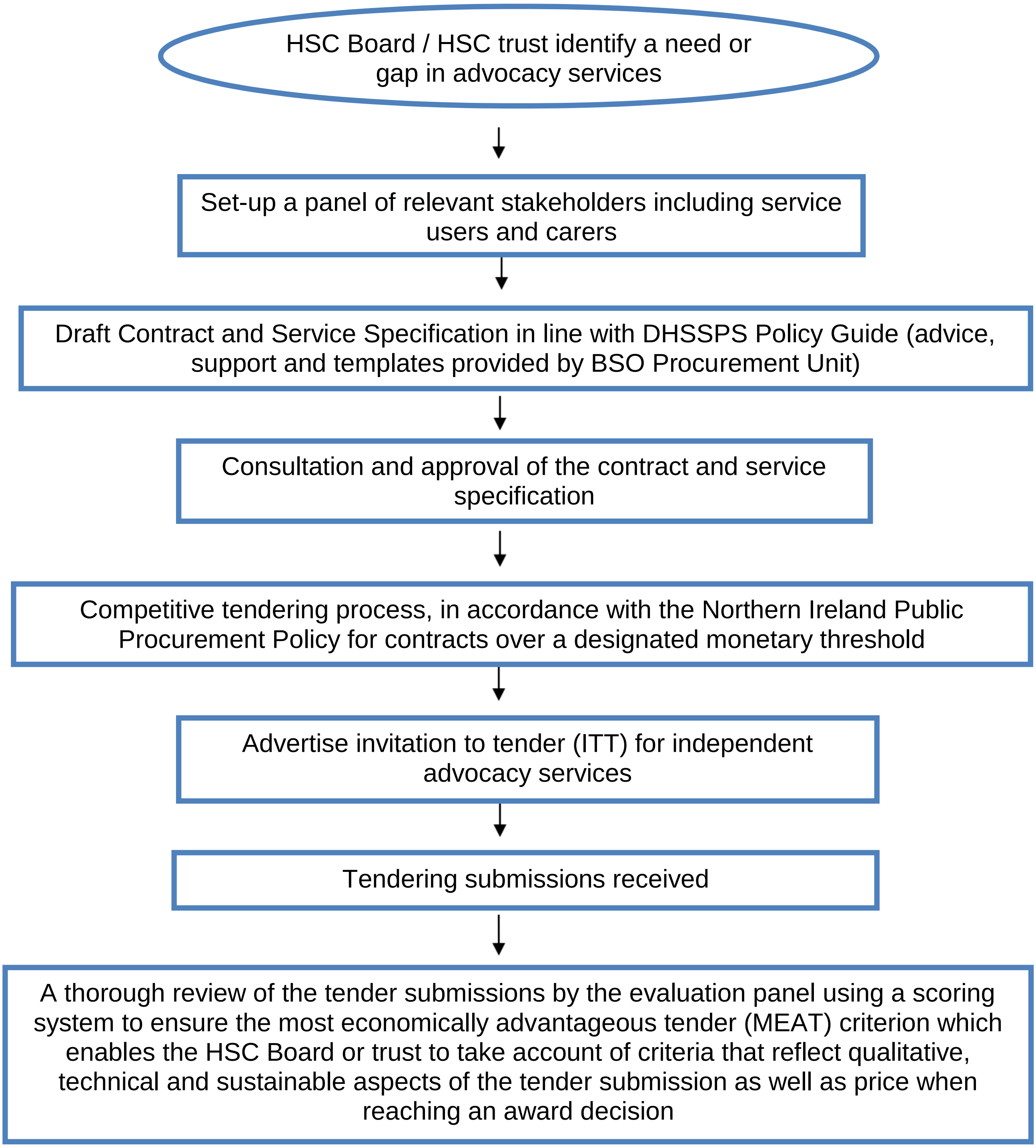
Recommendation 5	**Priority 2**
HSC organisations should work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning.	

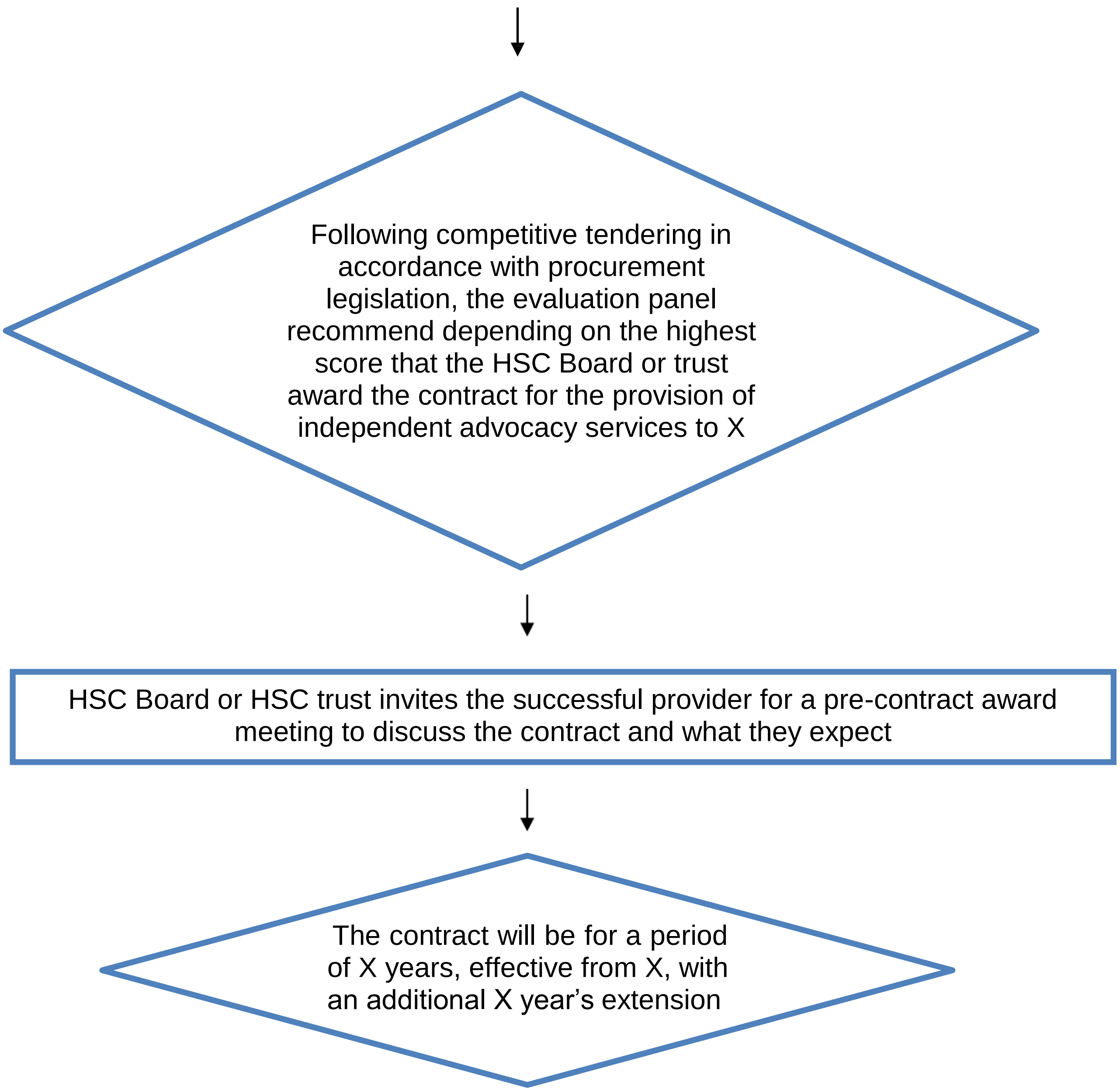
Recommendation 6	**Priority 2**
HSC trusts should review service agreements with independent advocacy providers to ensure clarity as to the arrangements for provision of services for clients across trust organisational boundaries.	

Recommendation 7	**Priority 1**
HSC commissioning organisations should review their arrangements to ensure that there is a clear point of contact for service providers to provide advice and clarification in relation to service agreements.	

Recommendation 8	**Priority 3**
DHSSPS should review potential options for the introduction of regulation for advocacy services to determine if a regulatory framework should be established for organisations providing advocacy or for individual advocates	

Appendix 1: Example Process Undertaken by the HSC Board and HSC Trusts when Commissioning Advocacy Services within Northern Ireland





Following competitive tendering in accordance with procurement legislation, the evaluation panel recommend depending on the highest score that the HSC Board or trust award the contract for the provision of independent advocacy services to X

HSC Board or HSC trust invites the successful provider for a pre-contract award meeting to discuss the contract and what they expect

The contract will be for a period of X years, effective from X, with an additional X year’s extension

Appendix 2: Abbreviations Used

AMH	Adult Mental Health
ALB	Arm Length Bodies
Belfast Trust	Belfast Health and Social Care Trust
BSO	Business Service Organisation
CAMHS	Child and adolescent mental health services
COPNI	Commissioner for Older People for Northern Ireland
CoPE	Centres of Procurement Expertise
DFP	Department of Finance and Personnel
EOLC	End of Life care
HSC Board	Health and Social Care Board
HSC	Health and Social Care
HSC trust	Health and Social Care trust
LCGs	Local Commissioning Groups
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NICCY	Northern Ireland Commissioner for Children and Young People
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
Northern Trust	Northern Health and Social Care Trust
OCN	Open College Network
PCC	Patient Client Council
PALs	Procurement and Logistics Service
PHA	Public Health Agency
SLA	Service Level Agreement
SIAA	Scottish Independent Advocacy Alliance
SCPG	Social Care Procurement Group
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
TILII Group	Telling It Like It Is
TOR	Terms of Reference
TYC	Transforming Your Care
Western Trust	Western Health and Social Care Trust
WTE	Whole Time Equivalent

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010

Review	Published
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013

Review	Published
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care

Exhibit 5

Independent Advocacy

Principles, Standards & Code of Best Practice

2019

Scottish
Independent
Advocacy
Alliance

The Scottish Independent Advocacy Alliance (SIAA)

SIAA is a Scottish Charitable Incorporated Organisation SC033576

SIAA is a membership organisation responsible for promoting, supporting and defending independent advocacy in Scotland. It has the overall aim of ensuring that independent advocacy is available to any person in Scotland.

SIAA provides information and support, gathers and distributes information, represents advocacy organisations at various levels and raises awareness and understanding of independent advocacy across Scotland. SIAA works to influence legislation, policy and practice in relation to independent advocacy. SIAA is funded by the Scottish Government Planning & Quality Division.

More information about the work of SIAA is available on **www.siaa.org.uk**.

ISBN: 978-0-9928552-5-3

> *“Many people in society are disempowered by systems which have a significant effect on almost every aspect of their lives. These are people who are disempowered to such an extent that they are unlikely to be able to fulfil their basic human needs or demand their basic human rights. A person’s initial hopes and dreams can be severely limited by this. Independent advocacy can help to widen a person’s horizons and enable them to become active members of society”.*
>
> PRINCIPLES AND STANDARDS IN INDEPENDENT ADVOCACY ORGANISATIONS AND GROUPS, ADVOCACY 2000 (2002)

Independent advocacy is an agent of change

Scottish Independent Advocacy Alliance

Independent Advocacy

Principles, Standards & Code of Best Practice

SIAA's
Vision Statement

We believe that everyone who needs independent advocacy should have access to it. Independent advocacy must be of the highest possible standard.

> *"There is no such thing*
> *as a single issue struggle,*
> *because we do not live*
> *single issue lives."*
>
> **AUDRE LORDE**

Who this document is for and how it can be used

This document is for:

- people who could benefit from independent advocacy so that they have a clear idea about what to expect from an independent advocacy organisation;
- independent advocacy organisations to support them in their working practice and to offer a means by which to evaluate their practice;
- those who commission, fund and regulate independent advocacy to ensure they have a clear understanding of what independent advocacy is, and how independent advocacy organisations should operate.

This document recognises that all independent advocacy organisations share the same principles. It has been developed to be used across Scotland, to ensure that independent advocacy is being delivered consistently and is of the highest possible standard. In this respect it has a safeguarding role, ensuring that people who access independent advocacy can have confidence in the help and support they receive.

This document also aims to safeguard independent advocacy itself by setting standards and promoting best practice, thereby helping to ensure that independent advocacy is understood, valued and effectively resourced.

These Principles, Standards & Code of Best Practice provide important foundational statements on practice. It remains the responsibility of independent advocacy organisations, commissioners and funders to put measures in place to ensure that the Principles, Standards & Code of Best Practice are adhered to. Independent advocacy organisations should have their own organisational policies and procedures that reflect this document.

> *“Injustice anywhere is a threat to justice everywhere”*
>
> **MARTIN LUTHER KING**

Definitions

INDEPENDENT ADVOCACY: independent advocacy is about speaking up for, and standing alongside individuals or groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice: addressing barriers and imbalances of power, and ensuring that an individual's rights are recognised, respected and secured.

Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.

Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs.

ADVOCACY PARTNER: an advocacy partner is a person who accesses independent advocacy. It is the preferred term because it emphasises the independent advocate and the person they are supporting working as equal partners. Some independent advocacy organisations also use client or service user.

ACTIVIST: an activist is a person who campaigns to bring about political or social change.

INDEPENDENT ADVOCACY ORGANISATION: an independent advocacy organisation *only* provides independent advocacy and all the activities it undertakes are about providing, promoting, supporting and defending independent advocacy. Independence means that it does not provide any other services and is structurally, financially and psychologically separate from other organisations and interests.

Independent advocacy happens in two distinct ways, Individual and Collective. These are explained in more detail in Appendix 1 (page 26).

Independent advocacy is about addressing an imbalance of power

The need for independent advocacy

People can find it difficult at times for their voice to be heard when actions or decisions are being taken that affect their lives. Some people in society are much more likely than others to be treated badly, either because of structural barriers, inequality, discrimination and prejudice or because of their own vulnerability, or a combination of factors.

The characteristics which may mean that people are at risk include the protected characteristics as identified by the Equality Act (2010). These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Other factors that will also have an impact on a person include socio economic background, personal capacity, adverse childhood experiences, reputation, dislocation, abuse, family breakdown and social isolation. Some people have to rely on powerful service systems for help with all aspects of their life including housing, personal assistance, decision-making, income, occupation and mobility. Institutions and support services can affect every aspect of someone's life (potentially with long term consequences), particularly when people have been immersed in the service system since childhood, and when they have no strong allies outside. For some people, their family can be part of the problem. Independent advocacy is about broadening horizons and widening the options that people have. It is about speaking up if you notice that something is wrong. Sometimes people tolerate things in their lives because they don't know they can be changed. Independent advocacy can help them address this.

Service systems are not and will never be perfect. Individuals who rely on these systems often have limited personal power and resources to argue their case. This is especially true for people who do not use words to communicate, for children and young people, for people who cannot read or write in the language of the system, for people who have been labelled with a negative reputation, and for people who are disabled or with capacity issues.

If people do not have well-motivated and capable family and friends to speak up for them, they are at risk of poor treatment and of not getting what they need. They may not have their views, wishes and feelings taken into account properly, as is their right. They are also the least likely to exercise their right to make a complaint. Even family and friends are often ignored.

People who are articulate and know the system might be ignored because other people's prejudice and dismissive attitude extends to them because of an imbalance of power.

This also applies to groups of people who are marginalised, discriminated against and disempowered. Even though there are many references in legislation and government policy that refer to an expectation that people are involved in decision making at all levels, these groups often find it challenging to have a collective voice, organise themselves and engage with the system. When they are included, they are sometimes patronised or side-lined, only able to respond to the agendas set by others. It is important groups are resourced and supported appropriately to explore and set their own agenda and influence decisions, policy, legislation and services that shape and effect their lives.

Even where people have rights in law, for example to an assessment or to a second opinion, they are often unaware of these rights. While policies may be in place, for example about medication being regularly reviewed, or about people being given information, these are not always followed.

Collective independent advocacy provides opportunities for people to have a meaningful voice in legislative processes, policy making and strategic planning, combating discrimination, inequality and enabling people to take part as active citizens.

> *"Power can be taken, but not given. The process of the taking is empowerment in itself."*
>
> **GLORIA STEINEM**

Commissioning independent advocacy should be in addition to, not instead of, improving services. Independent advocacy is not a sticking plaster to compensate for poor service quality. Statutory agencies have a duty to listen and respond to all the people they serve and to work to high standards. There is a huge disparity between the size and power of the service system and the powerlessness of the people and groups. Small neglects and mistakes by service systems can have a huge impact on individuals, the system and society.

The importance of independence in advocacy

Nurses, social workers, care staff, doctors, teachers and other professionals look out for and speak up for the people they serve. It’s their job, it is part of their professional code of conduct, but they aren’t and can’t be independent. Independent advocates, whether paid or unpaid, are clear that their primary loyalty and accountability is to the people who need them. To be on someone’s side, advocates have to be structurally, financially and psychologically independent of the service system, agencies providing services and local or national government. Independent advocates stand in a different place and see things from a different perspective.

Independent advocates do not have the same conflicts of interest as other professional workers who are expected to make judgements about who is in need, deserving or most eligible for a service. Because independent advocates do not have this sort of power over people and do not control access to resources, they are in a better position to see things from the person’s point of view. From the outset of the advocacy relationship they are more likely to have the trust of the people they are working with.

They can focus on representing the interests and wishes of the people who need an independent advocate and be clear that this is their only role. Other professionals who advocate strongly on behalf of a particular individual or group may be seen as acting unprofessionally or as being critical of their employer. This entails personal risks, and can also put the professional worker in a situation where their views on this and other issues are discounted.

There are three components of independence; structural, financial and psychological. For an advocacy organisation to be robust and effective it needs to be alert to all three.

- **STRUCTURALLY** – an independent advocacy organisation is a separate organisation in its own right. For example, it is registered as a charity or company and has its own Management Committee or Board of Directors. Everyone involved in the organisation recognises that it is separate and different from other organisations and services.

- **FINANCIALLY** – an independent advocacy organisation has its own source of funding that does not cause any conflicts of interest and that does not compromise the work it does.

- **PSYCHOLOGICALLY** – everyone involved in the organisation knows that they are only limited in what they do by the principles of independent advocacy, resources and the law. It is important to recognise that although there may be conflicts of interest present, psychological independence is vital.

Psychological independence, independence of mind, is equally important as structural or financial independence. Some independent agencies are funded in part or wholly by statutory agencies and therefore have a responsibility to account to their funders for how they are spending the money. But independent-minded advocates do not ask the funders for permission to disagree with them. Instead, they challenge agency policy and practice where these are compromising the rights and wellbeing of the people they represent. They do not expect to be popular with everyone, but they do seek to ensure they are respected for the quality and integrity of their work. Effective independent advocacy organisations do not seek confrontation but they maintain the principle of primary accountability to the people they serve. Effective commissioners welcome this spirit of independence, even if it makes their life harder.

It is important to remember that independent advocacy highlights opportunities and supports people to be more aware of their choices and rights, enabling them to make more informed decisions and to become more influential as agents of change. Through broadening horizons and widening understanding of options, independent advocacy enables people to educate themselves and be more active citizens.

In the context of individual advocacy, people appear to have supportive networks but they might still need independent advocacy because it is separate from all others and only follows the person's agenda.

In independent collective advocacy, space is created for people to come together to educate and support each other and influence the agendas and decisions that shape their lives. Groups are supported to challenge issues such as discrimination, poverty or human rights violations and marginalised groups can gain opportunities for learning.

- **Independent advocacy is delivered by organisations that *only* provide independent advocacy.**

- **Organisations cannot define themselves as independent advocacy providers simply by employing experienced independent advocates.**

- **Individuals cannot set themselves up as independent advocacy providers outwith an independent advocacy organisation.**

Best interests

People often think that independent advocacy is about working in the best interests of individuals. In fact, sometimes independent advocacy is about supporting people to explore, understand and express something that is not in their own best interests but is nonetheless what they want. Often professionals and organisations make decisions that are in the best interests of an individual because they have a duty to do so. Independent advocacy does not have such a legal duty.

An effective independent advocate needs to challenge, question and hold professionals to account when best interests are given as a reason for decisions made about their advocacy partner.

Independent collective advocacy and campaigning

Independent collective advocacy should campaign against and challenge discriminatory legislation, policy and practice and campaign for positive change for example for the removal of barriers. Indeed, independent collective advocacy has been responsible for significant changes in legislation, policy and practice. The right to access independent advocacy is one such key achievement.

Conflicts of interest

Sometimes there can be conflicts of interest for those supporting an individual or group, for instance where there are assumptions about 'what is best' for them.

Independent advocacy is as free as possible from conflicts of interest, being completely separate from service providers and funders and with the organisation involved providing no services other than advocacy. It is structurally, financially and psychologically free from interests such as being a provider of services, a gatekeeper of services, a funder of services, a statutory body or family and friends.

See Appendix 3 (page 30) for more information about what independent advocacy is not about.

Independent advocacy and Supported Decision Making

Supported Decision Making has no formal definition and different people use the term differently. It is used in this document to refer to any process in which an individual is provided with as much support as they need in order for them to be able to:

a) make a decision for themselves and/or

b) express their will and preferences within the context of substitute decision making (for example guardianship or compulsory treatment for mental disorder).

In both cases, the purpose of Supported Decision Making is to ensure that the individual's will and preferences are central to and fully respected in decisions that concern them. *(Mental Welfare Commission; Good Practice Guide Supported Decision Making, 2016)*

Independent advocacy provides a mechanism for enabling individuals and groups to make decisions for themselves. The independent advocacy relationship does not have the conflicts of interest inherent in other relationships with family, friends, service providers and professionals. People accessing independent advocacy are protected from undue pressure, advice or others' agendas.

Non-instructed advocacy

Non-instructed advocacy happens when there are issues with a person's capacity perhaps due to dementia, or limited communication due to a physical disability or a learning disability. In such situations a non-instructed advocate seeks to uphold their advocacy partner's rights and ensure that decisions are taken with full consideration of their unique preferences, rights and perspectives.

> *"Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such as the places where every man, woman and child seeks equal justice, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world."*
>
> ELEANOR ROOSEVELT

Independent advocacy and human rights

Everyone, everywhere, has basic rights and freedoms which are needed to live together with dignity based on a common humanity. These human rights are secured in law. The law applies to everyone equally and provides an important means of protection for the most vulnerable in our communities, including those who use independent advocacy services. It sets out the duties owed by those responsible for upholding human rights and the outcomes people are entitled to expect as a matter of right.

Independent advocacy plays an integral role in helping to ensure that an individual's human rights are respected by offering access to justice on an equal and non-discriminatory basis with others. It does this by addressing issues of autonomy and choice, and by supporting an individual's voice and opinions to be meaningfully heard. The Principles, Standards & Code of Best Practice for independent advocacy are based on an approach that promotes and defends human rights. Independent advocacy helps statutory services to practise a human rights based approach.

The internationally recognised PANEL Principles are of fundamental importance in applying a human rights based approach in the practice of independent advocacy. They are a practical tool for describing what a human rights based approach looks like in practice.

The five PANEL principles are:

Participation

Accountability

Non-discrimination and equality

Empowerment

Legality

More detail on these is provided in Appendix 2 (page 28).

Independent advocates are human rights defenders. Independent advocacy is built on enabling people to know and claim their rights and on increasing the ability and accountability of individuals and institutions responsible for respecting, protecting and fulfilling rights. Within the context of independent advocacy a human rights based approach is about ensuring that both the standards and the principles of human rights are integrated into procedures and processes, as well as embedded into the day to day running of organisations.

Statement of Principles and underpinning standards

PRINCIPLES:

- **Independent advocacy is loyal to the people it supports and stands by their views and wishes.**
- **Independent advocacy ensures people’s voices are listened to and their views taken into account.**
- **Independent advocacy stands up to injustice, discrimination and disempowerment.**

Independent advocacy is loyal to the people it supports and stands by their views and wishes.

STANDARDS:

- Independent advocacy follows the agenda of the people supported regardless of the views, interests and agendas of others.
- Independent advocacy must be able to evidence and demonstrate its structural, financial and psychological independence from others.
- Independent advocacy provides no other services, has no other interests, ties or links other than the delivery, promotion, support and defence of independent advocacy.

Independent advocacy ensures people's voices are listened to and their views are taken into account.

STANDARDS:

- Independent advocacy recognises and safeguards everyone's right to be heard.
- Independent advocacy reduces the barriers people face in having their voice heard because of communication, or capacity, or the political, social, economic and personal interests of others.

Independent advocacy stands up to injustice, discrimination and disempowerment.

STANDARDS:

- Independent advocacy recognises power imbalances or barriers people face and takes steps to address these.
- Independent advocacy enables people to have more agency, greater control and influence.
- Independent advocacy challenges discrimination and promotes equality and human rights.

Code of Best Practice

The indicators listed below are separated for advocates and advocacy organisations and apply to both individual and collective advocacy. All independent advocacy organisations are committed to the principles but advocacy practice might be slightly different depending on the different types of advocacy being delivered.

As an advocate you must:

1. Enable your advocacy partner or advocacy group to understand their rights, and ensure that they are recognised by others.
2. Ensure your work promotes equality and challenges discrimination.
3. Reflect on your practice and be aware of your own opinions, prejudices and discriminatory views and values and not let them affect your practice.
4. Identify and challenge any attitudinal, structural or environmental barriers to accessing, using or taking part in independent advocacy.
5. Address any power imbalance between yourself and your advocacy partner or the advocacy group, or within the group.
6. Not withhold information from your advocacy partner.
7. Look out for, declare and minimise conflicts of interest in line with the organisation's conflict of interest policy.
8. Uphold the confidentiality of your advocacy partner in line with the organisation's confidentiality policy including being honest when the policy should be breached.
9. Act on the issues agreed by your advocacy partner or advocacy group at the appropriate pace.
10. Enable your advocacy partner or advocacy group to outline, record and review their expectations.

> *"Alone we can do so little, together we can do so much"*
>
> **HELEN KELLER**

11. When advocating in a non-instructed context, make significant efforts to determine the rights, will and preferences of your advocacy partner, and where this is not genuinely practicable then make certain that decisions are taken with due consideration for their unique preferences, rights and perspectives.

12. Support your advocacy partner or advocacy group to gain information, understand options and explore possible outcomes.

13. Practice and promote effective communication with your advocacy partner or advocacy group, especially when they may face barriers.

14. Not take the side of anyone other than your advocacy partner or advocacy group or try to influence them on behalf of others.

15. Ask decision makers to explain why an action is taken where required.

16. Ensure that you seek and are guided by feedback from your advocacy partner or advocacy group members.

17. Support your advocacy partners or advocacy group members to gain more control and influence in the decisions and circumstances that affect their lives.

18. Make every effort to enable your advocacy partner or advocacy group members to have the opportunity to develop skills and confidence to advocate for themselves.

In addition the following indicators apply only to collective advocacy:

19. Make every effort to support an advocacy group to debate and reflect on the views and experiences of the group members as well as agreeing issues to take forward.

20. Enable advocacy group members to be open and regularly review the way the group works.

21. Support the advocacy group to define and agree the internal and external boundaries of confidentiality.

An effective independent advocacy organisation must have clear policies and procedures that reflect the Principles, Standards and Code of Practice, it must:

1. Identify and challenge any attitudinal, structural or environmental barriers to accessing, using or taking part in independent advocacy.
2. Ensure that although independent advocacy is accountable under the law, it must support challenges against discriminatory legislation, policies and practices or the way they are applied and where they infringe rights.
3. Make every effort to understand, monitor and overcome barriers faced by diverse, minority or marginalised groups to accessing, using or taking part in independent advocacy.
4. Be clear that advocacy is free to the people that use it.
5. Ensure that advocacy provision is accessible, including premises.
6. Promote the independence of the organisation.
7. Have accessible information about the organisation and independent advocacy which is made available to all parts of the community covered by the organisation.
8. Ensure that income streams don’t compromise the independence of the organisation.
9. Place a responsibility on everyone in the organisation to identify and declare any conflicts of interests and take appropriate steps where any conflict does exist. The organisation should keep and regularly review a register of these interests, including how they are managed.
10. Make every effort to ensure that Board of Directors or Trustees do not have a conflict of interest. If a conflict of interest does arise ensure they do not vote on the matter where that conflict exists.
11. Be embedded in the community or community of interest it serves.
12. Have a clear way of handling referrals and prioritising requests for advocacy and, where possible offer a choice of advocate.

13. Regularly seek feedback from advocacy partners and advocacy group members to help shape and direct its work.
14. Have a comprehensive Complaints Policy, including arrangements to support individuals who may continue to need advocacy.
15. Have quality assurance systems that use evidence based practice to measure the impact of independent advocacy.
16. Provide regular peer support opportunities for staff, volunteers, advocates and activists to discuss good practice, areas for improvement and advocacy dilemmas.
17. Provide continuous development and learning opportunities, guidance and information to all staff, volunteers, activists and Board of Directors or Trustees on the Principles, Standards and Code of Best Practice for Independent Advocacy.
18. Ensure that everyone in the organisation has training or preparation on equal opportunities, equalities duties, respect and dignity, discrimination and human rights.
19. Ensure that people who have accessed or are allies of independent advocacy have the opportunity to be involved at any level of the organisation, subject to the Articles or Constitution.

> *"There's no such thing as the 'voiceless'. There are only the deliberately silenced, or the preferably unheard."*
>
> **ARUNDHATI ROY**

20. Ensure the Board of Directors or Trustees know and understand their governance, legal and financial responsibilities including funding agreements for the organisation.
21. Have Articles or a Constitution, Mission Statement, relevant policies and procedures, annual reports and accounts that are clear and accessible as possible.
22. Make every effort that the organisation is independently evaluated at least once every 3 years, in line with the SIAA Evaluation Framework.
23. Make significant effort to influence local strategic planning, including the Strategic Independent Advocacy Plan.

Appendix 1

Different Types of Independent Advocacy

There are two types of independent advocacy – individual and collective

INDIVIDUAL OR ONE-TO-ONE ADVOCACY

This includes **professional or issue-based advocacy**. It can be provided by both paid and unpaid advocates. An advocate supports an individual to represent his/her own interests or represents the views of an individual if the person is unable to do so. Advocates provide support on specific issues and provide information, but not advice. This support can be short or long term.

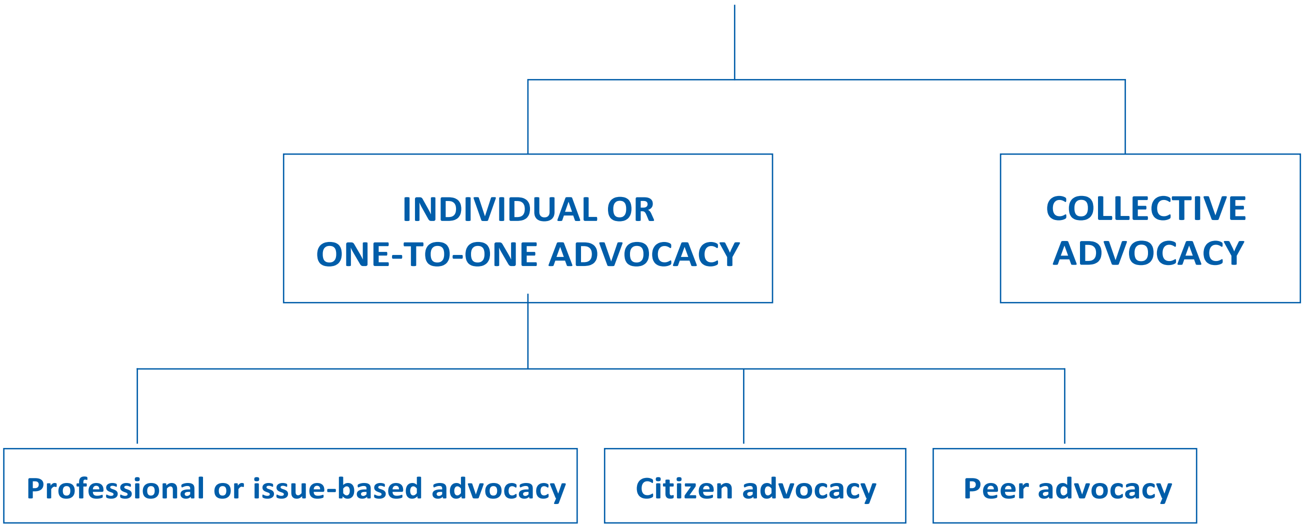
Another model of individual advocacy is **citizen advocacy**. Citizen advocacy occurs when an ordinary citizen is encouraged to become involved with a person who might need support in the community. The citizen advocate is not paid. The relationship between the citizen advocate and the advocacy partner is on a one-to-one, long term basis. It is based on trust between the partner and the citizen advocate and is supported, but not influenced, by the advocacy organisation. The citizen advocate supports the advocacy partner through natural skills and talents rather than being trained in the role.

Individual advocacy can also include **peer advocacy**. A peer advocate has life experiences they share with their advocacy partner. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and have empathy with their advocacy partners. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the peer advocate and their advocacy partner.

COLLECTIVE ADVOCACY

Collective advocacy creates spaces for people to get together, support each other to explore shared issues and find common ground. It supports people to speak up about their experiences, values and expectations. It enables people to find a stronger voice, to campaign and influence the agendas and decisions that shape and affect their lives. Collective advocacy can help planners, commissioners, service providers and researchers to know what is working well, where gaps are in services and how best to target resources. It helps legislators and policy makers to create opportunities for people to challenge discrimination and inequality and helps people learn to become more active citizens. Collective advocacy groups benefit from skilled help from an independent advocacy organisation and with the support of resources.

Different Types of Independent Advocacy



Self-advocacy is when a person advocates for themselves.

Appendix 2

The PANEL principles:

P**ARTICIPATION**: Everyone has the right to participate in decisions which affect their human rights. Participation must be active, free, meaningful and give attention to issues of accessibility, including access to information in a form and a language which can be understood.

The provision of independent advocacy is fundamentally about enabling people who may require help in speaking for themselves to participate in decisions that affect them, whether they be about healthcare, social activities or legal processes.

A**CCOUNTABILITY**: Accountability requires effective monitoring of human rights standards as well as effective remedies for human rights breaches. For accountability to be effective there must be appropriate laws, policies, institutions, administrative procedures and mechanisms of redress in order to secure human rights.

Independent advocacy helps people to access a wide range of accountability mechanisms such as complaints processes, courts and tribunals.

N**ON-DISCRIMINATION AND EQUALITY**: A human rights based approach means that all forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated. It also requires the prioritisation of those in the most marginalised situations who face the biggest barriers to realising their rights.

There are times when those in need of independent advocacy can be amongst some of the most vulnerable and marginalised people in our society – a human rights based approach means we must pay particular attention to the protection and realisation of their rights. Sometimes, because of their support needs, people are discriminated against in access to services or in opportunities to express their views. People also have different identities based on their gender, ethnicity, religion and many other grounds. Each of these identities should be respected when receiving any services, including independent advocacy.

EMPOWERMENT OF RIGHTS HOLDERS: A human rights based approach means that individuals and communities should know their rights. It also means that they should be fully supported to participate in the development of policy and practices which affect their lives and to claim rights where necessary.

Independent advocacy plays an essential role in helping people to know and understand their rights, participate in legal processes and hold decision makers to account.

LEGALITY OF RIGHTS: A human rights based approach requires the recognition of rights as legally enforceable entitlements and is linked in with national and international human rights law.

All public bodies in Scotland must be sure that their practices and procedures are grounded in human rights thinking. Under the law they must not breach the human rights of anyone. The situations which independent advocacy supports people are grounded in legally enforceable human rights, such as the right to private and family life, the right to liberty and the right to a fair trial. They are also grounded in non-legally enforceable, but internationally agreed human rights such as the right to health, the right to education and the right to an adequate standard of living. Making the explicit connection to human rights helps back up representations made on behalf of people.

Appendix 3

Myth Busting – Advocacy is not…

- making decisions for an advocacy partner or group
- giving advice or telling an advocacy partner or group what to do
- providing mediation
- providing counselling
- providing befriending
- providing care and support
- solving all someone’s problems for them
- providing therapy
- creating a dependency
- acting in the interests or wishes other than those of an advocacy partner or group
- agreeing with everything a person says and doing anything a person asks

Notes

Scottish Independent Advocacy Alliance
www.siaa.org.uk

SIAA is a Scottish Charitable Incorporated Organisation SC033576

Exhibit 6

Background Research Paper, May 2019

Advocacy in Health and Social Care in Northern Ireland: Mapping current roles and responsibilities

Contents

1 Introduction

The purpose of this background paper is to support the work of Workstream 7 in its consideration of the following IHRD recommendation:

> *"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."*

In order to aid the Workstream Group's understanding of advocacy, the first section of this paper explores the definition of advocacy, including key themes and principles, and identifies different types of advocacy. It also explores what advocacy is *not* and finally provides an overview of the benefits that health and social care organisations can derive from effective advocacy.

In consideration of the IHRD recommendation for a future Patient Advocacy Service, it is important for the Workstream Group to gain an understanding and overview of current advocacy structures in Northern Ireland including different organisational roles and responsibilities. The second half of this paper, therefore, provides a synopsis of the roles and responsibilities of various organisations that are either key to the delivery of effective advocacy and/or have a remit in investigating and supporting patients (and their families and carers) when rights have potentially become comprised. The roles and responsibilities of the following organisations are explored (although this list may not be definitive):

- The Department of Health
- Health and Social Care Board
- Health and Social Care Trusts
- Public Health Agency
- Regulation and Quality Improvement Authority
- Patient and Client Council
- Safeguarding Board for Northern Ireland
- Northern Ireland Guardian Ad Litem Agency
- Northern Ireland Public Services Ombudsman
- Northern Ireland Commissioner for Children and Young People
- Commissioner for Older People for Northern Ireland
- Northern Ireland Human Rights Commission
- Equality Commission for Northern Ireland

In addition to organisational responsible, individual health professionals are also responsible for advocacy and the protection of patient rights and wellbeing. This section also provides an overview of the various codes of conduct/standards of different professional health and social care bodies, highlighting some of the relevant sections relating to advocacy.

It is important to acknowledge that this introductory paper is not intended to be definitive. Whilst it provides an overview of roles and duties (including statutory duties), it would be advisable for the Workstream Group and/or Department to ask each of these organisations directly about their roles and responsibilities in relation to advocacy. It is also crucial to obtain their views about the current gaps in advocacy, including independent advocacy services, in Northern Ireland. To aid the Workstream Group/Department, this paper contains a series of suggestions as to how the Working Group/Department may wish to take this work forward.

2 What is advocacy and why is it important in health and social care?

What is advocacy?

The current guide for commissioning advocacy services in health and social care in Northern Ireland, "Developing Advocacy Services: A Policy Guide for Commissioners" (published by the DHSSPS in May 2012) highlights that advocacy can mean different things to different people depending upon the context[1]. Whilst the guide does not identify its own definition of advocacy it does include a range of definitions from different reports and publications which it felt captures the essence of what advocacy is in a health and social care context. One of these definitions is derived from Bamford Review Report on Human Rights and Equality of Opportunity which stated that[2],

> *"Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people".*

Results of a search for other definitions of advocacy reveals that other organisations across the UK concur with many of the points made in the Bamford Review's definition of advocacy. For example, the Advocacy Charter[3], which is commonly adopted by advocacy organisations throughout England and Wales, states that:

> *"Advocacy is taking action to support people to say what they want, secure their rights, pursue their interests and obtain services they need…Advocates and advocacy providers work in partnership with the*

---

[1] Department of Health, Social Services and Public Safety. Developing Advocacy Services: A Policy Guide for Commissioners. May 2012.

[2] The Bamford Review of Mental Health and Learning Disability. Human Rights and Equality of Opportunity. www.health-ni.gov.uk/publications/bamford-published-reports October 2006.

[3] The Advocacy Charter. 2018. https://advonet.org.uk/how-we-can-help-you/what-is-advocacy/

> *people they support and take their side. Advocacy promotes social inclusion, equality and social justice".*

Furthermore, the NHS Scotland 'Independent Advocacy Guide for Commissioners' states that[4],

> *"Advocacy plays an important role in supporting people to express their views and in providing a source of support which gives them the confidence to speak out. Advocacy is vital in nurturing trust and effectively supporting people to ensure their views are taken into account and that they are 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.*

Annexe 1 of this briefing paper provides further definitions of advocacy that the **Workstream Group may wish to consider** as part of its work on user experience and advocacy. What is evident from these definitions is that there are **many common themes** running through them which may provide an indication of what effective advocacy should provide. The table below provides an overview of some of these themes but is not exhaustive[5].

Table 1: Common themes in advocacy

To enable individuals/groups to express themselves and have their views heard	*"to support individuals to express and have their views heard"* *"taking action to help people say what they want"* *"help people have a strong voice"* *"seeks to ensure that people, particularly those who are the most vulnerable in society are able to have their voice heard on issues that are important to them…to have their views and wishes genuinely considered when decisions are being made about their lives"* *"Advocacy is about your voice being heard. Advocates support you to speak up, or they might speak up on your behalf if needed"* *"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"* *"Listen to what you want and take action on your behalf at all times"*
To help people make their own decisions about their own life as far as possible (but	*"It is concerned with empowerment, autonomy and self-determination"* *"Advocates and advocacy providers work in partnership with the people they support and take their side"*

---

[4] NHS Scotland. 2013. Independent Advocacy Guide for Commissioners. www.gov.scot/publications/independent-advocacy-guide-commissioners/

[5] Full quotation references are contained in Annexe 1 of this briefing paper.

advocates do not make decisions on their behalf)	*"Advocacy support involves…listening without judgment and respecting your views, providing information about your rights and options…exploring possible outcomes and consequences"* *"An independent advocate will not make decisions on behalf of the person/group they are supporting…they will help the person/group to get the information they need to make real choices about their circumstances and support the person/group to put their choices across to others"* *"[to] have their views and wishes genuinely considered when decisions are being made about their lives"* *"Advocacy is vital in nurturing trust and effectively supporting people to ensure that their views are taken into account and that they are heard"* *"Advocacy is a process of supporting and empowering people to…express their own views and concerns…."*
To empower individuals and/or redress power imbalances	*"it aims to redress any imbalance of power between the individual and professional"* *"An advocate can help you…understand what your rights are"* *"Advocacy can help people become more aware of their own rights, to exercise those rights and be involved in and influence decisions that are being made about their future"* *"Advocacy support involves…help[ing] you to communicate with professionals"*
To speak on behalf of those who cannot	*"An independent advocate may speak on behalf of people who are unable to do so for themselves"* *"In some situations an advocate may need to represent another person's interests. This is called non-instructed advocacy and is used when a person is unable to communicate their views"* *"Promoting and protecting the rights and interests of people not able to give clear instructions or protect their own interests*
To promote equality, social justice and social inclusion	*"the safeguarding of citizenship rights and the inclusion of otherwise marginalised groups"* *"Advocacy promotes social inclusion, equality and social justice"* *"Advocacy…safeguards people who can be treated unfairly as a result of institutional and systematic barriers as well as prejudice and individual, social and environmental circumstances that make them vulnerable"*

To help people make complaints or raise issues	*"Advocacy can help assist you to fill in forms…go to meetings and appointments with you….challenge professional decisions which are being made about you"* *"The role of advocate will vary according to circumstances and needs but is likely to include…support in meetings and through formal processes…support to make representations and complaints…supporting people access professional advice and guidance.*
To provide information on rights, processes and procedures and/or to signpost to other services	*"An advocate can help you…look at information about how different processes work (e.g. legal, health or social services)…look at any local services or community opportunities that might be useful for you"* *"Advocacy…empowers people to gain access to information, explore and understand their options, and to make their own wishes known"* *"Offers to get information on your behalf to help you come to a decision"* *"Advocacy can find out information to help you make an informed decision"*

The Workstream Group may wish to consider these themes, and supplement them with any additional themes they might identify, in order to determine a definition of advocacy and independent advocacy. Determining a definition of advocacy is likely to be an important element in determining the remit of a Patient Advocacy Service.

What is not advocacy?

In determining a definition of advocacy and what factors contribute to effective advocacy, it is equally important to identify what is not advocacy. The Department of Health's guide for commissioning advocacy services "Developing Advocacy Services: A Policy Guide for Commissioners" view on what does not constituency advocacy is as follows[6]:

> *"Advocacy does not, however, in any way involve taking decisions on behalf of people being supported. Nor is it a mediation, counselling, befriending, lobbying or complaints service, although some of these may be useful skills for an advocate to have and advocacy may be used to support people through for example a complaints process. Advocacy is also not an*

---

[6] Department of Health, Social Services and Public Safety. Developing Advocacy Services: A Policy Guide for Commissioners. May 2012.

> *advice service in the sense that it is not an advocate's role to tell someone what they should and not should not do"*

A search of advocacy organisations across the UK and their determination of what does not constitute advocacy, concurs with many of the points made by the Department's commissioning guide. Further information is provided in **Annexe 2** of this briefing paper, however, to summarise some of the points made, it is argued that advocacy services do not/cannot:

- Provide mediation or counselling
- Provide support workers or personal care
- Provide a crisis service
- Investigate an organisation
- Provide emotional support or befriending
- Express their personal opinion
- Tell or advise someone what they think they should do

The Workstream Group may wish to consider in further detail the types of services, activities and behaviours that do not constitute advocacy. Again, this is an important element in determining the remit of a Patient Advocacy Service.

Identifying different types of advocacy

Advocacy can be delivered in a variety of ways depending upon the needs of the person requiring support and other factors such as age, disability, and the issue that the needs to resolved. It is important to note that there are different types of advocacy and organisations that provide advocacy services can often provide more than one model of advocacy. Some of the main types of advocacy are identified in the table below:

Table 2: Types of advocacy[7]

Model of Advocacy	Description
Self-advocacy	In simple terms, it means standing up for oneself. The goal of self-advocacy is for people to decide what they want and to carry out plans to help them get it. Self advocacy is the process by which people are empowered to develop the skills and confidence to represent their own views and interests. It involves making informed decisions and taking responsibility for those decisions. The core components of self-advocacy have been identified as:

---

[7] Information in this section is directly extracted from Mongan, D.; Long, J. & Farrragher, L. (2016) Models of Patient Advocacy: Evidence Brief. Health Board Research. https://health.gov.ie/wp-content/uploads/2016/12/Final-Version-Patient-Advocacy-Services.pdf

	• Being able to express thoughts and feelings with assertiveness if necessary; • Being able to make choices and decisions; • Have clear knowledge about rights; and • Being able to make changes.
Group/collective advocacy	Group advocacy evolves from self-advocacy and it involves people with shared experiences, positions or values coming together in groups to talk and listen to each other and speak up collectively about issues that are important to them. These groups aim to influence public opinion, policy and service provision. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a group can also help to reduce an individual's sense of isolation when raising a difficult issue. Groups can vary considerably in size, influence and motive. Similar to self-advocacy, group advocacy is seen as enabling people to have a voice, enhancing personal identity and raising self-esteem. It involves a process through which individuals acquire and develop the skills and confidence to represent their own needs, concerns and interests within a group setting.
Peer advocacy	Peer advocacy occurs when one person advocates for another person who shares a common experience, difficulty or discrimination. Peer advocates are experts by experience, and they use this experience to understand and empathise with their advocacy partner. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves. Power dynamics are more equal in peer advocacy, because both parties have experienced and struggled through similar issues and experiences. Peer advocacy can be conducted on an individual or collective basis. It is also known as *support advocacy* and is often used by support groups.
Citizen/Volunteer Advocacy	Citizen advocacy is when ordinary citizens are encouraged to become involved with a person in their community who might need support. The citizen advocate is not paid and is not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long-term basis. It is based on trust between the partner and the advocate. Citizen advocates are encouraged to represent the interests of the person as if they were their own. They should be independent of service providers, potential service providers and families, in order to avoid conflicts of interest. The advocate supports their partner using natural skills and talents, rather than being trained in the role. Citizen advocates attempt to foster respect for the rights and dignity of those whose interests they are representing. This may involve helping the person express his or her concerns and aspirations, and providing other practical or emotional support to him or her.

Representative/independent advocacy	Representative advocacy is an independent service where trained advocates are employed to deal with specific problems and to work with an individual until that problem is resolved. It usually involves casework and complex issues that require specific knowledge and expertise. This tends to be a more formal type of advocacy, and trained advocates working to a code of practice are often paid to provide this service. The advocates are experts by training and not necessarily through direct experience. This form of advocacy can apply to formal advocacy enshrined in statute (for example, in New Zealand), where advocates are appointed by an Advocacy Commissioner). An advocate supports an individual to represent their own interests, or the advocate may represent the views of an individual if the person is unable to do this themselves. The advocate provides support, information and representation, with the aim of empowering their partner and enabling them to express their needs and choices.
Legal advocacy	Legal advocacy seeks to defend the rights and interests of people on a one-to-one basis through the legal system. Legal advocacy is undertaken by a lawyer or individual with appropriate legal knowledge. It involves members of the legal profession helping individuals to exercise their rights through the courts and legal system. Legal advocacy has a significant role to play in the areas of mental health, where people can be detained in hospital against their wishes.

Other types of advocacy

Non-instructed advocacy[8]	Most one to one advocacy is instructed. However, there are occasions when a non-instructed advocacy is required. Non-instructed advocacy happens when a person who needs an independent advocate cannot tell the advocate what they want. This may be because the person has complex communication needs or has a long term illness or disability that prevents them from forming or clearly stating their wishes/desires. This usually takes place with people who have dementia or profound and/or severe learning difficulties. The advocate will take time to get the know the person and relatives/friends and look for alternative methods of communication which will enable the person to express their views and wishes to ensure their rights are upheld. The advocate will change service providers in order to promote a person-centred independent approach.

---

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

The Workstream Group may wish to consider the different types of advocacy, which types of advocacy are currently provided in Northern Ireland and by whom, and what types of advocacy a potential future Patient Advocacy Service should provide.

What benefits can health and social care organisations derive from advocacy?

Effective advocacy clearly plays an important role in helping to empower patients (and their families and carers) but it also has a wide range of benefits for health and social care organisations as identified by NHS Scotland's 'Independent Advocacy Guide for Commissioners'[9] (set out in detail in the table below):

Table 3: What benefits do health and social care organisations get from Independent Advocacy?[10]

Better outcomes for people	Advocacy makes a difference to what happens to people. It leads to a better understanding between individuals and service providers and can lead to greater self-help and independence and better decisions about treatment and services. People feel better about themselves and their situation. People get out of places where they are unhappy, get included in places where they want to be. Advocacy can also have a preventative role, ensuring that the interests of vulnerable individuals are not forgotten so that problems and crises for that person do not arise. Group or collective advocacy can provide information to support commissioners and planners to make sure that support services are targeted, that planning leads to the most efficient use of available resources leading to better outcomes for groups and individuals.
Intelligence and feedback	Advocacy organisations can provide alternative source of constructive intelligence and feedback about how well services are meeting the needs of the most vulnerable groups and inform future needs and priorities while protecting the confidentiality of individuals. This can assist the systems of clinical governance within NHS Boards. As well as highlighting quality and problems in current service provision, independent advocacy can inform joint planning for the future.
Added Value	A relatively small investment in independent advocacy can yield significant results. Advocacy organisations engage the skills and commitment of ordinary members of the public. They empower people who are being ignored, giving people the support and information they need to make their own decisions and take more control of their own life. Advocacy organisations also have an interest in avoiding dependence on a single agency, so core funding from statutory sources may be extended through other grants and fundraising activity.

---

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

[10] This section has been extracted verbatim from NHS Scotland. (2013) Independent Advocacy Guide for Commissioners.

Constructive challenge to service providers	Advocacy organisations provide a constant challenge to service providers to improve what they do. This challenge may be at least as effective in achieving higher quality as the more formal processes of standard-setting, inspection and regulation.
Keeping the focus on people who are most at risk	By concentrating on people who are most likely to fall through the net, independent advocacy helps the formal service system to improve the quality of what is provided for people who are hardest to serve. This is the acid test for any service system, and independent advocacy helps keep this on the agenda.
Designing person-centred services and supporting greater choice and control for users of services	Advocacy supports the development of person-centred services because it involves people whose circumstances do not readily fit standard arrangements. By testing the limitations of current services, advocacy can help professionals to redesign and refine the system so that it works better for everyone. Advocacy helps to support greater choice and control for people who use services by providing a voice to individuals at all stages in their support.
Enabling carers to be respected as equal partners	Advocacy organisations can support carers to be heard as equal partners with other professionals in the delivery of care and, collectively, in the development of services and support that affect them or the person they care for. Whilst the views of the service user are central, the views of carers should be heard and their experience respected by professionals involved. They are a key part of providing support and the term equal partner recognises not only their critical role in sustaining and supporting individuals to remain in their own homes and communities but also their unique knowledge and experience. By supporting carers to be heard and to manage and understand the often complex systems surrounding health and social care, advocacy can help sustain the caring role, reduce crisis and deliver better outcomes.

The benefits of advocacy, particularly independent advocacy, across all health and social care in Northern Ireland is succinctly summarised by the following extract from the Department's advocacy services commissioning policy guide[11]:

> *"…investing in advocacy services not only benefits the person needing support. It can also benefit commissioners and providers of health and social care services. For example, advocacy can help prevent crises arising in a person's life which otherwise may result in an intervention that has much greater resource implications.*
>
> *…by giving the most at risk a vehicle through which they can have their voice heard, advocacy can also help commissioners and service providers gain a better understanding of the needs of this important group. If*

---

[11] Department of Health, Social Services and Public Safety. Developing Advocacy Services: A Policy Guide for Commissioners. May 2012.

> *engaged, they can act as a valuable channel for seeking ideas and views on how current health and social care services can be improved to better meet those needs and to inform planning for future needs and service redesign."*

If it has not already done so the Workstream Group may wish to consider what principles should be enshrined in the development of a Patient Advocacy Service for Northern Ireland. For illustrative purposes, **Annexe 3** of this paper provides an extract from the Advocacy Charter devised by the National Development Team for Inclusion[12] and adopted by many advocacy providers across England and Wales. In short, these principles include:

- **Independence**: i.e. the advocacy provider is independent from statutory organisations and all other service delivery and is free from conflict of interest.
- **Confidentiality**: i.e. information held by the advocacy service about individuals will be kept confidential unless in exceptional circumstances.
- **Person-led:** i.e. the advocacy provider and advocates will put the people they advocate for first and shall be directed by their wishes and interests.
- **Empowerment:** i.e. the advocacy provider will support people to self-advocate as far as possible. Advocates will support people to access information and to exercise choice and control in the style of advocacy services they want. Where people lack capacity, the provider will ensure the advocacy remains person-led and enable those with an interest in the welfare of the person to be involved.
- **Equality and diversity:** i.e. the advocacy provider will have an up-to-date equality and diversity policy and advocates will make reasonable adjustments to ensure that people have an opportunity to engage and benefit from the service.
- **Accessibility:** i.e. advocacy will be provided free of charge to eligible people. Premises, policies, procedures and publicity materials will promote full access for the population it serves.
- **Accountability:** i.e. the advocacy provider is well managed, with appropriate governance arrangements. People accessing the service will have a named advocate and a means of contacting them.
- **Safeguarding:** i.e. as part of supporting people to realise their human rights, the advocacy provider will have a thorough understanding of safeguarding responsibilities and processes as set out in law and best practice.
- **Supporting advocates:** i.e. the advocacy provider will ensure that advocates are suitability trained, supported and supervised in their role and provided with opportunities to develop their knowledge, skills and experience.

---

[12] These standards have been extracted verbatim from National Development Team for Inclusion. The Advocacy Charter. v4. 1 May 2018. https://qualityadvocacy.org.uk/resources/advocacy-charter/

3 Which organisations are important to advocacy in a health and social care settings in Northern Ireland?

In order to fully explore the potential for a future Patient Advocacy Service, it is important to establish what current services are provided and by whom and to identify the current gaps in service provision. It is important to gain an understanding of the roles and responsibilities, including statutory duties, of various organisations that are relevant to advocacy. This section of the paper provides an overview of those organisations. It is advisable that the Workstream Group/Department consults with these bodies, and any others it feels relevant, in relation to their role in advocacy and/or the investigation of complaints which are relevant to advocacy.

In addition to organisational responsibility, individual health professionals are also responsible for advocacy and the protection of patient rights and wellbeing. This section also provides an overview of codes of conduct/standards of various professional health and social care bodies, highlighting some of the relevant sections relating to advocacy.

It should be noted that this paper does not include information on two crucial aspects of advocacy, that is, the role of independent advocacy providers and the role of patients, service users, their carers and families. Independent advocacy providers, primarily third sector bodies, play a crucial role in the delivery of advocacy services for which they have agreed contracts in place either with the HSC Board or trusts. In 2016, RQIA in a review of advocacy services for children and adults in Northern Ireland found that there is *no regional information system in place to capture the full picture of the current profile of advocacy services in Northern Ireland*[13].

The Department of Health have therefore requested that the HSC Board and trusts provide the Workstream Group with information on what advocacy services are commissioned, from whom they are commissioned, and which programme of care they relate to. However, in order to identify gaps in current and future service provision, the Workstream Group may wish to consider the methodology for obtaining such views. RQIA, for example, in its review of advocacy services in 2016, used the following methodology:

- Discussions with HSC Board, HSC Trusts, independent advocates
- Self-assessment questionnaire completed and returned by HSC Board and Trusts
- Self-assessment questionnaire completed and returned by independent advocacy providers.
- Meetings and telephone discussions with independent advocacy providers.

---

[13] RQIA. Review of Advocacy Services for Children and Adults in Northern Ireland. January 2016. https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf

- Regional summit event and group discussions involving all relevant stakeholders.

The Workstream Group/Department may wish to consider using a similar methodology in order to obtain a comprehensive overview of the views of patients, service users, their carers and families, although notably the Workstream Group has an existing valuable source of knowledge amongst the membership of the Group.

An Overview of Organisational Roles and Responsibilities:

This section of the paper provides an overview of the roles and responsibilities of various organisations that are important to an advocacy infrastructure in Northern Ireland. An overview of the body is provided as well as a brief description of how the organisation is relevant to advocacy (although notably these organisations may have supplementary information in relation to their role). Where possible, some additional information is provided on the current thinking of that organisation in relation to advocacy. In considering this section, the Workstream Group/Department may wish to identify how the remit of a Patient Advocacy Service would interact with the remit of these various bodies.

1. The Department of Health

Department of Health
An Roinn Sláinte
Männystrie O Poustie

The Department of Health has a general duty under Section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[14] to promote an integrated system of health and social care that secures improvement in the physical, mental and social well-being of people in Northern Ireland.

The 2009 Act states that the Department of Health must:

- Develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland.
- To determine priorities and objectives for the provision of health and social care in Northern Ireland.

---

[14] Section 2. Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/section/2

- Allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.
- Set standards for the provision of health and social care.
- Prepare a framework document setting out the main priorities, objectives, and other matters for each health and social care body in connection with the carrying out of its functions.
- Secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland.
- Monitor and hold to account the Regional HSC Board, the Regional Business Service Organisation, the Public Health Agency and HSC Trusts in the discharge of their functions;
- Make and maintain effective arrangements to secure the monitoring and holding to account of other health and social care bodies in the discharge of their functions.

Under Section 3 of the 2009 Act[15], the Department of Health also has a general power to *"provide, or secure the provision of, such health and social care as it considers appropriate"* or *"do anything else which is calculated to facilitate, or is conducive or incidental to"* discharging its duties under Section 2 and the functions outlined above.

What are the Department's responsibilities in relation to advocacy and the provision of advocacy services?

The Department has a number of duties directly relating to advocacy or issues that are significantly aligned with advocacy including, for example:

- legislative equality duties and obligations;
- the formulation of strategic frameworks including measurable outputs and outcomes;
- formulating and issuing guidance on issues relevant to advocacy including the commissioning of advocacy services, Personal and Public Involvement (PPI), and co-production; and
- A monitoring role in relation to the activities of health and social care bodies such as the HSC Board, Trusts, and the Public Health Agency.

This section looks briefly at each of these responsibilities. However, the Department way wish to expand upon this and provide the Workstream Group with additional information on its role and responsibilities. This section does not include financial arrangements for the funding of advocacy services and the Department wish to provide the Workstream Group with further details information on how advocacy services are financed.

---

[15] Section 2. Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/section/2

Legislative equality duties and obligations

The Bamford Review maintained that one of the key facets of advocacy is the promotion of equality and the social inclusion of marginalised individuals and groups[16]. If one accepts this definition, then the Department of Health has a central and fundamental role in advocacy and that the basis of this role is contained within the Department's legislative obligations. The Department, along with all public authorities in Northern Ireland, has a **statutory duty** under **Section 75** of the Northern Ireland Act 1998 to have due regard to the need to promote equality of opportunity between the nine equality categories[17]. It also has further duty under **Section 2** of the Health and Social Care (Reform) Act 2009 to develop policies that reduce health inequalities in Northern Ireland.

Strategic Service Frameworks

In addition to its equality duties, the Department is responsible for setting strategic priorities and devising **service frameworks** for health and social care in Northern Ireland. Several of these frameworks have recognised the importance of advocacy and included standards in relation to advocacy services. For example:

- **Standard 12** of the Service Framework for Mental Health and Wellbeing[18] and the consultation document on a revised Service Framework for Mental Health and Wellbeing 2018-2021 states that *"a person using specialist mental health services should have access to advocacy services in both community and hospital settings".*
- **Standard 2 (Generic)[19]** of the Service Framework for Respiratory Health and Wellbeing 2015-2018[20] **and Standard 9 (Generic)** of the Service Framework for Learning Disability[21] state that *"users of Health and Social Care Services and their carers should have access to independent advocacy as required"* and that *"independent advocacy should be available throughout the care pathway and, in particular, should be available early in the process as this may prevent a crisis developing".*

---

[16] The Bamford Review of Mental Health and Learning Disability. Human Rights and Equality of Opportunity. October 2006. www.health-ni.gov.uk/publications/bamford-published-reports

[17] Persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation; between men and women generally; between persons with a disability and persons without; between persons with dependents and persons without. Section 75 also requires public authorities such as the Department of Health to promote good relations between persons of different religious belief, political opinion or racial group.

[18] Department of Health. Service Framework for Mental Health and Wellbeing. August 2012. www.health-ni.gov.uk/publications/mental-health-and-well-being-service-framework-documents

[19] All Service Frameworks were to incorporate a specific set of standards that are identified as generic. Independent advocacy was identified as a generic standard applicable to all the population, HSC professionals or all service users, regardless of their health condition or social grouping.

[20] Department of Health. Service Frameworks for Respiratory Health and Wellbeing 2015-2018. October 2015. www.health-ni.gov.uk/publications/respiratory-health-and-well-being-service-framework-documents

[21] Department of Health. Service Framework for Learning Disability. January 2015. www.health-ni.gov.uk/publications/learning-disability-service-framework-documents

- **Standard 5** of the Service Framework for Older People[22] states that *"older people should have access to independent advocacy that provides information, advice and support to enable them to make informed choices and be fully involved in decisions affecting them".* Furthermore, Standard 6 (Generic) states that *"users of health and social care services and their carers should have access to independent advocacy as required".*
- **Standard 3 (generic)** of the draft Service Framework for Children and Young People[23] similarly stated that *"users of Health and Social Care services and their carers should have access to independent advocacy as required".* But also identified via **Standard 30** the need for independent advocacy support for vulnerable children (e.g. any child who is outside his/her country of origin and is separated from parents or primary care givers; homeless 16/17 year olds etc.).

Whilst the Department of Health strategically determines the standards in frameworks, the frameworks identify a range of bodies that are responsible for the implementation of the standards including the HSC Board, HSC Trusts, Public Health Agency as well as other delivery parties such as third sector organisations.

All service frameworks were required to have had measurable outputs and specific timeframes and expected outcomes. Given that independent advocacy was a generic standard applicable to all such service frameworks, the Workstream Group may wish to seek further information on latest position on each of the frameworks in terms of outputs and outcomes associated with independent advocacy services if available.

Guidance on commissioning independent advocacy services

The Health and Social Care (Reform) Act (Northern Ireland) 2009 requires the Department to set standards for the provision of health and social care and also to secure the commissioning of programmes and initiatives conducive to the improvement of health and wellbeing and the reduction of health inequalities. The Department should therefore play a pivotal role in **developing principles and standards for the commissioning and delivery of advocacy services** in a health and social care setting.

In light of the recommendations of the Bamford Review Report on Human Rights and Equality of Opportunity (2006)[24] which identified that *"advocacy services are unevenly and poorly developed in Northern Ireland"* and that there was a need for *"a range of independent advocacy support services delivered by a range of providers"* the

---

[22] Department of Health. Service Framework for Older People. July 2014. www.health-ni.gov.uk/publications/older-people-service-framework-documents

[23] Department of Health. Service Framework for Children and Young People. Consultation document. www.health-ni.gov.uk/consultations/service-framework-children-and-young-people-consultation

[24] Bamford Review of Mental Health and Learning Disability (Northern Ireland). Human Rights and Equality of Opportunity. October 2006. www.health-ni.gov.uk/publications/bamford-published-reports

Department published a "Developing Advocacy Services: A Policy Guide for Commissioners"[25] and an associated action plan[26] in May 2012.

If it has not already done so, the Workstream Group may wish to:

- **Consider the guidance;**
- **Consider speaking with, or requesting further information from, appropriate staff in the HSC Board, Trusts and independent advocacy providers to gain an understanding of how commissioning works in practice and assess whether improvements to the current arrangements are necessary;**
- **Assess whether the current guidance is still fit for purpose and whether any changes to the guidance are necessary in the immediate term to reflect the findings of the IHRD report.**

Guidance on Personal and Public Involvement

The Department also plays an important role in issuing guidance on Personal and Public Involvement (PPI)[27]. The Health and Social Care (Reform) Act (Northern Ireland) places a legislative requirement on certain health and social care organisations to involve and consult patients, families, carers and local communities on the planning, deliver and evaluation of services. PPI is clearly closely aligned and interfaces with professional and independent advocacy given that, as the Public Health Agency highlights, effective PPI can[28]:

- ensure responsive and appropriate services;
- reduce perceived power imbalances;
- contributes to tackling health inequalities;
- reduce complaints;
- reduce adverse incidents;
- acknowledge rights;
- increase levels of accountability; and
- improve dignity and self-worth.

---

[25] DHSSPS. Developing Advocacy Services: A Guide for Commissioners. June 2012.

[26] DHSSPS Advocacy Action Plan 2012-13. www.health-ni.gov.uk/publications/advocacy-action-plan-2012-13

[27] Further information on Personal and Public Involvement (PPI) is available at www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi and www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-5

[28] Public Health Agency. Personal and Public Involvement (PPI). www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-5

The Department of Health has issues several pieces of guidance to health and social care organisations on PPI which is available to download here[29].

If it has not already done so, the Workstream Group may wish to explore in further detail the interface between PPI and advocacy.

The Department's monitoring role

The Department must, under the Health and Social Care (Reform) Act (Northern Ireland) 2009, monitor and hold to account various health and social care bodies in the discharge of their functions. This includes the Health and Social Care Board and Health and Social Care Trusts. The Department has, for example, discharged this monitoring role by commissioning the Regulation and Quality Improvement Authority (RQIA) to undertake a review of the commissioning arrangements for the provision of advocacy services for children and adults in Northern Ireland. RQIA's report 'Review of Advocacy Services for Children and Adults in Northern Ireland[30]' was published in January 2016. This review examined the commissioning systems and processes to *"gain assurance as to the effectiveness of the existing commissioning processes undertaken by the HSC Board and Trusts"*[31].

RQIA stated that there were a number a factors driving the need for this review, i.e.:

- There was need for greater parity and consistency in relation to the commissioning and delivery of advocacy services in a HSC setting in Northern Ireland.
- In terms of what was being commissioned by the statutory sector, existing provision was "patchy" with some HSC Trusts having more established arrangements in place than others.
- Significant importance was placed on advocacy as a means of empowering and safeguarding some of the most vulnerable and at risk individuals.

As part of the review process, RQIA:

- Met with commissioners of advocacy services for children and adults to obtain their views and experiences of the commissioning arrangements;
- Met with independent advocacy providers to get their views and experiences in relation to the commissioning arrangements;
- Considered information provided by commissioners which included the HSC Board and HSC Trusts through the completion of self-assessment questionnaires;
- Met with staff and managers from the HSC Board, HSC Trusts, and independent advocacy providers;

---

[29] Department of Health. Personal and Public Involvement (PPI). DoH Guidance to HSC. www.health-ni.gov.uk/publications/personal-and-public-involvement-ppi-dhssps-guidance-hsc

[30] RQIA. Review of Advocacy Services for Children and Adults in Northern Ireland. January 2016. https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf

[31] RQIA. Review of Advocacy Services for Children and Adults in Northern Ireland. January 2016. https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf

- Held a regional summit event which involved all relevant stakeholders to further underpin the final report.

The Department may wish to consider the merits of conducting a similar consultative exercise in order to further assess the current provision of advocacy services and to identify gaps in service provision.

The RQIA report drew a number of important conclusions which it would be pertinent for the Workstream Group to consider. For example:

- That there is **no regional information system in place to capture the full picture of the current profile of advocacy services in Northern Ireland**. Due to the lack of regional information the review team recommended a needs assessment to determine future requirements and to assist in the development plans for future demands on advocacy services.
- **Workforce and workload varied across each independent advocacy organisation** and that this is **heavily influenced by funding, type of contract and by programme of care**.
- The number of service users and complexity of cases **varied considerably across providers and HSC Trusts**.
- Cases varied from those that could be resolved quickly via telephone or by a single visit from an advocate to **cases that were lengthy and complex** and which could take more than six months to resolve.
- Independent advocacy providers advised that some complex cases could require advocates to **link with other sectors** (e.g. housing and education) but that there was no clear framework for this to occur.
- There was **no regular forum through which learning about advocacy services is shared across the commissioners** and providers of advocacy services (although the Advocacy Network NI did facilitate meetings and discussions amongst its member organisation).

The report made the following **eight recommendations which the Workstream Group** may wish to consider in further detail:

- HSC Trusts/commissioners should carry out a needs assessment to determine future capacity requirements, and improve access to advocacy in keeping with the overall direction of services in Northern Ireland and the new mental capacity legislation. **The Workstream Group may wish to ascertain whether HSC Trusts/commissioners have conducted the recommended needs requirement.**
- HSC Board in partnership with relevant organisations should review and clarify arrangements for advocates to link with other sectors, including housing and education, when this is required in seeking to resolve cross-agency issues for their clients. **The Workstream Group may wish to ascertain what progress the Board has made on this issue.**

- HSC Board should work in partnership with HSC Trusts and independent advocacy providers to consider shared learning events or newsletters in order to share learning and experiences across organisations. **The Workstream Group may wish to ascertain what progress has been made in relation to this recommendation, whether any shared learning events have taken place and the outcome of these activities.**
- The resource and training implications for advocacy services should be included in the assessment of requirements to take forward the implementation of the mental capacity legislation. **The Workstream Group may wish to explore this issue further with the Board, Trusts and independent advocacy providers.**
- HSC organisations should work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning. **The Workstream Group may wish to explore the progress made on this issue particularly in relation to the development of outcome measures.**
- HSC Trusts should review service agreements with independent advocacy providers to ensure clarity as to the arrangements for the provision of services for clients across Trust organisational boundaries. **The Workstream Group may wish to explore what progress each Trust has made on this issue.**
- HSC commissioning organisations should review their arrangements to ensure that there is a clear point of contact for service providers to provide advice and clarification in relation to service agreements. **The Workstream Group may wish to explore what progress the HSC Board and Trusts have made in relation to this issue.**
- The Department should review potential new options for the introduction of regulation for advocacy services to determine if a regulatory framework should be established for organisations providing advocacy or for individual advocates. **The Workstream Group may wish to consider requesting an update on progress on this issue.**

2. Health and Social Care Board

The Health and Social Care Board[32] (HSCB) is a statutory regional body established under Section 7 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[33]. The role of the Health and Social Care Board is broadly contained in three functions[34]:

- To **arrange or commission** a full range of health and social services for the population of Northern Ireland.
- **Performance management of Health and Social Care Trusts**. This includes **supporting service improvements** to ensure optimal **quality and value for money**, in line with relevant **government targets**.
- **Deploying and managing annual funding** to ensure that this is targeted according to need and reflects the aspirations of local communities and their representatives.

What are the Board's responsibilities in relation to advocacy and the provision of advocacy services?

RQIA's report 'Review of Advocacy Services for Children and Adults in Northern Ireland[35]',published in January 2016, explored the role of key HSC bodies in relation to advocacy. The report described the role of the Health and Social Care Board in relation to the provision of independent advocacy services as follows:

"The HSC Board advised RQIA that its main role is to identify the needs of the Northern Ireland population and to commission HSC services to meet those needs, within the strategic priorities identified by the DHSSPS and the funding made available. Where independent advocacy is the most appropriate service to meet an identified need or strategic objective, and funds are available, the HSC Board will commission that type of service.

The HSC Board currently has a number of regional contracts to deliver independent advocacy across different programmes of care including, children services, people with hearing impairment, and children with disabilities. The HSC Board also commissions advocacy in relation to resettlement of learning disability patients from hospital.

---

[32] Health and Social Care Board. www.hscboard.hscni.net/

[33] Section 7. Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/section/7

[34] Information extracted from the HSCB website - www.hscboard.hscni.net/our-work

[35] RQIA. Review of Advocacy Services for Children and Adults in Northern Ireland. January 2016. https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf

In September 2012, the HSC Board established an Advocacy Commissioning Group which involved representatives from the five local commissioning groups (LCGs) and five HSC Trusts. This group agreed terms of reference and operated until December 2013, when it was deemed that the major objectives of the group had been achieved.

The HSC Board also established an internal advocacy group, and currently employs four social care commissioning leads, responsible for taking forward the action plan associated with the DHSSPS policy guide. The role and remit of the group is to support the service improvements identified in the action plans as they apply to independent advocacy services for people with serious mental illness, learning disability, children's services, older people and physical disability"

The Workstream Group may wish to request information from the HSC Board in order to enhance its understanding of the current role of the Board in the provision of advocacy services:

- **Does the HSC Board still concur with the RQIA report regarding its role in the provision of advocacy services (see quote above);**
- **Does the HSC Board have any further comments to add in relation to its role in the commissioning of advocacy services?**
- **Can the HSC Board provide further details as to how advocacy services are currently evaluated?**
- **Does the HSC Board perceive there to be any gaps in the current provision of advocacy services?**
- **The HSCB established an Advocacy Commissioning Group in 2012 which operated until December 2013. Does the HSC Board feel there is any merit in forming a similar group to reflect the need for independent advocacy identified by the IHRD report?**
- **Does the 'internal advocacy group' (referred to in the quotation from the RQIA report) still exist? If not, why is this the case? If it does exist, could the HSC Board provide an update on its key activities.**

HSC Board's statutory responsibility to provide certain advocacy support and services

It is important to note that the HSCB is required by law to provide certain advocacy services. For example, Section 21 of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015[36] states that the Board must make arrangements to enable a person (referred to as an 'independent guardian') to be appoint to assist, represent and support a child where that child is a victim, or a potential victim, of human trafficking, or who is determined to be a separated child. The Act states that the independent guardian will only be appointed where there is no-one available to effectively exercise parental responsibility for the child[37].

The Workstream Group may wish to consider requesting further information from the HSC Board in order to gain an understanding of the appointment, role and responsibilities of independent guardians.

3. Health and Social Care Trusts

HSC Belfast Health and Social Care Trust
caring supporting improving together

HSC South Eastern Health and Social Care Trust

HSC South Eastern Health and Social Care Trust

HSC Western Health and Social Care Trust

HSC Northern Health and Social Care Trust

There are six Health and Social Care Trusts in Northern Ireland. Five of these trusts provide integrated health and social care services across Northern Ireland[38]. The five HSC Trusts are the main providers of health and social care services commissioned by the Health and Social Care Board[39]. They are also responsible for exercising certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust has a statutory obligation to put in place arrangements for monitoring and improving the quality of health and social care under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Each HSC Trust has a duty to exercise its functions with the aim of improving the health and

---

[36] Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015. www.legislation.gov.uk/nia/2015/2/section/21/enacted

[37] Explanatory Memorandum. www.legislation.gov.uk/nia/2015/2/notes/division/4/21

[38] The sixth Trust is the NI Ambulance Service; this section of the paper refers only to the role and responsibilities of the five trusts.

[39] DHSSPS. Health and Social Care: Reform and Transformation. Getting the Structures Right.

social wellbeing, and reducing health inequalities between, those from whom it provides, or may provide, health and social care[40].

Monitoring Trust performance against agreed objectives and targets is the responsibility of the HSCB. In addition to performance monitoring, the HSCB and the Public Health Agency (PHA) will work in co-operation to support Trusts in improving performance. Separately to the lines of responsibility between Trusts and the HSCB, Trust Chairs and Chief Executives are accountable to the Minister and the Department of Health (reflecting the accountability arrangements between a parent department and its arm's length bodies). The division of responsibility is said to require that the HSCB, the PHA, Trusts and the Department to work closely to ensure services which are commissioned can be delivered within the resources available[41].

What is the role of Health and Social Trusts in relation to advocacy and the provision of advocacy services?

The five Trusts have responsibility for commissioning advocacy services from independent advocacy providers. These are commissioned through a tendering processing which should adhere to the Department of Health's policy guide on the commissioning of advocacy services and to procurement legislation.

Advocacy services are commissioned across various programmes of care, primarily within family and childcare; children and adult learning disabilities; children and adult mental health; and adult physical disability. HSC Trusts may also commission specific advocacy services for conditions such as dementia and autism on a short-term basis as and when required[42].

Part 4 of the Mental Capacity Act (Northern Ireland) 2016[43] places a statutory duty on each HSC Trust to make arrangements to ensure that independent mental capacity advocates (IMCAs) are available to be instructed as the Act requires. In making these arrangements, Trusts must have regard to the principle that the advocacy should be independent. An "appropriate healthcare professional" may request that a Trust instructs an independent advocate to represent and provide support to the individual.

In addition to the commissioning of services, it is worth bearing in mind that HSC Trusts also have statutory obligations with significant relevant to advocacy such as their statutory equality duties under Section 75 of the Northern Ireland Act 1998; quality duties under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; and Personal and Public Involvement (PPI) duties under the Health and Social Services (Reform) Northern Ireland Act 2009.

---

[40] Information extracted from the Health and Social Care website http://online.hscni.net/hospitals/health-and-social-care-trusts/

[41] DHSSPS. Health and Social Care: Reform and Transformation. Getting the Structures Right

[42] RQIA. Review of Advocacy Services for Children and Adults in Northern Ireland. January 2016. https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf

[43] Mental Capacity Act (Northern Ireland) 2016.

If it has not already done so, the Workstream Group may wish to consider requesting a briefing on the advocacy aspects of the Mental Capacity (Northern Ireland) Act and an update on the latest developments.

4. Public Health Agency

The Public Health Agency was established under Section 12 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[44]. Section 13 of the Act sets out the functions of the Public Health Agency in relation to the areas of health improvement and health protection.

The **health improvement functions** of the Public Health Agency as provided for in Section 13 are:

- Developing and providing, or securing the provision of, programmes and initiatives designed to secure the improvement of the health and social well-being of, and reduce inequalities between, people in Northern Ireland; and
- Health promotion, including in particular enabling people in Northern Ireland to increase control over and improve their health and social well-being.

The **health protection functions** of the Public Health Agency as provided for in Section 13 are to protect the community (or any part of the community) against:

- Communicable diseases, in particular by the prevention or control of such diseases; and
- Other dangers to health and social well-being including dangers arising on environmental or public health groups or arising out of emergencies.

In the exercise of its functions, the Public Health Agency may:

- Engage or commission research;
- Obtain and analyse data and other information;
- Provide laboratory and other technical and clinical services;
- Providing training in relation to matters in which it has functions;
- Make available to any other body such persons, materials and facilities as it thinks appropriate; and
- Provide information, advice and assistance.

---

[44] Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/contents

The Act also provides that in exercising its functions, the Public Health Agency must co-operate with other bodies which exercise functions relating to health improvement or protection (e.g. local government). It must also provide the Department of Health, the Health and Social Care Board and Local Commissioning Groups with such information, advice and assistance as the may reasonably require in connection with the exercise of its functions.

What is the role of the Public Health Agency in advocacy?

Advocacy in a health and social care setting is often required when there has been a breakdown in communication between health professionals and service users and their families; when service users and their families feel that they have not been listened to and/or kept informed; or where service users feel disempowered because they feel they have had little say in how services are shaped and delivered. Personal and Public Involvement (PPI) is a statutory requirement for Health and Social Care organisation which aims to embed meaningful and effective engagement of service users, carers and the public within the formulation of policy, the delivery of services and the culture and values of health and social care organisations.

The Public Health Agency (PHA) has a role to play in advocacy in that has responsibility for leading implementation of policy on PPI across HSC[45]. Whilst it may not act as an advocate per se, the PHA is responsible for leading on a policy (i.e. PPI) that should create the conditions in which key principles of advocacy such as equality and the acknowledgement of rights, empowerment and the redress of power imbalances, dignity, communication, and co-production of services should flourish in all health and social care organisations.

Many of the PHA's leadership functions relating to PPI are said to be delivered through the Regional HSC PPI Forum[46]. Working with and through the Forum, PHA is responsible for[47]:

- Establishing and leading the Regional HSC PPI Forum;
- Encouraging collaboration, consistency and coordination in approach to PPI across HSC;
- Raising awareness of PPI and communication;
- The provision of professional advice, guidance and information on PPI;
- Encouraging and facilitating PPI to be embedded into HSC culture and practice;
- The production of an Annual Report on PPI;
- Commissioning of PPI training for HSC;

---

[45] 45 Information extracted from the Public Health Agency website - www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-5

[46] See http://engage.hscni.net/who-we-are/meeting-minutes/

[47] Ibid

- Design, development and implementation of monitoring mechanisms and arrangements for PPI in the HSC system;
- Ensuring that HSC Trusts meet their PPI statutory responsibilities;
- Providing of assurances to the Department of Health in respect of Trust compliance with the statutory duty to involve and consult; and
- Commissioning of research and the production of reports into the barriers to involvement and ways to overcome these.

The PHA website Engage provides further information on PPI including information on standards, research and PPI case studies[48].

The role of the PHA is also to **support service users** (and indeed their carers, families and advocates) in **expressing their views on the health and social services.** This PHA uses a range of mechanisms to obtain those view and facilitate a more patient and client-focused approach to services such as the 10,000 more voices initiative which provides people with an opportunity to tell the PHA about their experience of receiving health and social care, highlighting what is important to them and describing their health and social care journey. The 10,000 more voices website has a number of live surveys on people's experiences of adult safeguarding, children's audiology services, health and social care in Northern Ireland, mental health, and the Northern Ireland Ambulance Service[49].

If has not already done so, the Workstream Group may wish to seek further information from the Public Health Agency on the interface of PPI and advocacy. It may also wish to gain understanding of how the voices of service-users and advocates/advocacy providers are heard through initiatives such as'10,000 voices' and whether any further action is required to capture user and advocacy service provider experience.

5. The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[50]. RQIA is an independent body responsible for monitoring and

---

[48] Engage http://engage.hscni.net/what-is-ppi/policy-and-legislation/

[49] 10,000 more voices https://10000morevoices.hscni.net/about-us/

[50] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. www.legislation.gov.uk/nisi/2003/431/contents/made

inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

What is the role of RQIA in advocacy?

Two of the functions of RQIA under the 2003 Order are to:

- "carry out investigations into, and making reports on, the management, provision or quality of health and personal social services for which statutory bodies have responsibility"; and
- "conducting review of, and making reports on, the management, provision or quality of, or access to or availability of, particularly types of health and personal social services for which statutory bodies or service providers have responsibility".

RQIA therefore play a central role in investigating and/or reviewing, and making reports, on advocacy services provided directly by HCS bodies or by independent advocacy services commissioned by HSC bodies. An important part of this work is to make recommendations to improve the quality of these services. RQIA has conducted a number of reviews in relation to advocacy:

- **Review of Advocacy Services for Children and Adults in Northern Ireland**, January 2016 www.rqia.org.uk/reviews/review-reports/2015-2016/
- **Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland: Overview Report**. February 2013 (this review commended that HSC Trust should ensure that patients and relatives on all wards have access to advocacy services. www.rqia.org.uk/reviews/review-reports/2012-2015/
- **Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland**, March 2012. www.rqia.org.uk/RQIA/files/6d/6d57b251-a508-45c5-bb55-4e37d1cf64b1.pdf

In order to gain an understanding of the current provision of advocacy services across Northern Ireland, the Workstream Group may wish to consider requesting a briefing from RQIA on its reports into advocacy services, the recommendations made and identify actions taken by relevant health and social care organisations in response to those recommendations.

6. Patient and Client Council

Patient and Client Council

Your voice in health and social care

The Patient and Client Council (PCC) was established under Section 16 and Schedule 4 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[51]. The high level functions of the PCC in relation to the provision of health and social care are set out in Section 17 of the Health and Social Care (Reform) Act 2009 Act as follows[52]:

- **To represent the interests of the public.** The Patient and Client Council must consult the public about matters relating to health and social care and report the views of those consulted to the Department of Health (where it appears to the Council to be appropriate to do so) and to any other body to which this section of the Act applies who appears to have an interest in the subject matter of the consultation.
- **To promote the involvement of the public**. The Patient Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body to which this Section of the Act applies would or might affect (whether directly or not) the health and social well-being of the public.
- **To provide assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care**. The Patient Client Council shall arrange, to such an extent as it considers necessary to meet all reasonable requirements, for the provision (by way of representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.
- **To promote the provision of advice and information to the public about the design, commissioning and delivery of health and social care**.
- **"such other functions as may be prescribed"**.

The 2009 Act also provides that the Patient and Client Council shall carry out research into the best methods for consulting with the public about involving them in health and social care and to provide advice about these methods to certain health and social care bodies.

Definitions:
The **"public"** is defined in this section of the Act as *"individuals, a group or community of people and a section of the public, however selected".*

A body is responsible for health and social care under this Section of the Act if it (a) provides or will provide care to individuals; or (b) if another person provides, or will provide,

---

[51] Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/contents

[52] Article 17. Health and Social Care (Reform) Act (Northern Ireland) 2009 www.legislation.gov.uk/nia/2009/1/section/17

that care to individuals at that body's direction, on its behalf, or in accordance with an agreement or arrangements made by that body with the other person. This also includes care that is provided jointly with another person.

Duty to co-operate with the Patient and Client Council

Section 18[53], of the 2009 Act requires certain health and social care bodies to co-operate with the Patient and Client Council in carrying out its functions. Furthermore, it requires health and social care bodies to have due regard to advice provided by the Patient and Client Council about the health and social care for which that particular body is responsible.

What is the role of the Patient Client Council in relation to advocacy?

The Patient and Client Council (PCC) plays a pivotal role in advocating on behalf of users of health and social care services in Northern Ireland. It also has key responsibilities in respect of Personal and Public Involvement (PPI) including representing the public interest/promoting/supporting the involvement of the public, and undertaking research into best practice for involving and consulting the public in regard to health and social care matters[54].

Whilst it is a statutory body, the core values of the PCC are to "speak independently" and "put people at the centre of all we do"[55]. Indeed, the PCC states that *"Being an advocate for patients and clients is an important part of our work".* For illustrative purposes, this section provides a brief overview of three of the means by which the PCC acts as an advocate for patients and clients, i.e.:

- the role of the PCC in assisting with complaints;
- the role of the PCC in conducting thematic reviews; and
- the role of the PCC in providing advice and information.

The role of the Patient Client Council in assisting with complaints

One of the most important functions of the Patient Client Council in relation to advocacy is the provision of assistance to individuals making or intending to make a complaint relating health and social care. Information on the Patient Client Council's complaints process is available in its publication 'How can we help?: your guide to making a complaint about Health and Social Care Services[56]' and accompanying video on the Complaint Support Service .

---

[53] Section 18. Health and Social Care (Reform) Act (Northern Ireland) 2009. www.legislation.gov.uk/nia/2009/1/section/18

[54] Duffy, J. et al. Personal and Public Involvement (PPI) and its impact. Monitoring, measuring and evaluating the impact of PPI in Health and Social Care in Northern Ireland. January 2017. www.patientclientcouncil.hscni.net/publications/index/reports

[55] Patient and Client Council website www.patientclientcouncil.hscni.net/about-us

[56] Patient and Client Council. How can we help? Your guide to making a complaint about Health and Social Care services. www.patientclientcouncil.hscni.net/making-a-complaint

The Patient Client Council Complaints Support Service is a “confidential, independent and free service” that will[57]:

- Provide clients with information on the complaints procedure and advice on how to take a complaint forward;
- Discuss a complaint with a client and draft letters on their behalf;
- Make telephone calls for clients about their complaint on their behalf;
- Help clients prepare for, and accompany them to meetings about their complaint and ensure that their concerns are heard and responded to;
- Help and support clients to prepare a complaint for submission to the Ombudsman or other regulatory bodies;
- Refer to other agencies, for example, specialist advocacy services; and
- Help access medical and/or social services records.

The Patient Client Council also publishes an ‘Annual Complaints Report’ which provides an account of the number, type and nature of complaints received and dealt with by the PCC each year. The latest report is the ‘Annual Complaints Report 2017-18[58]’ (published in February 2019) and provides the follow service activity data:

- In 2017/18 the Patient Client Council Complaints Support Service provided specific help or advocacy in relation to **881 new cases**. These included **662 formal complaint cases** and **219 issues or concerns** (see definition in footnote)[59]. It is important to note that the Patient Client Council Complaints Service does not offer legal support to clients.
- The PCC Complaints Service also provided support to 934 requests for advice or information during 2017/18. These requests are dealt with through the PCC Helpline.
- Comparative figures for formal complaints and issues/concerns for 2016/2017 and 2017/18 are provided in Table 1. Please note activity data relates only to new cases and requests dealt with between 1 April 2017 and 31 March 2018. It does not include continuing work by PCC Complaints Support Officers and on cases opened before 1 April 2017.

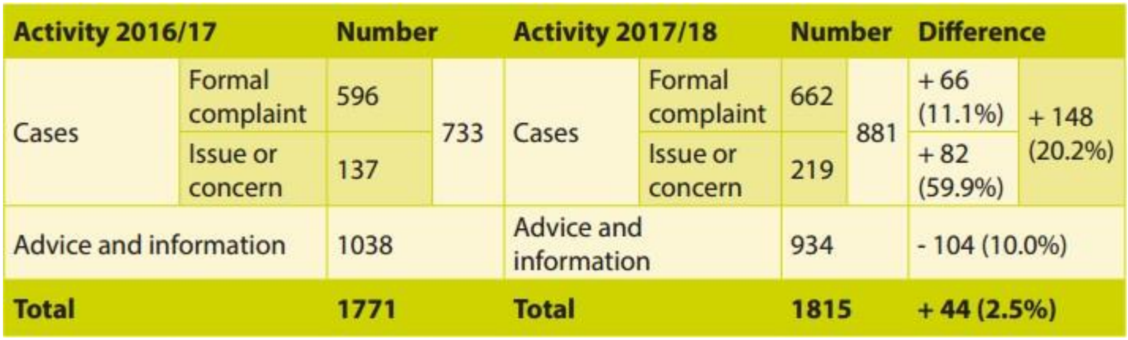
---

[57] Patient and Client Council. Annual Complaints Report 2017-18. www.patientclientcouncil.hscni.net/publications/index/reports

[58] Patient Client Council. Annual Complaints Report 2017-18. www.patientclientcouncil.hscni.net/publications/index/reports

[59] Not all cases are formal complaints. Some people contact the service with an “issue or concern” that they wish to resolve but not through a formal complaint process. The Patient Client Council state that often Complaint Support Officers can work with these clients to have the concerns or issues resolved e.g. by putting clients in touch with, or advocating on their behalf with, local Health and Social Care teams.

Table 1: Comparison of complaints activity in 2016/17 and 2018/19[60]



Activity 2016/17		Number		Activity 2017/18		Number		Difference	
Cases	Formal complaint	596	733	Cases	Formal complaint	662	881	+ 66 (11.1%)	+ 148 (20.2%)
	Issue or concern	137			Issue or concern	219		+ 82 (59.9%)	
Advice and information		1038		Advice and information		934		- 104 (10.0%)	
Total		**1771**		**Total**		**1815**		**+ 44 (2.5%)**	

- Between 2015/16 and 2016/17, the Patient Client Council observed a reduction in the number of advice and information requests (a 16.4% decrease) and a further reduction in advice and information requests from 2016/17 to 2018/19. The Patient Client Council states that it is likely that this reduction is attributable to the availability of an online self-help pack and ongoing development of online signposting on the Patient Client Council website. Improve information provision on the NI Direct website may also be having a positive impact.
- The Patient Client Council Annual Complaints report states that there is a continued shift in activity of the Complaints Support Service away from advice and information work to **case management**.
- The majority of clients of the Complaints Support Service are supported through the HSC complaints process (71.7%), 21.9% of clients are supported through an informal complaints process.
- The Complaints Support Service also support clients involved in other formal processes in operation within the HSC to investigate and resolve concerns raised by patients and the public. Table 2 below provides data on the range of other processes through which clients were supported during 2017/18.

The Patient Client Council states that it fully acknowledges that the number of complaints made by patients about services are *“small in comparison with the volume of patient interactions with HSC services throughout the year overall”.* However, it believes that *“by studying complaints and reporting this information there is an opportunity to learn and to improve services”*. The Patient Client Council states that it is committed to promoting learning from complaints to the wider HSC system including through the publication of thematic reports. It reiterates that it is also committed to sharing recommendations with various HSC Trusts and key decision makers via ongoing engagement which is aimed at influencing service improvement[61].

---

[60] Table extracted directly from Patient Client Council. Annual Complaints Report 2017-18, p4.

[61] Patient Client Council. Annual Complaints Report 2017-18, p30.

The role of the Patient and Client Council in conducting thematic reviews

The aim of these reviews is to identify learning from complaints in order that it can be used to promote service change and improvement. These thematic reports are important to the statutory function of the Patient and Client Council in relation to representing the interests of the public and reporting back to relevant HSC bodies on the views of those consulted with a view to improving the way in which services are delivered. In 2017/18 the PCC undertook three in-depth pieces of work to review themes arising from the data of the Complaints Support Service;

- ‘End of Life: Key issues arising from complaints about End of Life Care’ (April 2017)[62]
- ‘The experience of living in a nursing home: Literature review and summary of key issues raised with the Patient Client Council Complaints Service’ (June 2018)[63]
- ‘Relationships Matter: An analysis of complaints about social workers[64]’ (December 2018)

Such thematic reviews are clearly important components of advocacy in that they are independent from statutory HSC bodies. They should be free from conflict of interest so that they can represent the views of the person or persons for whom they advocate. Such reviews maintain a focus on those who are vulnerable and most at risk and provide a constructive challenge to service providers to achieve higher quality and user-led inclusive services.

The role of the Patient and Client Council in providing advice and information

Empowering individuals and groups with advice and information and the tools in which they need to speak up for themselves is key to one of the ultimate principles of advocacy which is self-advocacy. Self-advocacy is an important skill which can be used when service users (or their carers and families) seek to be listened to; when they are assessed or treated; when they are making a complaint; or in other circumstances such as developing or reviewing a care plan[65]. The Patient and Client Council should play an important part in helping people develop the skills for self-advocacy (where people can self-advocate) by providing information on their rights and advice on how they can complain and who they can complaint to[66].

In order to gain an insight into the current status of advocacy and advocacy services in Northern Ireland, the Workstream Group may wish to request a briefing from the Patient and Client Council on its role in advocacy, including

---

[62] Patient Client Council. End of Life: key issues arising from complaints about the end of life care experience – Year 2. April 2017. www.patientclientcouncil.hscni.net/uploads/research/End_of_Life_Care_27-9-17.pdf

[63] Patient Client Council. The experience of living in a nursing home: literature review and summary of key issues raised with the Patient Client Council Complaints Service. www.patientclientcouncil.hscni.net/uploads/research/1658_B4MXEc.pdf

[64] Patient Client Council & Queen’s University Belfast. Relationships Matter: an analysis of complaints about social workers to the Northern Ireland Social Care Council and the Patient Client Council. December 2018. www.patientclientcouncil.hscni.net/uploads/research/1731_qt4CwA.pdf

[65] Disability Rights UK. Self-advocacy. www.disabilityrightsuk.org/self-advocacy

[66] Patient and Client Council. Making a complaint. www.patientclientcouncil.hscni.net/making-a-complaint

examples of its recent activities/reports. The Workstream Group may also wish to ascertain whether any views have been feed into the PCC regarding the current provision independent advocacy Northern Ireland (e.g. user and independent provider experience, gaps in provision, future service needs etc.).

7. Safeguarding Board for Northern Ireland

The Safeguarding Board for Northern Ireland (SBNI) was established under the Safeguarding Board Act (Northern Ireland) 2011[67]. The primary objective of the Safeguarding Board of Northern Ireland is to *"co-ordinate and ensure the effectiveness of what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children"*. According to the SBNI website, the membership of the SBNI is made up of an independent chair, three non-executive directors and membership from the following bodies[68]:

- Health and Social Care Board
- Public Health Agency
- Health and Social Care Trusts
- Police Service of Northern Ireland
- Probation Board of Northern Ireland
- Youth Justice Agency
- Education Authority
- District councils
- National Society for the Prevention of Cruelty to Children
- A designated nurse
- Five representatives from the voluntary and community sectors
- A GP (who will be a member of the British Medical Association)

The SBNI is made up of a number of committees responsible for overseeing different areas of the Board's work, with membership representing the breadth of agencies working with children and young people[69]. The SBNI describes itself as *the key process for agreeing how children's agencies will co-operate to safeguard and promote*

---

[67] Safeguarding Board Act (Northern Ireland) 2011.

[68] Information extracted from the Safeguarding Board for Northern Ireland website. www.safeguardingni.org/meet-board

[69] Ibid.

the welfare of children in Northern Ireland and for ensuring the effectiveness of those agencies"[70].

The functions of the SBNI are as follows[71]:

- To promote awareness of the need to safeguard children and promote their welfare;
- To develop good communication between the Board and children and young people;
- To undertake case management reviews, in order to learn lessons in cases where children have died or have been seriously injured;
- To review information in relation to the sudden and unexpected deaths of children;
- To develop policies and procedures to help professionals and agencies work together more effectively;
- To arrange consultation and discussion, where appropriate, in relation to safeguarding matters; and
- To produce an annual report setting out the work of the SBNI.

What is the role of the Safeguarding Board in relation to advocacy?

Two of the key functions of SBNI is to "promote the welfare" of children and young people and to "develop good communication between the Board and children and young people". The SBNI can also conduct, e.g. by Ministerial Direction, "thematic review" on issues pertinent to child safety and child welfare[72]. These functions sit closely with many of the principles of advocacy such as empowering and enabling the voices of children and young people to be heard and safeguarding the most vulnerable members of society.

If it has not already done so, the Workstream Group may wish to consider requesting information from SBNI in regards to the operation of their functions and its impact on advocacy for children and young people. The membership of the SBNI is diverse and comprised of key organisations that have regular contact with children and young people, this may be a rich resource from which to gain information on the effectiveness of current health and social care advocacy arrangements for children and young people and to identify if further services are required.

---

[70] Information extracted from the Safeguarding Board for Northern Ireland website www.safeguardingni.org/

[71] Ibid.

[72] In September 2013, for example, SBNI received a Ministerial Direction to carry out a thematic review in relation to 22 cases of alleged child sexual exploitation in Northern Ireland. www.safeguardingni.org/thematic-review-child-sexual-exploitation

8. Northern Ireland Guardian Ad Litem Agency

The Northern Ireland Guardian Ad Litem Agency (NIGALA) was established under the Children (Northern Ireland) Order 1995 to safeguard and promote the interests of children by providing **independent social work investigation and advice** in specified proceedings under the Children (Northern Ireland) Order 1995 and the Adoption (Northern Ireland) Order 1987 (i.e. children involved in adoption or care proceedings). A key role of NIGALA is to provide effective representation of children's views and interests to the court. A Guardian Ad Litem, is an independent officer of the court, who is required to represent the interests of the child in court and to report to the Court the wishes and feelings of the child regarding the child's circumstances and preferred outcome to the proceedings[73]. The Guardian is required, for example, to[74]:

- Thoroughly investigate the child's circumstances and provide an independent recommendation to the Court;
- Appoint a solicitor to represent the child, unless a solicitor has already been appointed;
- Achieve the best possible outcome for the child;
- Assess the impact of the proceedings on the child and, if necessary, act promptly to protect the child from further stress or distress; and
- Evaluate the level, timing and the manner of state intervention in the life of the child.

The Workstream Group may wish to consult with NIGALA to ascertain whether it perceives there to be any gaps in advocacy services for children and young people.

---

[73] Information extracted from the NI Guardian Ad Litem Agency. www.nigala.hscni.net/professionals.htm

[74] Information extracted from the NI Guardian Ad Litem Agency. www.nigala.hscni.net/professionals.htm

9. Northern Ireland Public Service Ombudsman

Northern Ireland
Public Services
Ombudsman

The Northern Ireland Public Service Ombudsman's legal authority to investigate complaints (including complaints made against HSC bodies) and to make recommendations (as appropriate) is contained in the Public Services Ombudsman Act (Northern Ireland) 2016[75]. The Ombudsman is an independent role who is not subject to the direction or control of a Minister or Department; Secretary of State, nor the Northern Ireland Assembly. The Ombudsman has to the power either to investigate complaints made by a member of the public (or a Member of the Assembly acting on behalf of the complainant) or investigate a complaint on their "own initiative".

The Ombudsman has the power to investigate health and social care bodies under Sections 15, 16 and 17[76] of the 2016 Act where there:

- Is alleged maladministration through action taken in the exercise of administrative functions by the health and social care body; or
- The merits of a decision of that body to the extent that it was taken in consequence of the exercise of professional judgement.

Some examples that the Ombudsman may regard as maladministration include (this list is not exhaustive)[77]:

- Avoidable delay;
- Faulty procedures or failing to follow correct procedure;
- Unfairness, bias or prejudice;
- Giving advice that is misleading or inadequate;
- Refusing to answer reasonable questions;
- Discourtesy and failing to apologise for errors; and
- Mistakes in handing complaints.

The Ombudsman does not usually accept a complaint if[78]:

- It is made to the Ombudsman more than six months after completing the organisation's complaints procedure (unless the Ombudsman decides there are special circumstances);
- The complainant could take their case to a tribunal;

---

[75] Public Services Ombudsman Act (Northern Ireland) 2016 www.legislation.gov.uk/nia/2016/4/contents/enacted

[76] Section 15. Public Services Ombudsman Act (Northern Ireland) 2016 www.legislation.gov.uk/nia/2016/4/section/15/enacted

[77] Northern Ireland Public Service Ombudsman. Information leaflet for all authorities within the Ombudsman's jurisdiction.

[78] Ibid.

- They could have gone to court or have already begun legal action;
- The Ombudsman believes the action or decision they are complaining about was reasonable;
- It is about government policy; or
- It is about private health care.

If the Ombudsman decides to conduct an investigation, the complaint will be passed to an Investigation Team to establish if the allegations made in the complaint can be substantiated and whether there has been maladministration by the organisation. When investigating complaints about health and social care the Ombudsman may seek the opinion of medically qualified Independent Professional Advisers.

Where the Ombudsman finds that there has been maladministration, she will, if appropriate, made recommendations about what the organisation should do to put things right. She does not award compensation or penalise individuals but may decide that the organisation should issue an apology or recommend changes in practice to bring about service improvements.

The Workstream Group may wish to request further information from the Ombudsman on her role in relation to health and social care related complaints. The Workstream Group may also wish to obtain further information about the role of independent advocates in complaints. The Workstream Group may wish to explore whether there is sufficient awareness of the role of the Ombudsman amongst patients and independent advocacy organisations.

10. Northern Ireland Commissioner for Children and Young People

NICCY
PROMOTING THE RIGHTS OF
CHILDREN & YOUNG PEOPLE

The Northern Ireland Commissioner for Children and Young People was established under The Commissioner for Children and Young People (Northern Ireland) Order 2003[79]. The principle aim of the Commissioner under the legislation is to “safeguard and promote the rights and best interests of children and young persons”. The duties of the Commissioner, under Article 7 of the Order, are as follows[80]:

---

[79] The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/contents/made

[80] Article 7. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/7/made

- To promote an understanding of the rights of children and young persons, to promote an awareness of those rights; and to promote an awareness of matters relating to the best interests of children and young people;
- To keep under review, the adequacy and effectiveness of law and practice relating to the rights and welfare of children and young people;
- To keep under review, the adequacy and effectiveness of services provided for children and young persons by relevant authorities;
- To advise the Secretary of State and relevant authorities on matters concerning the rights or best interests of children and young persons.
- To take reasonable steps to ensure that children and young people and their parents are made aware of the role of the Commissioner;
- To ensure that children and young people are encouraged to communicate with the Commissioner and to seek the views of children and young people in the exercise of its functions.

The Commissioner has a number of general powers under Article 8 of the 2003 Order, i.e. the Commissioner may[81]:

- Undertake, commission or provide financial or other assistance, for research or educational activities concerning the rights or best interests of children and young people.
- After consultation with such bodies or persons as she feels appropriate, issue guidance on best practice in relation to any matter concerning the rights or best interests of children and young persons.
- Conduct such investigations as she considers necessary or expedient in relation to any of the functions of the Commissioner.
- Make representations or recommendations to any body or person about any matter concerning the rights or bests interests of children or young persons.

What is the role of the Commissioner for Children and Young People in advocacy?

NICCY plays a central role in advocating for, and promoting and protecting the rights of, children and young people in a range of settings including health and social care. The Commissioner has a significant range of powers in relation to reviewing and monitoring the functions of a range of public bodies, assisting children and young people with complaints, and investigative powers. This section outlines in further detail the powers and functions of the Commissioner.

---

[81] Article 8. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/8/made

Power to review and monitor advocacy and complaints arrangements made by health and social care bodies

Article 9 of the 2003 Order[82] sets out the general reviewing and monitoring functions of the Commissioner in relation to the operation of advocacy, complaints, inspection and whistleblowing arrangements made by a relevant authority. The purpose of any such reviews or monitoring is to enable the Commissioner to determine whether, and what extent, the arrangements have been effective in promoting and safeguarding the rights and best interests of children and young people[83].

Providing children and young people with assistance in making a complaint

Under Article 11[84], the Commissioner **may provide assistance (including financial assistance) to a child or young person in making a complaint** to a relevant authority that (a) the rights of the child or young person have been infringed by that or another relevant authority) or (b) that the interests of the child or young person has been affected by such action. However, the Commissioner shall not provide any assistance to a child unless it appears to the Commissioner that there is no other person or body likely to provide such assistance.

The Commissioner may act (a) on behalf of a child or young person to make such a complaint to a relevant authority and (b) act on behalf of a child or young person in any investigation or other proceedings conducted by that authority pursuant to the complaint. However, the Commissioner shall not provide any assistance to a child or young person unless it appears to the Commissioner that there is no other body likely to take such action.

The NICCY website states the following in relation to Article 11[85]:

> *"It has been our experience that many of the issues we would have dealt with in the past could be dealt with by other agencies so we have moved away from taking these complaints, signposting instead to a more appropriate person or body to assist the child or young person. This means that going forward we are unlikely to deal with many cases where we previously provided assistance to a child or young person making a complaint to a relevant authority. There will always be unusual cases where we do not believe anyone else provides assistance and we will continue to assist with these. However, we will now be provided more of our services under Article 12 of the Order instead".*

---

[82] Article 9. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/9/made

[83] The Commissioner for Children and Young People Order (Northern Ireland) 2003. Explanatory Memorandum.

[84] Article 11. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/11

[85] NICCY website www.niccy.org/professionals-practitioners-policymakers/legal-and-investigations/investigations/

Power to conduct an investigation into a complaint

Article 12[86] of the 2003 Order provides the Commissioner with the **power to conduct an investigation into a complaint made by a child or young person** that (a) his/her rights have been infringed by any action taken by a relevant authority or (b) that his/her interests have been adversely affected by such action. To conduct an investigation, the Commissioner must be satisfied that the complaint raises a question of principle and the *complaint does not fall within an existing statutory complaints system*.

In relation to Article 12, the NICCY website states that[87]:

> *"For a complainant this means that we can deal with such complaints but they must have already complained to the authority and exhausted any complaint mechanism available to them before referring the matter to us. If we decide to investigation the complaint we will do so on a neutral basis, being neither an advocate for the child, nor an adversary of any authority complained about. Any investigation will be carried out on a neutral basis".*

Power to conduct formal investigations

Article 16[88] of the 2003 Order provides the Commissioner with the power to conduct formal investigations and to prepare a report on that investigation. The investigation may relate to the advocacy, complaint, inspection or whistleblowing arrangements of a relevant authority. The Commissioner cannot conduct a formal investigation into a matter in respect of which they have previously brought, intervened in, or provide assistance, with legal proceedings.

What are some of NICCY's more recent comments of advocacy in a health and social care setting?

The NICCY response to the Department of Health on the Mental Capacity Act (Northern Ireland) 2016 Code of Practice provides an insight into NICCY's view on independent advocacy services for children and young people in relation to health and social care[89]:

"One of the key safeguards of the Mental Capacity Act is the provision of independent mental capacity advocates for people who lack capacity as provided for by Chapter 5 of the Mental Capacity Act. NICCY has consistently called for the

---

[86] Article 12. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/12

[87] NICCY website www.niccy.org/professionals-practitioners-policymakers/legal-and-investigations/investigations/

[88] Article 16. The Commissioner for Children and Young People Order (Northern Ireland) 2003. www.legislation.gov.uk/nisi/2003/439/article/16

[89] Northern Ireland Commissioner for Children and Young People. Response to Department of Health on the Mental Capacity Act (Northern Ireland) 2016 Code of Practice. February 2019. www.niccy.org/publications/2019/february/22/mental-capacity-act/

extension of the provision of independent advocacy services to children and young people with learning disabilities and/or mental ill health as and when required. In particular, we have called on the Government to provide independent advocacy services to children and young people when admission to hospital is being considered in the community to ensure that if possible, formal detention can be avoided and courses of action which cause least harm can be progressed. It is both surprising and confusing, given the centrality of the issue of independent advocacy services to the development of the Mental Capacity Act and the emphasis in the Act on the provision of all practical support to all people who lack capacity to make decisions, that there is no chapter in the Code of Practice on advocacy. Advocacy is mentioned only twice in the Code, one of these references relates to, 'non-statutory advocates'. NICCY would have expected the Code to refer at length to when health and social care professionals should employ the services of an independent advocate to assist people who lack capacity. The absence of any reference to the availability of independent advocates is extremely concerning.

Under Article 12 of the UNCRC, children and young people have a right to have their views heard and taken into account in matters which impact on their lives. In addition, Article 7 of the UNCPRD places an obligation on Government to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. State Parties must ensure that children with disabilities have the right to express their views freely on all matters affecting them and their views are to be given due weight in accordance with their age and maturity on an equal basis with other children. In ensuring that children and young people have these fundamental rights upheld it would be vitally important to provide them with the support of independent advocacy services. Independent advocates will be even more important for 16 and 17 years olds who, under the current, flawed version of the Code of Practice, now face additional barriers to accessing the safeguards of the Mental Capacity Act. Independent advocates will also be vitally important to this group in ensuring that the core focus of the Act for them remains as supported, as opposed to substitute, decision making. The provision of independent advocacy services to all children and young people who require this service, regardless of their age, is essential for the realisation of their right to meaningful participation without discrimination as provided for by both the UNCRC and the UNCRPD.

NICCY is aware that the Department intends to commence the Act in stages, with provisions relating to advocacy coming later in the commencement process….The effect of this would be that legislation would commence without the provision of the advocacy safeguard. Given this and the almost complete lack of reference to advocacy in the current version of the Code NICCY has serious concerns about the intentions of the Department regarding the provision of and perceived role of the advocacy service. It is NICCY's view that such an approach raises serious *questions around the compatibility of the Act with the ECHR and UNCRPD. The Department states in its letter of 26th February,*

"During the Assembly process the Bill (and subsequently the Act) was determined as being compatible with all international obligations, such as the European Convention on Human Rights and the United Nations' Convention on the Rights of Persons with Disabilities. Without such compliance the Assembly would not have had the competence to legislate and the passage of the Bill would have been stopped, either through procedures in the Assembly itself or by the Supreme Court. As this did not happen competence was assured and the Bill received Royal Assent."

The commencement of the Act without the advocacy service was not something that was considered when the Act was being subjected to scrutiny with regard to ECHR compatibility. NICCY believes that the commencement and implementation of the Act without the advocacy safeguards now raises the question of ECHR compatibility. As outlined above, access to independent advocacy is fundamental in the realisation of children's rights under this Act. ***NICCY therefore strongly advises that the advocacy provisions are commenced at the outset. NICCY will be seeking legal advice on the issue of the ECHR and UNCRPD compatibility of the Act if commenced without the advocacy provisions."***

NICCY in its response to the Patient Client Council Draft Corporate Plan for 2017-2021 recognised the role of the PCC in relation to advocacy[90]:

"We wish to highlight the specific role of the PCC in being a key statutory advocate for children and young people using health and social care services. We recognise the commitment outlined by the PCC in its draft corporate plan "to ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all health and social care services". Children and young people have an innate vulnerability because of their age and evolving capacity. In the context of the work of the PCC this means that specific measures need to be considered in order to ensure that children and young people are facilitated in having their statutory rights met. Children and young people are one of the groups most vulnerable to being discriminated against with regard to access to health care services and likely to have most difficulty in using complaints systems. In both cases this is often because services and systems are devolved by adults, for adults. It is well understood that services are more effective when they are shaped by people using them."

However, it made a number of recommendations particularly in relation to the development of a child friendly complaints system for health and social care:

"One of the four statutory functions of the PCC is to provide assistance to individuals making or intending to make a complaint relating to HSC services.

---

[90] Northern Ireland Commission for Children and Young People. NICCY response to the Patient Client Council on Draft Corporate Plan for 2017-2021. January 2017. www.niccy.org/publications/2017/january/10/patient-client-council-draft-corporate-plan/

…Alongside domestic legislation, the UNCRC is very clear that child friendly complaints systems are an important way for children and young people to have their rights realised. More specifically, good complaints processes help ensure their rights to non-discrimination (Article 2), that their best interests are a primary consideration in actions concerning them (Article 3) and to have their voice heard and taken seriously (Article 12). As a consequence, the realisation of these rights ensures that service providers are developing practice in partnership with health service users that is responsive to need.

The UNCRC general comments provide additional information on the rights of children to access an appropriate complaints system. General comment 5 sets out a range of general measures to ensure the full implementation of children's rights. This includes the importance of effective remedies for redressing rights violations that include independent complaint procedures. Furthermore, it highlights the need for child sensitive procedures for children and their representatives due to their special and dependent status which creates difficulties for them in pursing remedies for breaches of their rights.

…General comment 12 also highlights the importance of ensuring any complaints system is accessible, flexible and age appropriate:

"(…) Children need access to information in formats appropriate to their age and capacities on all issues of concern to them. This applies to information, for example, relating to their rights, any proceedings affecting them, national legislation, regulations and policies, local services, and appeals and complaints procedures."

In view of the fact that the PCC receive no complaints from or on behalf of children and young people, we would welcome any further information on any assessment the PCC have made on why this is the case, including plans you have to rectify this issue, including reaching out to children and young people and their parents/guardians to promote your services and ensure they are set up in a way that is approachable and young person friendly."

The Workstream Group may wish to consider requesting a briefing for NICCY on its role in advocacy in a health and social care setting and for its assessment of the current advocacy services for children and young people in a health and social care setting including any gaps in service provision.

11. Commissioner for Older People for Northern Ireland

COPNI Commissioner for Older People for Northern Ireland

The role of Commissioner for Older People was established under the Commissioner for Older People Act (Northern Ireland) 2011[91]. A commitment to establish a Commissioner for Older People was included in the Programme for Government 2008-11 in reaction to the increasing aging population of Northern Ireland; a greater awareness of issues relating to older people; and a recognition by the Northern Ireland Executive that there was a need to provide a 'strong independent voice' for older people. The intended outcome of the Act was to[92]:

- Create a society in which older people's voices are heard and respected and their interests and rights are safeguarded and promoted;
- To promote positive attitudes towards older people and their participation in public life;
- To establish a co-ordinated approach to matters affecting the lives of older people across all government departments and other public bodies (known in the Act as "relevant authorities";
- To promote the active participation of older people on matters affecting their interests; and
- To ensure that there are more effective ways for older people to obtain help if their interests have been adversely affected.

The principle aim of the Commissioner, as set out in Section 2 of the Act, is to *"safeguard and promote the interests of older persons"*[93]. In considering what the interests of older people are and in the course of carrying out his or her work as Commissioner, the Commission is required under the Act to take account of the United Nations Principles for Older Persons[94].

What is the role of the Commissioner in advocacy?

The Commissioner plays a central role in advocating for, and promoting and protecting the rights of, older people in a range of settings including health and social care. The Commissioner has a significant range of duties in relation to older people that are highly relevant to advocacy and complaints in a health and social care setting. The duties of the Commissioner are set out in Section 3 of the 2011 Act (duties most relevant to advocacy and complaints are highlighted in bold)[95]:

---

[91] Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/contents

[92] Commissioner for Older People Act. Explanatory Memorandum.

[93] Section 2. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/2

[94] United Nations Principles for Older Persons. www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx

[95] Section 3. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/3

- Promote an awareness of matters relating to the interest of older people and of the need to safeguard those interests;
- **Keep under review the adequacy and effectiveness of the law and practice** relating to older people;
- **Keep under review the adequacy and effectiveness of the services provided to older people by relevant authorities**;
- Promote the provision of opportunities for, and the elimination of discrimination against, older people;
- **Encourage best practice in the treatment of older people**;
- Promote positive attitudes towards older people and encourage participation by older people in public life;
- Advise the Assembly, the Secretary of State and a **relevant authority on matters concerning the interests of older people**;
- Take reasonable steps to make older people aware of the existence and function of the Commissioner and his/her functions;
- Take reasonable steps to encourage older people to communicate with the Commissioner and his or her staff and to seek the views of older people; and
- Make themselves or their staff available, as far as is practicable, at a place convenient for older people.

The Commissioner also has a wide range of powers set out in legislation that are also of relevance to advocacy and/or complaints in health and social care. Section 4(6) specifically provides for the **advocacy powers** and role of the Commissioner, i.e. *"The Commissioner may make representations or recommendations to any body or person about any matter concerning the interests of older persons".*

The general powers of the Commissioner are set out in Section 4 of the 2011 Act[96]. The general powers include:

- Undertaking, commissioning or providing assistance for research or educational activities concerning the interests of older people;
- Issuing guidance on best practice in relation to any matter concerning the interests of older people;
- Conducting investigations into any matter; and
- Compiling, providing and publishing information on matters concerning the interests of older people.

Power to review advocacy and complaints arrangements

Section 5 set out the Commissioner's **powers in relation to the "review of advocacy, complaint, inspection and whistleblowing arrangements of relevant authorities**",

---

[96] Section 4. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/4

these include health and social care bodies and organisations[97]. The Commissioner's powers under this section enable him/her to review a range of activities carried out by "relevant authorities". According to the Explanatory Memorandum of the Act the purpose of such reviews is to enable the Commissioner to discover whether the procedures that these organisations have in place have been effective in promoting and protecting the interests of older people[98]. Before, the Commission is able to use his powers under this section, he/she must first confirm[99]:

- That he/she has good reason to believe that the organisation's procedures are not working properly or are not working at all; and
- In the case of inspection arrangements, that there is no other organisation or person that is likely to review the inspection arrangements. This is to avoid the Commissioner reviewing inspection arrangements when there is already an organisation that has the legal power to undertake this and has done so or is planning to do so.

In the case where an organisation does not have appropriate procedures in place at all, the Commissioner can carry out a review to see what the effect of this is on older people.

Section 6 of the Act is similar to Section 5. Whilst section 5 enables the Commissioner to carry out general reviews of an organisations procedures, Section 6 gives the Commissioner the power to carry out such reviews whilst specifically looking at the effect of those procedures on a particular person or at a particular location. However, the Commission must confirm the two points listed above before he/she can act[100].

Power to provide assistance to enable an older person to bring a complaint

The Commissioner has the power, under Section 7 of the Act, to provide assistance (including financial assistance) to enable an older person to bring a complaint to an organisation or organisations involved. According to the Act's Explanatory Memorandum this *"includes acting on behalf of an older person both in making the complaint and in any investigation or other proceedings by the organisation or authority following the complaint".* This section enables the Commissioner to help an older person bring a complaint to the Northern Ireland Office, NI Commissioner for Complaints, the Assembly Ombudsman for Northern Ireland, the Information Commissioner and the Pensions Ombudsman. However, in deciding whether to provide assistance to an older person, the Commissioner may take account of whether there is another organisation or person likely to support the older person taking a complaint.

---

[97] Section 4. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/5

[98] Commissioner for Older People Act (Northern Ireland) 2011. Explanatory Memorandum. www.legislation.gov.uk/nia/2011/1/notes/division/5/5

[99] Information extracted from Commissioner for Older People Act (Northern Ireland) 2011. Explanatory Memorandum. www.legislation.gov.uk/nia/2011/1/notes/division/5/5

[100] Section 6. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/6

Powers in relation to the investigation of complaints

Section 8 of the Act provides the Commissioner with powers in relation to the **investigation of complaints** against "relevant authorities"[101]. The Act's Explanatory Memorandum explains the power of the Commissioner under this section as thus:

> *"Sometimes complains do not get sorted to the satisfaction of the older person making them. This Section gives the Commissioner the power to investigate a complaint made by an older person against one of the organisations known as "relevant authorities".*

To make sure that only the most serious cases come to the Commissioner, the Commissioner must be satisfied that the case raises a question of principle. The Commissioner must also check that the complaint is not covered with an existing statutory complaints system. The Explanatory Memorandum further states that:

> *"In addition in relation to the public bodies referred to in the Act as relevant authorities, if the Commissioner believed that such a body did not take action or did not, in a timely manner, adequately investigate a complaint coming under its responsibility, the Commissioner may challenge that organisation by making representations or recommendations…..(or) formally review the complaint procedures of that organisation"*[102]*.*

The Commissioner cannot carry out an investigation in a[103]:

- case where the older person involved has a right of appeal, complaint or review to a tribunal set up by law or to a court. However, the Commissioner can act if he/she believes that it is not reasonable to expect the older person to have used the right to appeal or complaint or review or to take the case to court.
- case involving criminal proceedings or civil proceedings by any person other than a relevant authority.
- case that a local or public inquiry is investigating or any case where there has been unreasonable delay in making the complaint.

Power to bring civil proceedings or assist in legal proceedings

The Commission has power, under Section 10 of the 2011 Act, to **bring civil proceedings** relating to the law or practice relating to the interests of older persons, and to **assist in any legal proceedings** which relate to the interests of older people[104]. However, the Commissioner must consider whether the case involves a question of principle and whether there are special circumstances involved. This section also provides the Commissioner with the power in any court case (except for criminal cases)

---

[101] Section 8. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/8

[102] Commissioner for Older People Act (Northern Ireland) 2011. Explanatory Memorandum. www.legislation.gov.uk/nia/2011/1/notes/division/5/8

[103] Ibid

[104] Section 10. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/section/10

to act as a “friend of the court” by giving information to the court on matters affecting older people e.g. as an expert witness[105].

__Power to conduct formal investigations__

Section 13 of the Act gives the Commissioner the power to conduct formal investigations into the actions of “relevant authorities”[106]. According to the Act’s Explanatory Memorandum the Commissioner would have the power to carry out a formal investigation of the following actions of “relevant authorities”:

- Their advocacy arrangements;
- Their complaints procedures;
- The inspection procedures to examine how they manage and treat older people; and
- Their whistleblowing arrangements.

The Commissioner also has the power to carry out a formal investigation of a complaint made by an older person against a relevant authority.

The Commissioner has previously relied upon more informal powers of advocacy and alternative dispute resolution when dealing with cases brought before the Commissioner. However, more recently the Commissioner decided to exercise his discretion to commence a statutory investigation in specific matters affecting older people in Dunmurry Manor Care. This resulted in the publication of the report “Home Truths: A Report on the Commissioner’s Investigation into Dunmurry Manor Care Home”[107]. This report makes a number of points relation to advocacy and the complaints process:

- The integrated health care system in Northern Ireland is extremely complex to navigate for the general public and many older people seek the advocacy support of the Commissioner for Older People to make and resolve complaints. The previous Commissioner make a recommendation in the 2014 Changing the Culture of Care report that complaints processes should be more accessible and visible for service users, relatives and staff.
- Through legal and advocacy casework, the Commissioner’s office has had extensive experience of the importance of effective complaints processes in care homes. Poorly handled complaints processes can lead to resentment between parties and feelings of helplessness if older people or their families feel that their complaints are not being listened to, or they do not receive adequate feedback. The evidence provided to the Commissioner shows that some families who had made serious complaints about the care given to their relatives in Dunmurry Manor, were

---

[105] Commissioner for Older People Act (Northern Ireland) 2011. Explanatory Memorandum. www.legislation.gov.uk/nia/2011/1/notes/division/5/10

[106] Section 13. Commissioner for Older People Act (Northern Ireland) 2011. www.legislation.gov.uk/nia/2011/1/notes/division/5/13

[107] Commissioner for Older People for Northern Ireland. Home Truths: A Report on the Commissioner’s Investigation into Dunmurry Manor Care Home. June 2018. www.copni.org/publications

not taken seriously, found it difficult to get their complaints addressed and were frustrated by the process. On occasions, complaints were clearly not handled in a way that met the requirements of the minimum standards.

The Workstream Group may wish to consider requesting a briefing from the Commissioner on his role in advocacy in a health and social care setting including an assessment of the current advocacy arrangements for older people.

12. Northern Ireland Human Rights Commission

NORTHERN IRELAND
HUMAN RIGHTS
COMMISSION

The Northern Ireland Human Rights Commission was established under the Northern Ireland Act 1998[108]. One of the Commission's key functions, as set out in Section 69 of the Act, is to keep under review the adequacy and effectiveness in Northern Ireland of law and practice relating to the protection of human rights. Its other statutory functions are to[109]:

- Advise the Westminster government, the Northern Ireland Executive, the Northern Ireland Assembly, and key agencies on legislation and compliance with human rights frameworks;
- To promote awareness of human rights through education, training and research;
- International treaty monitoring work; and
- Legal advice work including taking strategic legal cases.

In addition, the Commission has powers to[110]:

- Give assistance to individuals who apply to it for help in relation to proceedings involving law or practice concerning the protection of human rights;
- Bring proceedings involving law or practice concerning the protection of human rights;
- Conduct investigations;

---

[108] Northern Ireland Act 1998. www.legislation.gov.uk/ukpga/1998/47/section/68

[109] Information extracted from the NIHRC website. www.nihrc.org/about-us/what-we-do

[110] Northern Ireland Human Rights Commission. 2017 Annual Statement: Human Rights in Northern Ireland. www.nihrc.org/publication/category/Annual-statements

- Require a person to provide information and documents in their possession, and to give oral evidence, in respect of an investigation;
- Enter a specific place of detention in Northern Ireland, in respect of an investigation; and
- Publish its advice and the outcomes of its research and investigations.

What is the role of the Commission in relation to advocacy in a health and social care setting?

The Commission plays a vital role in promoting awareness of human rights, monitoring that those rights are upheld and advising government on compliance with human rights and associated international treaties. A key component of a human rights based approach is empowering people to know and claim their rights, and to increase the capacity and accountability of individuals and institutions responsible for respecting, protecting and fulfilling rights. Independent advocacy providers play an essential role in helping clients know and understand their rights, particularly during legal processes such as detention in hospital or the appointment of a guardian to make decisions on their behalf[111]. Therefore, there is a very important interface between advocacy and human rights particularly in relation to mental health advocacy (as the caption below demonstrates) and advocacy in a care home setting[112]:

RIGHTS IN THE HUMAN RIGHTS ACT PARTICULARLY RELEVANT TO MENTAL HEALTH

Right to life. Example issue: placing a Do Not Resuscitate notice on your file, without your consent

Right to be free from inhuman and degrading treatment. Example issue: malnutrition and dehydration in hospital

Right to liberty. Example issue: restraining you for long periods and for no good reason

Right to respect for private and family life. Example issue: not giving you information about your treatment or care

Right to be free from discrimination. Example issue: refusing to treat a patient because of their mental health

The Workstream Group may wish to note that the Northern Ireland Human Rights Commission's latest Annual Statement for 2018 provides some indication of its current thinking in relation to human rights in a health and social care setting. Under the section on "freedom from torture, inhuman and degrading treatment" the Statement makes reference to the findings and recommendations of Commissioner for Older

---

[111] Scottish Human Rights Commission & Scottish Independent Advocacy Alliance. Advocating for Human Rights.

[112] Extracted from British Institute of Human Rights. Mental Health Advocacy and Human Rights: Your Guide.

People NI report on its investigation into Dunmurry Manor care home. The Northern Ireland Human Rights Commission noted that this report highlighted a range of human rights issues and recommended changes in the criminal law framework to ensure that sufficient robust protection of individuals reliant on others for their health and social care needs. The Commission further recommended that the Department for Justice should prioritise the introduction of a free standing offence where an individual, who has the care of another individual by virtue of being a care worker, ill-treats or wilfully neglects that person[113].

The Workstream Group may wish to consider requesting a briefing from Commission to ascertain its opinion on whether current advocacy provision meets human rights obligations and whether it has proposals to address any gaps identified.

13. Equality Commission for Northern Ireland

Equality Commission
FOR NORTHERN IRELAND

The Equality Commission was established under Section 73 of the Northern Ireland Act 1998[114]. The Equality Commission has a statutory remit which involves[115]:

- Promoting equality of opportunity and affirmative action;
- Working towards the elimination of unlawful discrimination;
- Keeping relevant legislation under review;
- Promoting good relations between persons of different racial groups and good disability practice; and
- Oversee the effectiveness of statutory equality duties on public authorities (e.g. section 75).

The Commission’s role in Section 75 includes:

- Keeping under review the effectiveness of the duties imposed by Section 75;
- Offer advice to public authorities and others in connection with those duties;
- Carry out other functions conferred on it including approval of equality schemes;
- Preparation of guidelines; and
- Investigating complaints of failure to comply with an approved scheme.

---

[113] Northern Ireland Human Rights Commission. 2018 Annual Statement: Human Rights in Northern Ireland. www.nihrc.org/publication/category/Annual-statements

[114] Northern Ireland Act 1998. www.legislation.gov.uk/ukpga/1998/47/section/73

[115] Equality Commission for Northern Ireland. Welcome to the Equality Commission. www.equalityni.org/AboutUs

Significantly under Schedule 9, paragraph 10 of the Northern Ireland 1998, the Commission can consider complaints against public authorities alleging they have failed to comply with their approved equality scheme and it may also investigate such complaints. Under paragraph 11, the Equality Commission can also investigate public authority compliance on its own volition[116].

The Equality Commission acts as an advocate in terms of promoting and protecting the rights to equality of access and equality of opportunities in a range of settings including health and social care. The Commission can also provide legal support and advice for people who feel they have been discriminated against. Whilst many people in these cases resolve their complaint informally, the Commission can provide assistance to pursue a legal case in the county court or Industrial Tribunal. These can include cases involving alleged discrimination in relation to goods and services such as health and social care services. Further information on the Equality Commission's legal work is available to view here[117].

The Workstream Group may wish to consider requesting a briefing from the Equality Commission on (a) its legal work and how this fits in with legal advocacy; (b) its legal duties, including its power of investigation, and how this fits with/interfaces with advocacy in a health and social care setting.

14. Health and social care: professional codes of conduct

Advocacy, or behaviours and policies relevant to the principles of advocacy, are enshrined in many of the professional codes that govern the conduct of health and social care professionals. One of the most explicit in this regard is the Nursing & Midwifery Council's 'Professional standards of practice and behaviour for nurses, midwives and nursing associates'[118] that states clearly in Standard 3.4. that registered nurses, midwives and nursing associates must,

> *"act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care"*

Whilst it does not specifically include the word "advocate" or "advocacy", the Northern Ireland Social Care Council's "Standards of Conduct and Practice for Social Workers"[119] equally contains very unambiguous standards in relation to advocacy. For example:

- **Standard 1.3:** Social workers should empower service users and carers to communicate their views, needs and preferences.

---

[116] Equality Commission for Northern Ireland. Annual Report and Accounts 2017-18.

[117] Equality Commission. Our legal work. www.equalityni.org/Delivering-Equality/Legal

[118] Nursing & Midwifery Council. The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. www.nmc.org.uk/standards/code/

[119] Northern Ireland Social Care Council. Standards of Conduct and Practice for Social Workers. November 2015. https://niscc.info/registration-standards/standards-of-conduct-and-practice

- **Standard 1.4:** Social workers should, respect, and where appropriate, represent the individual views and wishes of both service users and carers.
- **Standard 1.5:** Social workers should, support service users' rights to control their lives and make informed choices about the services they receive.

Annexe 4 of this briefing paper contains extracts of some of the relevant sections of codes from the General Medical Council, the Nursing & Midwifery Council; the Pharmaceutical Society of Northern Ireland; the Northern Ireland Social Care Council; the General Dental Council; the General Chiropractic Council; the General Optical Council and the General Osteopathic Council. Whilst this is not intended to be in any way definitive, there are relevant themes across all codes that either relate directly to advocacy or are relevant to the principles of advocacy such as the protection of rights and safeguarding the welfare of the patient. For example, the codes:

- Reinforce the importance of putting the interests of the patient first;
- State that prompt action must be taken if the patient's safety or dignity has been, or may be compromised.
- This includes raising a concern or reporting an issue to an appropriate member of staff or professional body if health or social care professional becomes aware of a colleague or other health or social care professional's actions, omissions or working practices is, or may, comprise patient safety.
- All codes/standards state that a professional must take appropriate action if they have concerns about the possible abuse of children and vulnerable adults in order to safeguard their welfare.
- All codes/standards state that there must be an appropriate complaints procedure in place, and reinforce the need for professionals to listen to patients concerns and to be polite and considerate of those concerns.

The Workstream Group may wish to take note of the relevant extracts from the various codes/standards documents in Annexe 4 and may wish to consider the extent to which advocacy or the principles of advocacy are included, or need to be enhanced, in professional standards.

Annexe 1

What is advocacy?

Bamford Review Report on Human Rights and Equality of Opportunity[120]	*"Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised groups'*
Advocacy Charter Code of Practice (2018)[121]	*"Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice."* *See Advocacy Charter and Easy Read Advocacy Charter - https://advonet.org.uk/how-we-can-help-you/what-is-advocacy/*
Scottish Independent Advocacy Alliance[122]	*"Independent Advocacy is a way to help people have a stronger voice and to have as much control as possible over their own lives. Independent advocacy organisations are separate from organisations that provide other types of services. An independent advocate will not make decisions on behalf of the person/group they are supporting. The independent advocate helps the person/group to get the information they need to make real choices about their circumstances and support the person/group to put their choices across to others. An independent advocate may speak on behalf of people who are unable to do so for themselves".*
SEAP (Support Empower Advocate Promote)[123]	*"Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society are able to have their voice heard on issues that are important to them; defend and safeguard their rights; and have their views and wishes genuinely considered when decisions are being made about their lives.* *Advocacy is a process of supporting and enabling people to express their views and concerns; access information and services; defend and promote their rights and responsibilities; and explore choices and options."*
VoiceAbility[124]	*"Advocacy is about your voice being heard. Advocates support you to speak up, or they might speak up on your behalf if needed.* *An advocate can help you:*

---

[120] The Bamford Review of Mental Health and Learning Disability. Human Rights and Equality of Opportunity. October 2006. www.health-ni.gov.uk/publications/bamford-published-reports

[121] Advocacy QPM. Code of Practice. Revised Edition 2014.

[122] Scottish Independent Advocacy Alliance. www.siaa.org.uk/us/independent-advocacy/

[123] SEAP is an independent charity that specialises in the provision of advocacy and related services. www.seap.org.uk/im-looking-for-help-or-support/what-is-advocacy.html

[124] VoiceAbility www.voiceability.org/about-advocacy/

	• *Understand what your rights are.* • *Look at information about how different processes work e.g. legal, health or social services.* • *Look at any local services or community opportunities that might be useful for you.* • *Understand what choices you have and help you to make your own decision.*
NHS Scotland Independent Advocacy Guide for Commissioners[125]	*"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 nurturing trust and effectively supporting people to ensure their views are taken into account and that they are 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.* *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."*
National Autistic Society[126]	*"Advocacy is a process of supporting and enabling people to express their views, to use information and services, to find out about options and make decisions, and to make sure their rights are respected"*
Advocacy Centre North[127]	*"Independent advocacy is taking action to help you say what you want, secure your rights, represent your interests and obtain services you need. Advocates work in partnership with the people you support and take your side"*
Office of the Public Guardian[128]	*"Advocacy is taking action to help people:* • *express their views and wishes;* • *secure their rights;* • *have their interests represented;* • *access information and services; and* • *explore choices and options.* *Advocacy promotes equality, social justice and social inclusion.*

---

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

[126] National Autistic Society www.autism.org.uk/advocacyandautism

[127] Advocacy Centre North www.advocacycentrenorth.org.uk/what-is-advocacy

[128] Office of the Public Guardian. Making decisions: the independent Mental Capacity Advocate Service.

	It can empower people to speak up for themselves. *Advocacy can help people become more aware of their own rights, to exercise those rights and be involved in and influence decisions that are being made about their future.* *In some situations an advocate may need to represent another person's interests. This is called non-instructed advocacy and is used when a person is unable to communicate their views."*
Advocacy Centre North (Newcastle)[129]	*"An advocate:* • *Offers to get information on your behalf to help you come to a decision* • *Helps you explore the pros and cons of a situation* • *Helps you way up weigh up your options* • *Supports you to speak up for yourself to say what you want* • *Makes you sure you are always at the centre of decisions about you* • *Help you to feel in control* • *Is independent from service providers, your family or carers so is free to help you work out what is best for you* • *Keeps your confidence (unless there is a risk to you or someone else)"*
York Advocacy Hub[130]	*"A person may need advocacy because:* • *They feel no-one is listening to them;* • *They have an important decision to make;* • *They can't get the help they need;* • *They don't agree with decisions that are being made about them* *Advocacy can help:* • *Challenge professional decisions which are being made about you* • *Speak out on your behalf or support you to speak out* • *Tell you about your rights* • *Find out information to help you make an informed decision* • *Go to meetings and appointments with you* • *Assist you to fill in forms* • *Enable you to access specialist advice and support"*
Advonet[131]	*"Advocacy is working with you to:* • *Listen to what you want and act on your behalf at all times* • *Think about what choices you have* • *Put forward your views so that they are heard* • *Stand up for your rights and interests* *Advocacy is free, independent and confidential."*

---

[129] Advocacy Centre North www.advocacycentrenorth.org.uk/what-is-advocacy
[130] York Advocacy Hub www.yorkadvocacy.org.uk/
[131] Advonet. https://advonet.org.uk/how-we-can-help-you/what-is-advocacy/

	See Advonet video on "What is Advocacy" - https://advonet.org.uk/how-we-can-help-you/what-is-advocacy/
n-compass northwest[132]	*"Advocacy seeks to ensure that everyone in society is able to:* • *Have their voice heard on issues that are important to them* • *Defend and safeguard their rights* • *Have their views and wishes genuinely considered when decisions are being made about their lives* *Advocacy is a process of supporting and empowering people to:* • *Express their views and concerns* • *Access information and services* • *Defend and promote their rights and responsibilities* • *Explore choices and options* • *Self advocate* *Advocacy support involves:* • *Listening without judgement and respecting your views* • *Support you to understand your situation* • *Provide information about your rights and options* • *Explore possible outcomes and consequences* • *Supporting you to prepare to and put your views and wishes forward* • *Help you to communicate with professionals"*
Onside Advocacy[133]	*"the role of advocate will vary according to circumstances and needs and within the different services but is likely to include the following:* • *Obtaining information, advice and guidance and ensuring it is accessible and understandable* • *Helping people to identify and understand options and supporting them to make decisions* • *Support in meetings and through other formal processes* • *Support to make representations and complaints* • *Supporting people to access professional advice and guidance* • *Supporting the person to express their views and wishes or representing them where they are not able to do so* • *Promoting and protecting the rights and interests of people not able to give clear instructions or protect their own interests"*

---

[132] N-compass northwest www.ncompassnorthwest.co.uk/services/advocacy-service/what-advocacy
[133] Onside Advocacy www.onside-advocacy.org.uk/advocacy

Annexe 2:

What is NOT advocacy?

People with Disabilities Western Australia (PWDWA)[134]	*We are not able to:* • *Give legal advice, financial advice or assessments* • *Manage or co-ordinate services (such as applying for a service or benefit)* • *Provide people with personal care or support workers* • *Provide mediation or counselling* • *Make decisions for them* • *Investigate an organisation and take action*
Advocacy Centre North (Newcastle)[135]	*An advocate does not:* • *Give you advice about what to do* • *Tell you what they think you should do* • *Express their opinion* • *Try to convince you to do something* • *Have a hidden agenda*
York Advocacy Hub[136]	*Advocacy is not:* • *Crisis support* • *Counselling* • *Emotional support* • *Befriending* • *Giving advice*
Advocacy Orkney[137]	*"Advocates and not mediators, advisors, campaigners, befrienders, support workers or counsellors. Advocacy cannot ensure you get the result you want or decisions you do not like reversed. Our role is to ensure your voice is heard, duly considered and your rights upheld.* *Advocates cannot advise you or tell you what you should do, instead they help you understand the options you may have and what the consequences of these options might be to help you decide what you want to do.* *…Advocates cannot support any illegal practice or activity, accept payment beyond donations or fail to follow up on information that constitutes disclosure, where they believe their client or someone else involved in the case is at risk."*

---

[134] People with Disabilities Western Australia. www.pwdwa.org/advocacy.html

[135] Advocacy Centre North www.advocacycentrenorth.org.uk/what-is-advocacy

[136] York Advocacy Hub www.yorkadvocacy.org.uk/about-advocacy/

[137] Advocacy Orkney www.orkneycommunities.co.uk/advocacyorkney/index.asp?pageid=591624

Scottish Independent Advocacy Alliance[138]	*Independent advocacy is not:* - *Making decisions for someone* - *Mediation* - *Counselling* - *Befriending* - *Care and support work* - *Consultation* - *Telling or advising someone what you think they should do* - *Solving all someone's problems for them* - *Speaking for people when they are able to express a view* - *Acting in a way which benefits other people more than the person you are advocating for.* - *Agreeing with everything a person says and doing anything a person asks you to do."*

---

[138] Scottish Independent Advocacy Alliance. www.siaa.org.uk/us/independent-advocacy/

Annexe 3:

Principles for Advocacy Services – The Advocacy Charter[139]

Principle	Full Description	Easy Read Description
Independence	The advocacy provider is independent from statutory organisations and all other service delivery and is free from conflict of interest, both in design and operation of advocacy services. The advocacy provider's culture supports advocates to promote their independence with individuals, professionals and other stakeholders. Advocates will be free from influence and conflict of interest so that they can represent the person for whom they advocate.	We are separate from other services and will help you ask for things that are important to you.
Confidentiality	Information held by the advocacy service about individuals will be kept confidential to the advocacy service. The advocacy provider will have a Confidentiality Policy that reflects current legislation. It will be clear about how personal information held by the advocacy provider will be kept confidential, under what circumstances it may be shared, the organisation's approach to confidentiality in the delivery of Non-Instructed Advocacy and how the organisation responds if confidentiality is breached. Advocates will ensure that information concerning the people they advocate for is shared with these individuals unless there are exceptional circumstances, when a clear explanation will be recorded. Advocates must also be aware of situations that require making a child or adult safeguarding alert.	We will keep information about you private and safe. If we need to share information, to keep you or other people safe, we will try to talk to you first.
Person Led	The advocacy provider and advocates will put the people they advocate for first, ensuring that they are directed by their wishes and interests. Advocates will be non-judgmental and respectful of people's needs, culture and experiences.	We will ask you what you want to happen, and give you information to make choices.
Empowerment	The advocacy provider will support people to self-advocate as far as possible, creating and supporting opportunities for self-advocacy, empowerment and enablement. Advocates support people to access information to exercise choice and control in the style of advocacy support they want. Where people lack capacity to influence the service, the advocacy provider will ensure the advocacy remains person led and	We will help you to speak up for yourself.

---

[139] These standards have been extracted verbatim from National Development Team for Inclusion. The Advocacy Charterer v4. 1 May 2018. https://qualityadvocacy.org.uk/resources/advocacy-charter/

	enable those with an interest in the welfare of the person to be involved. People receiving advocacy will be involved in the wider activities of the organisation up to and including the Board.	
Equality and Diversity	The advocacy provider will have an up to date Equality and Diversity Policy that recognises the need to be pro-active in tackling all forms of inequality, discrimination and social exclusion so that all people are treated fairly. Advocates time will be allocated equitably. Advocates make reasonable adjustments to ensure people have appropriate opportunity to engage, direct and benefit from the advocacy activity.	We will treat all people fairly and with respect and make sure other people do too. We will make sure you get the support you need to have an advocate and will change things for you if you need us to. We will make sure other people treat you fairly and with respect.
Accessibility	Advocacy will be provided free of charge to eligible people. The advocacy provider will ensure that its premises (where appropriate), policies, procedures and publicity materials promote full access for the population it serves. Advocates will provide information and use language that is easy to understand and accessible to the person.	Our services are free. We will use words you can understand. We will make sure you can see your advocate in a place that is good for you.
Accountability	The advocacy provider is well managed, with appropriate governance arrangements in place, meeting its obligations as a legally constituted organisation. People accessing the service will have a named advocate and a means of contacting them. The advocacy provider will have systems in place for effective recording, monitoring and evaluation of its work, including identification of the impact of the advocacy service and outcomes for people supported. In addition, it will be accountable to people who use its services by obtaining and responding to feedback and complaints. The advocacy provider will address systemic issues in health and social care provision or other services.	We will check what we do for you, and ask you what you think.
Safeguarding	As part of supporting people to realise their Human Rights, the advocacy provider will have a thorough understanding of safeguarding responsibilities and processes as set out law and best practice guidance. The advocacy provider will have a clear, up to date policies and procedures in place to ensure safeguarding issues are identified and acted upon. Advocates support people to have their rights upheld and will be supported to understand and recognise different forms of abuse and neglect, issues relating to confidentiality and what to do it they suspect an individual is at risk.	We will make sure advocates know about your rights and how to help you stay safe.

Supporting Advocates	The advocacy provider will ensure that advocates are suitably trained, supported and supervised in their role and provided with opportunities to develop their knowledge, skills and experience, including access to legal advice where necessary. It will create a supportive culture that enables advocates to undertake their role in line with this Charter.	We will help and support advocates to be good at their job. That way they can help you to speak out.

Annexe 4:

Standards relevant to advocacy in professional codes of conduct and standards. This section touches on some of the relevant sections of the various codes, it is not intended to be fully comprehensive.

Body	Code/Guidance/Standards	Sections relevant advocacy
General Medical Council	**"Good Medical Practice"**[140]	**Paragraph 23:** To help keep patients safe you must (23c) report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person at risk; and 23(d) report suspected adverse drug reactions. **Paragraph 25:** You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised e.g. if a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight way; or if you have concerns that a colleague may not be fit to practice and may be putting patients at risk, you must ask for advice from a colleague, your defence. **Paragraph 27**: Whether or not you have vulnerable adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied. **Paragraph 34:** When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.
Nursing & Midwifery Council	**"The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates"**[141]	**Prioritise people:** you put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged. **Standard 1:** Treat people as individuals and uphold their dignity. **Standard 1.5:** Respect and uphold people's human rights. **Standard 2.3:** Encourage and empower people to share in decisions about their treatment and care. **Standard 2.4:** Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care. Standard 3.3: Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it. **Standard 3.4.:** Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

---

[140] General Medical Council. www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

[141] Nursing & Midwifery Council. www.nmc.org.uk/standards/code/

		Standard 4: Act in the best interests of people at all times. **Standard 4..3:** Keep to relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and bests interests of those who lack capacity are still at the centre of the decision-making process. **Standard 14.1:** Act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm. **Standard 16:** Act without delay if you believe that there is risk to patient safety or public protection. **Standard 16.1:** Raise, and if necessary, escalate any concern you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices. **Standard 16.4:** Acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so. **Standard 17**: Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection. **Standard 17.1**: Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse. **Standard 17.2**: Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information. **Standard 17.3**: Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.
Pharmaceutical Society of Northern Ireland	**"The Code for Pharmacists in Northern Ireland"**[142]	**Standard 1.1**: Always consider, and act in, the best interests of the patient or service user. **Standard 1.2.2:** Ensure that an effective complains procedure is readily available for the patient or service user and follow that procedure at all times. **Standard 1.2.7:** Raise a concern, at an appropriate level, if you become aware of a colleague or other healthcare professional whose actions, omissions, working practices, professional performance or mental or physical health may compromise patient safety. **Standard 4.1.1:** Listen to patients and service users, respect the choices they make about their treatment and care and respond appropriately to their needs. **Standard 4.2.3**: Encourage and seek to empower patients and service users to be knowledgeable about their medicines.
Northern Ireland Social Care Council	**"Standards of Conduct and Practice for Social Care Workers'**[143]	**Standard 1:** As a social worker, you must protect the rights and promote the interests and wellbeing of service users and carers. **Standard 1.3:** Empowering service users and carers to communicate their views, needs and preferences. **Standard 1.4:** Respecting and, where appropriate, representing the individual views and wishes of both service users and carers.

---

[142] Pharmaceutical Society of Northern Ireland. www.psni.org.uk/psni/about/code-of-ethics-and-standards/

[143] Northern Ireland Social Care Council. https://niscc.info/registration-standards/standards-of-conduct-and-practice

		Standard 1.5: Supporting service users' rights to control their lives and make informed choices about the services they receive. **Standard 3:** As a social worker, you must promote the autonomy of service users while safeguarding them as fare as possible from danger or harm. **Standard 3.1:** Promoting service users' independence and empowering them to understand and exercise their rights. **Standard 3.5:** Informing your employer or an appropriate authority, without delay, where the practice of colleagues or others may be unsafe or adversely affecting standards of care. **Standard 6.9:** Helping service users and carers to make complaints where required, taking complaints seriously and responding to them or passing them to the appropriate person including your employer or NISCC.
General Dental Council	**"Standards for the Dental Team"**[144][145]	One of the nine core principles is "Put patients' interests first' and "raise concerns if patients are at risk'. **Standard 1.1:** You must listen to your patients. **Standard 1.7:** You must patients' interests before your own or those of any colleague, business or organisation. **Standard 5.1.1**: It is part of your responsibility as a dental professional to deal with complaints properly and professionally in accordance with the complaints procedure. Standard 8.1: You must always put patients' safety first. You must raise any concern that a patient might be at risk due to e.g. the behaviour or professional performance of a colleague, any aspect of the environment where treatment is provided, someone asking you to do something that you think conflicts with your duties to put patients' interests first and act to protect them. **Standard 8.2:** You must act promptly if patients or colleagues are at risk and take measures to protect them. **Standard 8.5**: You must take appropriate action if you have concerns about the possible abuse of children and vulnerable adults.
General Chiropractic Council	**"The Code: Standards of Performance, Conduct and Ethics"**[146]	One of the eight principles of the Code is "to put the health interests of patients first". Other relevant sections include: **Standard A3:** You must take action if you have concerns about the safety of a patient. **Standard A7:** You must safeguard the safety and welfare of children and vulnerable adults, you must fulfil your legal obligation if you suspect a child or vulnerable adult is at risk from abuse or neglect. **Standard B1:** you must protect patients and colleagues from harm if your health, conduct or performance, or that of a regulated healthcare professional, puts patients at risk.

---

[144] General Dental Council. www.gdc-uk.org/professionals/standards

[145] Standards for the Dental Team applies to dentists, dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.

[146] General Chiropractic Council. www.gcc-uk.org/good-practice/

		Standard F5: you must listen to, be polite and considerate at all times with patients including any complaint that a patient may have.
General Optical Council	"Standards for optometrists and dispensing opticians"[147]	**Standard 1:** Optometrists and dispensing opticians should listen to patients and ensure that they are at the heart of the decisions made about their care. This includes assisting patients in exercising their rights and making informed decisions about their care (Standard 1.3) and encouraging patients to ask questions take an active part in the decisions made about their treatment and aftercare (Standard 1.7). **Standard 2.6:** Optometrists and dispensing opticians should be sensitive and supportive when dealing with relatives or other people close to the patient. **Standard 4.2:** Optometrists and dispensing opticians should respond with humanity and kindness to circumstances where, patients, their family or carers may experience pain, distress or anxiety. **Standard 11.1 to 11.7:** Optometrists and dispensing opticians must be aware of and comply with their legal obligations in relation to safeguarding of children, young people and vulnerable adults including considering the needs and welfare of the patient; acting quickly in order to prevent further risk of harm, and reporting concerns to an appropriate organisation.
General Osteopathic Council	"Osteopathic Practice Standards"[148]	**Standard A2:** Listen to patients and respect their concerns and preferences. Effective communication is a two-way process which involves not just talking but also listening. **Standard C9:** You should act quickly to help patients and keep them from harm. You should take steps to protect patients if you believe that a colleague's or practitioner's health, conduct or professional performance poses a risk to them. You should consider one of the following courses of action – discuss concerns with the colleague/practitioner; report your concern to other colleagues or principle of the practice; report the practitioner their regulatory body or voluntary council; report to social services or police where you have immediate or serious concerns. You must comply with the law to protect children and vulnerable adults. **Standard D7:** Be open and honest when dealing with patients and colleagues and respond quickly to complaints.

---

[147] General Optical Council. www.optical.org/en/Standards/Standards_for_optometrists_dispensing_opticians.cfm

[148] General Osteopathic Council. www.osteopathy.org.uk/news-and-resources/document-library/osteopathic-practice-standards/osteopathic-practice-standards/