PCC
PATIENT & CLIENT COUNCIL

Advocacy: A Call to Action

PCC Thought Paper

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Your Voice,
Our Journey

www.pcc-ni.net

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Foreword

Advocacy as a term has become more common in our society. It is often described in different ways. Some definitions are based in legislation and policy, other definitions are more informal and relate to the support people receive from friends, family members, professionals or organisations to have their voice heard.

What is for certain is that when people are vulnerable or something has gone wrong in their lives, providing support for them to speak up to ensure their views and wishes are heard, and that their rights are respected and taken seriously, plays a vitally important role in our society.

The PCC has a statutory duty to represent the interests of the public in Health and Social Care. We also have a duty to assist members of the public making or intending to make a complaint relating to health and social care. We deliver against this duty by providing an *independent* advocacy service to members of the public in health and social care in Northern Ireland.

Based on this experience, as well as feedback from the public and learning from a number of public inquiries[1], it is clear to us that standardised independent advocacy support is crucial to supporting quality, safety and good governance within the HSC. It is of clear benefit to individuals and families, supporting them to ensure their voice is heard, rights are protected and their issues are resolved appropriately. But it has significant potential within the HSC to help deliver an open and transparent system, improve patient safety, support staff, encourage learning and reduce costs.

There are excellent examples of advocacy support across the voluntary and community sector and beyond. And, in order to deliver a consistent and standardised approach - which ensures everyone who requires independent advocacy support can get it when they need it – the evidence tells us that we need to think systemically and on a regional basis. It is timely to evolve advocacy support in Northern Ireland towards a regional approach, trusted by the public, genuinely independent, clearly defined and understood, easily accessed and consistently delivered to agreed standards. This thought paper seeks to begin a conversation on what independent advocacy is, what a standardised, regional approach should look like and how this should be valued by, and integrated into, the HSC system. It sets out steps to achieve this. We recognise that transformation will not happen overnight but PCC are committed to using our statutory functions as the foundation to lead in this area, focused on setting out a blueprint for incremental change.

M. Monaghan

Meadhbha Monaghan
Chief Executive

[1] The Muckamore Abbey Hospital Inquiry report, published 18th June 2026, recommends (R20) that 'Properly trained independent advocates should be made available to service users and families to support effective communication with staff and for raising concerns and complaints...'

Advocacy and PCC's Statutory Role

The PCC is a statutory corporate body established in 2009 to provide a **powerful, independent voice for patients, clients, carers, and communities on health and social care issues within Northern Ireland**, through the exercise of its legislative functions which are:

- Representing the interests of the public;
- Promoting the involvement of the public;
- Providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care
- Promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of services; and
- Undertaking research into the best methods and practices for consulting and engaging the public[2].

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

Paragraphs 6.40 to 6.42 of the HSC Framework Document (2011) further outlines the independent challenge function the Department conferred on the PCC.

PCC meet our statutory duties through a strategic and operational delivery model[3] of policy advocacy, collective advocacy and independent advocacy. This thought paper and call to action is a function of PCC's statutory role within the health and social care system. It represents a culmination of evidence and insights from PCC's practice, representation to recent reviews and Public Inquiries and critically, what we have heard from working directly with people.

The families affected by the recent Muckamore Abbey Hospital Inquiry made clear that they wanted to see strong, independent advocacy services[4] and asked the Inquiry to endorse the recommendations set out by PCC in PCC's statement to the Inquiry of March 2024[5]. The Muckamore Abbey Hospital Inquiry report, published 18th June 2026, makes a recommendation (R20) for DoH/SPPG that 'Properly trained independent advocates should be made available to service users and

[2] Health and Social Care (Reform) Act (Northern Ireland) 2009. Accessed here: Health and Social Care (Reform) Act (Northern Ireland) 2009
[3] PCC (2026) *PCC Support* Accessed here: PCC Support
[4] Muckamore Abbey Hospital Inquiry report: "Families say the time for accountability and lasting change is now | Phoenix Law
[5] AFM-SPFM Closing Submission.pdf pg 51, para 157

families to support effective communication with staff and for raising concerns and complaints. DoH/SPPG should specify the level of advocacy services required for people with learning disabilities in the annual commissioning plan.'

The Role of Advocacy

Advocacy seeks to support individuals to express and have their views heard. It can be defined as acting to help people say what they want, secure their rights, represent their interests and obtain services they need[6].

> *"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**

What is *independent* Advocacy?

Independent advocacy is ***structurally, financially and psychologically independent*** from service providers and other services. This entails that the advocacy provider is a separate organisation in its own right, with funding sources and operating models that are 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.
- **Financial**; an independent advocacy organisation has sources of funding that do not cause any conflict of interest, and which do 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 in mitigating these.

Independent Advocacy can and is provided through a range of models which are helpfully outlined by the Scottish Independent Advocacy Alliance: Types of independent advocacy

[6] Combination of definition on PCC website and from Department of Health (2012) '*Developing Advocacy Services - A Policy Guide for Commissioners'* Accessed here: Developing advocacy services - A policy guide for commissioners - Action Plan 2012/2013

"Independence is what makes independent advocacy work. Independent advocacy organisations must be structurally, financially, and psychologically independent from service providers and statutory organisations. This freedom from conflicts of interest enables advocates to support people's views and wishes, even when these conflict with professional opinions or perceived risk".

SIAA Independent Advocacy 2026 Manifesto

siaa.org.uk

In the present day the primary sources of advocacy support to service users and families within the NI Health and Social Care sector are:

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

b) A number of voluntary and Community sector organisations which are directly commissioned by HSC Trusts to provide advocacy services. This may include a range of other provider 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"* commissioned by the HSCB/SPPG

There are also a number of statutory bodies[7] including the Commissioners, which service users can approach for support both within and outside the area of Health and Social Care.

PCC Support' is PCC's independent advocacy and support model. It focuses on ***relationship building*** *and a* ***partnership approach****, putting the voice of the person at the centre of our work. This approach uses* ***advocacy and mediation skills*** *on an individual and group basis, to enable us to provide assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care in the most effective way.*

[7] Commissioners including: Northern Ireland Public Services Ombudsman (NIPSO), Commissioner for Older People Northern Ireland (COPNI), Northern Ireland Commissioner for Children and Young People (NICCY), Commissioner for Victims of Crime Northern Ireland, Mental Health Champion for Northern Ireland (MHCNI).

The value and benefits of independent advocacy

The NI Health and Social Care Service is a complex system, which is currently under significant financial and operational pressure. The public can face considerable, and intractable, challenges when navigating their care. These challenges amplify when something has gone wrong. Independent advocacy offers significant value in response:

"Independent advocacy is about speaking up for and standing alongside individuals or groups, without being influenced by others' views. It addresses barriers and power imbalances, ensuring people's human rights are recognised, respected, and secured."

The Scottish Independent Advocacy Alliance

Enablement and Rights - First Line of Defence for Vulnerable People

- Listening to and hearing people and family's experiences should be the first line of defence when safeguarding vulnerable people. To truly listen to understand, organisations, systems and structures must critically be able to demonstrate how listening to experience is contributing to institutional and systemic change, improving the quality and safety of services for others. Independent Advocacy plays a key role in ensuring organisations listen for patient safety.
- Independent advocacy can support and safeguard 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. It can assist in addressing health inequalities.
- It can enable people who need a stronger voice by supporting them to express their own needs and make their own decisions, especially when people are dealing with trauma.
- It can enable people to gain access to information, explore and understand their options, and to make their views and wishes known.
- Independent Advocates can speak up on behalf of people who are unable to do so for themselves."[8]

Independent advocacy can help the public and HSC providers to solve problems together and reach mutually beneficial outcomes.

[8] Adapted from NHS Scotland. (2013) Independent Advocacy Guide for Commissioners. Accessed here: Independent Advocacy Guide for Commissioners

Key role in Governance and Assurance

- Independent advocacy assists in creating a culture of openness, transparency and learning. If acknowledged as the asset it is and embraced as part of an open, just and learning culture, it can play a fundamental role in HSC organisation's governance, assurance and quality frameworks and standards.

- Appropriately supported and embedded, independent advocacy services can provide a level of assurance that HSC Trusts and organisations are committed to being learning organisations, committed to meeting their Statutory Duty of Quality, are appropriately invested in the Duty of Candour and, most importantly, to protecting patients and the public.

Timely Resolution and Psychological Safety

- Independent Advocacy can bring members of the public and HSC organisations together to resolve concerns and complaints, preventing unnecessary escalation. Independent advocacy and timely resolution can reduce the psychological toll on healthcare professionals and support a more constructive, less punitive working environment.

- Independent Advocacy focused on timely resolution contributes to an open and learning culture. By addressing concerns and complaints promptly, staff are more likely to view feedback as an opportunity for improvement rather than a threat, which enhances engagement and professional development[9].

- Timely resolution of concerns and complaints can reduce the number of lengthy processes and costly litigation, saving HSC organisations and the public money.

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[9] Findings from DoF Innovation Consultancy Service review of PCC Early Resolution Model – report forthcoming in 2026;

NHS Improvement (2018) *'Patient experience improvement framework'* Accessed here: nhsi-patient-experience-improvement-framework.pdf;

National Institute for Health and Care Research (2024) *'Harnessing the power of language to enhance patient experience of the NHS complaint journey in Northern Ireland: a mixed-methods study'* Accessed here: Harnessing the power of language to enhance patient experience of the NHS complaint journey in Northern Ireland: a mixed-methods study;

Healthwatch (2025) *'A pain to complain Why it's time to fix the NHS complaints process'* Accessed here: Briefing;

NHS (2026) *'NHS Resolution homepage'* Accessed here: Home - NHS Resolution

Advocacy in Northern Ireland today - the Case for Change

A historically closed system

We recognise the recent efforts of the Department of Health and the HSC system to advance openness, transparency and learning to improve patient safety and public trust. When the expected routine of governance, regulation, complaints, SAI's and Lookback Reviews have historically failed, the public have called for the most serious and visible form of investigation and reform through a Public Inquiry. In the last 10 years, there have been five Public Inquiries into failures in health and social care in Northern Ireland, including Hypernatremia, Neurology, Muckamore Abbey Hospital, Urology and the UK Covid-19 Inquiry.

Each Inquiry has explored systemic issues related to culture, leadership, resourcing, decision-making, performance, governance and safeguarding rather than isolated, individual mistakes. This has resulted in a significant loss of trust in the system[10] and calls for significant structural reform and the creation of a new relationship with the public[11].

Throughout, service users and families have highlighted their experience of a system that had poor governance stemming mostly from a lack of oversight and more critically a lack of openness to listening to their experiences, insights and concerns. They described organisational defensiveness, unheard voices, resistance to facilitating their engagement and limited support to challenge decisions constructively.

The public should be partners not bystanders

The public are frustrated at how health and social care can be slow to acknowledge harm, engage directly with families and be open to conversation and constructive challenge. PCC believe that there is an urgent need for a different relationship with the public, a stronger, more systemically integrated public voice, more transparent governance and a rethink on how assurance is sought, managed and monitored. Independent Advocacy has a key role to play in this change.

[10] Deloitte (2026) *'State of the State 2026'* Accessed here: State of the State UK 2026 | Deloitte UK, also relevant PCC (2025) *'What the Public Think'* Accessed here: what-the-public-think-key-findings-from-a-pcc-attitudinal-report-on-people-s-experiences-of-health-and-social-care-and-winter-pressures.pdf

[11] PCC and NICON (2025) *'People to Partner Developing a Unique Approach for Northern Ireland'* Accessed here: people-to-partners.pdf

A history of partial commitment and patchwork provision

Over the past four decades, the call for independent advocacy provision for service users and families in Northern Ireland has been repeatedly articulated in a wide range of inquiries, reviews and reports. Advocacy has been cited in pieces of legislation and has been considered in certain policies and procedures, but a regional approach or strategy has never been clearly defined or implemented. Commitment to a regionally supported advocacy system or structure does not currently exist in Northern Ireland, which has consequences for the public and the wider HSC system.

A table at **Appendix 1**, summaries key reviews and inquiry reports over the past four decades that have repeatedly recommended strengthening independent advocacy. The reports identify the potential opportunities and implications independent advocacy has for governance, assurance, increasing public voice and confidence.

> *"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".*
>
> **PCC Evidence Submission to MAHI 4 March 2024**

A post-code lottery and confused picture for the public

At present, each HSC Trust can and does commission their own advocacy services. Whilst they are to be commended for this investment; the unintended consequence is fragmented provision in which a postcode lottery exists. Predominantly, advocacy services are not commissioned on a regional basis, to an agreed, or, required standard, with related training, support and governance mechanisms. This compounds the disjointed nature of provision, but it also means the public do not know what to expect from advocacy services or how to engage to achieve best outcomes. There is also limited information for the public on what options are available to them.

> *"The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which dilutes the true independence of the service"*
>
> **Evidence to MAHI from third sector advocacy provider**

An added consequence of this, is that HSC organisations are currently not maximising the potential value of data, insights, intelligence and learning that advocacy services can provide for them. Governance, assurance and quality mechanisms do not routinely or systematically consider the evidence available from advocacy providers and services.

The current approach weakens independence

Each HSC Trust currently can and does directly commission their own advocacy services. The majority of this is delivered in the voluntary and community sector. The consequences of this approach can be a dilution of the independence of advocacy provision, arising from conflicts in the provider/commissioner relationship.

Financial, structural and psychological independence are interdependent and interrelated. Independence is contingent on, and strengthened by, all three conditions being met.

Northern Ireland is a small community. People are often connected through professional background and close cross-sectoral working relationships, which have been built up over many years. This can and does impact and influence psychological independence. Understanding and ensuring psychological independence in the decision-making process and particularly when needing to hold others to account is vital. In this context, psychological independence, that is independence of mind, must be given particular consideration going forward and has informed PCC's proposals for change.

"...[it] needs total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome".

PCC Closing Submission to MAHI

17 February 2025

Proposals for Change

The structure and nature of provision in Northern Ireland currently means that the advocacy service continuum experienced by service users and families is ***fragmented and uncoordinated***, leading to confusion and disorientation. In this thought paper, PCC are prompting thinking on the need for a dynamic shift in public policy, commissioning, culture and practice.

The following proposals are key components of what we consider is required, on the journey towards a regionalised approach to independent advocacy in Northern Ireland.

"Individuals and their families need a strong, effective advocacy service that is well-known and proactively made available."

Closing statement of Action for Muckamore Society for Parents and Friends of Muckamore Abbey

I. Work Regionally, Act Locally

Create and Develop an Independent Regional Support and Standards Structure

A new independent regional support and standards structure for advocacy providers would connect current advocacy service providers together, creating improved connections and adding value through a networked approach, becoming "*more than the sum of the parts".* It would also assist in providing the public with clear information on the advocacy services available and support in how to access them[12].

Establishing an independent regional support and standards structure for advocacy has the potential to create a ***culture of connectedness*** and a mechanism to:

- Develop and support new advocacy public policy and practice;
- Develop a skilled, stable advocacy workforce;
- Develop a regional training framework to include trauma informed practice, rights, participation, supervision and support;
- Develop a regional framework for quality, data and learning.
    - Consistently, robustly and routinely collecting data and intelligence from independent advocacy support, focused on complaints, safety incidents and reviews has significant potential to mitigate risk and contribute to quality and safety assurance across the HSC. The data and subsequent analysis should be integrated into current HSC processes, giving a more extensive in-depth overview to HSC Trust governance and assurance practices.
- Agree a requirement that systemic and recurrent issues identified by independent advocates, e.g. recurring rights breaches, unsafe care or placements are escalated to the regulators or NIPSO; and
- Develop a whistleblowing policy and protections for individual advocates.

II. A shift in how advocacy services are commissioned - towards Regional Independent Advocacy Services

The benefits of advocacy services to individuals, families and the HSC system will be fully actualised if advocacy services are truly independent, and structured and supported to be so. This requires a change to the current commissioning processes. PCC considers the following should underpin the provision of independent advocacy services within the Health and Social Care system:

[12] The Scottish Independent Advocacy Alliance (SIAA) siaa.org.uk has been funded from its establishment in 2002 by the Scottish Government. SIAA exist to ensure that advocacy is of the highest possible standard and is available to anyone in Scotland. A similar body does not exist in NI, England, Wales or the Republic of Ireland.

- Advocacy services should be commissioned as regional services;
- Advocacy services should be commissioned independently of HSC Trusts;
- Advocacy services should be commissioned on the basis of agreed standards and requirements, which drive service specification content. Standards may include:
    - Practice standards
    - Safeguarding standards
    - Regulation of services and workforce standards
    - Minimum data set requirements for system reporting/learning and service provider performance

> *"if you're receiving funding and you're in a contractual relationship with the Trust, it does make it difficult to feel totally independent of them, and we would prefer to have some kind of arm's length arrangement where the funder or commissioner is not the Trust"*
>
> **Evidence to MAHI from a third sector provider of advocacy services**

- Access to independent advocacy services should be client-led and not dependent on a referral by HSC Trust. The decisions about 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 in conjunction with the service user, patient and family concerned;

- Given PCC's unique independent statutory role and function within the HSC, service specifications should detail how service providers relate to the Patient and Client Council in the discharge of its statutory functions (where the PCC is not the provider or commissioner of the service);

- An Independent Regional Support and Standards Structure would assist in the development of standards and requirements and provide support to advocacy service providers to meet those standards.

III. An HSC and regulatory system which embraces and embeds independent advocacy as an asset

To fully actualise the potential benefits of a regional independent advocacy approach, the HSC system and the regulation of healthcare has to fully value, embrace and integrate independent advocacy services into their policies, practices and structures, including governance and assurance mechanisms. PCC considers the following actions can and should be undertaken to achieve this:

- Trusts should invest in training and awareness raising with their staff to enhance their understanding of the role and importance of independent advocacy and what is expected of them to ensure independence. This should include an element of joint training with advocacy providers to explore the mechanics of structural, financial and psychological independence. Training should also focus on the potential benefits of resolution focused advocacy.

- The public require a clear and simple understanding of the safeguarding processes within the HSC. This is different to understanding the complaints process. A plain English leaflet and clear map of the following should be developed:
    - Independent Advocacy Support available
    - How to raise a safeguarding concern and who to contact
    - How a safeguarding matter will be investigated, how it will be addressed and how remedial measures and learning will be identified and actioned to prevent a repeat of any identified safeguarding incidents in the future
    - How to escalate, to an independent resource/officer, concerns if a member of the public or an advocate consider they are not being heard or having their safeguarding matter addressed appropriately

- Independent advocacy data and intelligence should form a key part of Trust Boards' governance and assurance practices. Oversight and assurance is about Trust Boards weighing up the evidence, including from independent sources, and determining for themselves that quality standards, openness and patient safety are being met. Independent Advocacy data and intelligence holds a rich resource of thematic analysis in this regard.

- Independent Advocacy should be hardwired into the HSC's patient safety and accountability machinery. This includes being built into HSC complaints and reviews, regulatory inspections and regulation in general.
    - System regulators and regulators of healthcare professionals should consider advocacy evidence, patterns of issues, barriers, rights breaches and incidents in their investigations, judgements (when appropriate) and emerging concerns protocols. Advocacy organisations should have formal routes to escalate individual and systemic concerns to regulators.

What does success look like?

Success is a measurable shift from the current fragmented service provision to one where advocacy is systematically embedded into the culture, language and day to day practice across Health and Social Care, resulting in tangible benefits for the public and the system alike. Indicators include:

- Advocacy services are independent, meaning they meet the conditions of structural, financial and psychological independence, and are trusted as such;
- Independent Advocacy is knitted into the language, practices and culture within health and social care - with shared understanding and expectations between the public, health and social care staff and advocacy providers;
- Everyone who needs independent advocacy can access it quickly and easily, no postcode lottery, no gatekeeping, clear accessible information;
- Independent Advocacy is embedded in key decision points;
- The Independent advocacy workforce is skilled, stable and valued;
- The system learns from independent advocacy and, most importantly, acts on it;
- Regional data, insights and intelligence are co-ordinated and shared, with patterns identified and learning disseminated;
- The public can describe how earlier intervention through advocacy reduces harm and improves the outcomes for them;
- Public confidence and trust in services increases;
- HSC staff view feedback, concerns and complaints more as an opportunity for improvement and learning rather than a threat, enhancing engagement, professional development and psychological safety;
- A potential reduction in lengthy complaint processes and litigation, and associated costs;
- Advocacy is recognised as a cornerstone of a fair and accountable system; and
- Advocacy is delivered to regionally agreed standards, supported by appropriate regional oversight and governance e.g. for example The Advocacy Quality Performance Mark[13]. This is a formal accreditation that confirms an organisation delivers advocacy to a high, consistent and safe standard.

[13] National Development Team for Inclusion (2026) *'Advocacy QPM homepage'* Accessed here: https://qualityadvocacy.org.uk/

Conclusion – An Ambitious Vision

With 40 years in the waiting, it is time to be ambitious because only bold, systemic change can provide the decisive action required to hardwire independent advocacy into our complaints, patient safety, openness, governance and assurance processes. It is time to build the infrastructure that will support a skilled, professional and independent advocacy workforce that can be of significant benefit to the public and the health and social care system alike.

Whilst Northern Ireland has come a long way, our history has evidenced selective implementation of recommendations across the decades. Decisive action requires collaboration and synergy but the prize is "*more than the sum of its parts".* The public and the HSC system are eager for change.

Appendix 1

Independent Advocacy: 40 years in development and waiting

Over the past four decades, the call for independent advocacy provision for service users and families in Northern Ireland has been continually articulated in a wide range of inquiries, reviews and reports. A regional strategy with commitment to a regionally supported advocacy system or structure does not currently exist in Northern Ireland.

The table below summaries key reviews and inquiry reports over the past four decades that have repeatedly recommended strengthening advocacy and establishing independent advocacy. Each report identifies the potential implications independent advocacy has for governance, assurance, increasing public voice and confidence.

1986	Forty years ago, the Mental Health (NI) Order 1986 legislated to provide independent advocacy support and recognised the critical need for independence voice. The legislation was subject to a phased implementation, with the provision of advocacy support evolving as an ad hoc and fragmented system of support throughout the intervening period[14].
2002-2007	The Bamford Review[15] (2002-2007) established that the voice of service users and carers must be central to health and social care, grounded in human rights, participation and lived experience. The Review was grounded in Human Rights and equality obligations (NI Act 1998, Human Rights Act) and a focus on social inclusion and independence. This approach implicitly requires advocacy because service users and carers must be supported to understand and exercise their rights and implicitly requires independent support because of the vulnerability and power imbalance.
2012	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*", which described the context for the provision of advocacy services at that time and specifically detailed the various voluntary and community sector organisations providing

[14] See COPNI 2025: Freedom-Care-and-Wellbeing.-Review-of-Deprivation-of-Liberty-Safeguards.pdf
[15] The Bamford Review of Mental Health and Learning Disability (2006) *'Human Rights and Equality of Opportunity'* Accessed here: www.health-ni.gov.uk/publications/bamford-published-reports

advocacy services in each Trust area for Mental Health and Learning Disability services[16].

Subsequently in May 2012 the Department of Health published new guidance for HSC Trust commissioning of advocacy services[17] "*Developing Advocacy Services - A Policy Guide for Commissioners*". 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.

2014 The Advocacy Network for Northern Ireland, (ANNI) supported by the Health and Social Care Board provided a collaborative forum for advocacy organisations within the Voluntary and Community Sector. The goal was to promote and develop shared standards, training opportunities and have a space to share, explore and develop advocacy practice. This signalled the emergence of a networked, collaborative approach and ***a regional infrastructure***, though it no longer exists as a formal network. In June 2014, ANNI published a "*Code of Practice for Independent Advocates*".

2016 A follow up report by RQIA (2016) *"Review of Advocacy Services for Children and Adults in Northern Ireland"* highlights a number of issues and recommendations for improvements in the service stating:

"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; and*
- *There is no process for regulation of providers of advocacy services or for individuals undertaking advocacy".*

The report further 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*

[16] RQIA (2012) '*Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland*'
[17] Department of Health (2012) '*Developing Advocacy Services - A Policy Guide for Commissioners'* Accessed here: Developing advocacy services - A policy guide for commissioners - Action Plan 2012/2013

each independent advocacy organisation, which is heavily influenced by funding and type of contract.

2018 With the publication of the Inquiry Report, into Hyponatraemia-Related deaths (IHRD) the recommendations established the need for service users, and families to have access to independent advocacy support. Specifically, recommendation 37 (iv) sets out how '*Trust(s) should seek to maximise the involvement of families in SAI investigations and in particular: a fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases'*.[18]

2022 The Independent Neurology Inquiry[19] (2022) found that service users concerns were raised but not effectively heard or acted upon. There were clear failures in escalation, communication and governance. Patient safety and oversight was severely compromised with the concerns neither being heard or escalated. Going forward the implementation of independent advocacy would provide for a continuous patient voice, structured feedback into governance and ensure patient and service user engagement in assurance processes.

2020 Present day, in Muckamore Abbey Hospital Inquiry evidence and hearings, service users and families described situations in which they felt that they were ignored when they attempted to alert hospital staff, regulatory agencies, and other authorities about their concerns regarding patient care and treatment of their loved ones in Muckamore Abbey Hospital. This pointed to how families and service users experienced trying to be heard and alerting safeguarding matters. Initial complaints may have been safeguarding matters and required a clear process and rapid response to address, which is different from the complaints process.

Evidence given to the MAHI Inquiry[20] by a third sector advocacy provider illustrated the challenges and consequences when advocacy is not truly independent stating that:

[18] Inquiry into Hyponatraemia related Deaths (2018) '*The Inquiry into Hyponatraemia-related Deaths Report'* Accessed here: Full-Report.pdf

[19] Independent Neurology Inquiry (2022) *'Independent Neurology Inquiry Report'* Accessed here:

[20] J. Marley (2024) *'Muckamore Abbey Hospital Inquiry Witness Statement.'* Accessed here: M01 - 01 - Marley, Jo - Statement.pdf

"The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which ***dilutes the true independence of the service***" and that it "...*needs total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome".*

Clearly articulating the conflicts in the commissioner / provider relationship it was stated that:

"*if you're receiving funding and you're in a contractual relationship with the Trust, it* ***does make it difficult to feel totally independent of them****, and we would prefer to have some kind of arm's length arrangement where the funder or commissioner is not the Trust".*

2025 Serious Adverse Incident Redesign Programme[21]. The PCC welcomed the consultation and the opportunity to respond to the Framework for Learning and Improvement from Patient Safety Incidents Consultation, which is set to replace the current Serious Adverse Incident (SAI) Procedure in Northern Ireland. PCC submitted a report on what we heard during this event to the Department of Health and published the report, which can be found on our website. In the context of Patient Safety Incidents, the PCC believes that the Advocacy Service which is consistent with the recommendations of the Hyponatraemia Inquiry Report, should first and foremost, attend to the needs of families engaged in PSI reviews through ensuring:

- Recognition, understanding and response to the emotional needs of families (for example when people are bereaved)
- Accompanying families through the review and being by their side throughout (including, for example, reading through SAI reports with families when they receive them)
- Provide expert advice and information about the Serious Adverse Incident review process to enable families to understand what is going on and to enable families to make decisions and to ask questions.

2026 The Muckamore Abbey Hospital Inquiry report, published 18th June 2026, acknowledges the importance of independent advocacy throughout its report, whilst making commentary on weaknesses in existing provision. It makes a recommendation for DoH/SPPG (R20)

[21] Department of Health (2025) *'Framework for Learning and Improvement from Patient Safety Incidents Consultation'* Accessed here: Framework for Learning and Improvement from Patient Safety Incidents Consultation | Department of Health

that ‘Properly trained independent advocates should be made available to service users and families to support effective communication with staff and for raising concerns and complaints. DoH/SPPG should specify the level of advocacy services required for people with learning disabilities in the annual commissioning plan.’[22]

[22] Muckamore Inquiry Report June 2026 (Electronic Version).pdf

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