

Neighbourhood Model

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BY EMAIL ONLY

Dear Sir/Madam

Ref: Call for Evidence - Northern Ireland Neighbourhood Model of Care

In July 2025 the Health Minister published the [Health and Social Care NI Reset Plan](#) which included the following commitment to neighbourhood care:

“By March 2026, working with partners we will have developed a new neighbourhood model for primary, community and social care, which will deliver greater levels of care for citizens, including children and families, in their communities, alongside a funding plan to support delivery from April 2026. This model will see Community Pharmacy, GPs and their Federations, Voluntary and Community organisations, Trusts, independent providers, other statutory bodies and Local Government working closely together in formal partnership to provide integrated care”.

In our response to the Programme for Government the PCC stated that the public are experts, by experience, in the care they or someone they care for has received. This experience and expertise should not be lost to the system, and if appropriately utilised, the public can add significant value to delivering on HSC reform and the reform agenda across the Executive.

The PCC welcomes the Reset Plan and the proposed new model of primary, community and social care, which aims to deliver greater levels of care for the public within their communities and the proposed provision of integrated care. In particular, the efforts to obtain, define, collate and create a compendium of evidence-based neighbourhood practice initiatives which will be available and published on Department of Health's website, which will assist in informing the public of examples of best practice.

In order to deliver on the five key impacts of Improved health outcomes; greater patient and carer satisfaction; reduced GP/unplanned hospital admissions and more efficient and sustainable use of resources and obtaining stronger community resilience; PCC believes that transforming the Health and Social Care System, and improving the health and wellbeing of the population, can only be achieved through genuine partnership with the public.

There is a need to listen to the public, to understand how they currently experience services, what they need and their ideas about reform. There is also a requirement to inform the public of plans (local along with regional), manage expectations and alleviate unnecessary fears. The public should also be appropriately engaged in the development of all aspects of public health, including preventing disease, prolonging life, and promoting health through the organised efforts of society.

Through their lived experience, the public know what their needs and those of their communities are, what has worked and what has not. Understanding people's and communities lived experiences by working in partnership with them is crucial to tackling the persistent problem of health inequalities. When working in partnership, the principle of reciprocity, the need to ensure diversity and acknowledged access issues are vitally important.

PCC believe the Neighbourhood Model of Care should exist within the broader strategic whole system approach, within Health & Social Care NI, as reflected by the recommendations drawn out of the PCC People to Partners initiative.

The Neighbourhood Model of Care call for evidence links to two of the legislative functions of PCC in that we are tasked to:

- promote the involvement of the public; and
- undertake research into the best methods and practices for consulting and engaging the public.

PCC have been making for a more strategic approach to public participation, and for building a new relationship with the public, through which healthcare and wider public services, 'does with' (and not 'to') to collectively tackle the challenges we face. Our response focuses on:

1. Our 'People to Partner' report in utilising the agency of citizens which includes the relationship that people in NI have with their own health, giving them more agency to stay healthier and enabling the HSC to provide the right care when they need it.
2. We feature our award-winning initiative PCC 'Support in the Community', an initiative set up to combat health inequalities by reaching out to those hard to reach members of the public who may not usually access services.
3. We have set out our work with Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) on the Big Discussion Workshops which included PCC recommendations on a phased approach and the commissioning of an Attitudinal Poll via LucidTalk, leading to a key findings regional baseline report of 'What People Think' with a view to informing and supporting the Minister for Health's 'HSC Reset Plan'.
4. PCC have also included in this response key considerations such as Remuneration and Reciprocity, ensuring that people receive 'something back for putting something in', building upon the premise of recognising and valuing people's contribution in sharing their lived experience.

And finally, the importance of the provision of Independent Advocacy, a key recommendation of the IHRD Report, Recommendations 34, and 37 (iv) that the public should have access to independent advocacy support. Access to and the provision of structurally, financially, and psychologically independent advocacy support, is vital for the HSC system as a whole and the outworking of the Neighbourhood Model of Care within it. Having systems and structures, that are accessible, and promote and maximise openness, patient outcomes, purpose, quality and safety of services, with appropriate governance and assurance are essential in the effective delivery of all models of care.

In order for any Neighbourhood Model of Care to deliver on the five key impacts referred to above, improved health outcomes, greater patient and carer satisfaction, more efficient and sustainable use of resources and obtaining stronger community resilience; it will be essential that there is an understanding of the public and their needs, the current challenges and how they will be supported. That the public have a clear understanding of what the Neighbourhood Model of Care will look like and how it will operate in practice.

1. People to Partner Initiative

Our People to Partner¹ report explores the development of a unique approach to building a new relationship with the public, harnessing energy and agency of citizens as assets to reset and reshape the agenda. The essence of 'Do With' (and not just for) is encapsulated in a number of approaches. In exploring what 'Doing with' entails, Adam Lent argues that the core practices these approaches have in common include:

- Deep understanding – an effort to build a deeper understanding of the people with whom the public sector engages;
- Versatile response – developing approaches that are truly versatile, meeting the preferences and particularities of individuals or groups;

¹ Northern Ireland Confederation for Health, and PCC (2025) *People to Partners – Developing a Unique Approach for Northern Ireland*, Accessed here: [people-to-partners-final-for-print-081025.pdf](#)

- Collaborative delivery – developing and delivering approaches in close collaboration with the individuals and groups organisations serve, rather than assuming the public sector knows best.

PCC and the Northern Ireland Confederation for Health and Social Care (NICON) launched a new report, '[People to Partners – Developing a Unique Approach for Northern Ireland](#)', at the NICON 2025 Conference.

The report is the outcome of a roundtable hosted at Hillsborough Castle on 3 September 2025, where senior health and care leaders, thought leaders, representatives from local government, the Community and Voluntary sector and leaders from wider Northern Ireland Government departments came together to explore the potential collaborative advantage of a new relationship with the public in delivering public sector goals. Participants strongly endorsed the “People to Partners” approach, recognising it as a key opportunity to reshape services by embedding citizens as active partners in decision-making, design and delivery.

The report reflects the discussion which focused on the following areas:

- The case for change
- Key opportunities across government and within health and social care
- The collaborative advantage of a strategic approach
- Recommendations: developing a strategic framework for Northern Ireland
- Next steps

Opportunities for NI included:

Opportunities across wider government

- Interdepartmental collaboration
- Harnessing the potential of the public
- Policy integration and decision-making
- Focus on building trust and removing barriers to access and participation

Within health and social care:

- Collaborative partnerships and citizen activation

- Place-based initiatives and Integrated Care Models
- Applying “citizen-centred” design methods
- Data, digital, insights and evaluation

Building upon both the opportunities to be explored within the health sector and more widely across government, three collaborative advantages of developing a new relationship with the public to drive wellbeing and citizenship were identified.

1. **Enhanced partnership with citizens:** By fostering a partnership model that actively engages citizens, HSC (and wider public sector) organisations can leverage the collective knowledge, skills, and resources of the community that they serve. Applying “citizen-centred” design methods to policy development and service delivery will help translate this partnership into practical change. This collaboration not only enhances the effectiveness of health and care services but also facilitates individuals to take an active role in their own wellbeing. When citizens are viewed as partners rather than passive recipients of services, it creates a more responsive and adaptable system that can better meet the diverse needs of the population
2. **Builds a culture of shared responsibility and accountability:** By shifting the nature of the relationship between services and the public to one of partnership, this builds a culture of shared responsibility and accountability. Through engaging the public in 14 decision-making processes, organisations can gain valuable insights into the challenges and opportunities within communities. This two-way engagement fosters trust and transparency, which are essential for building strong relationships between citizens and public institutions. As a result, policies and services can be tailored to reflect the realities of people's lives, leading to more effective interventions, improved health outcomes and more efficient government through strengthened community agency and building local democracy.
3. **Supports integration of services, sectors and across government departments:** A strategic focus on collaboration can help break down silos between different sectors and departments. By working together, health and social care, education, communities, employment and other government

departments and public sector organisations can create integrated approaches that address the multi-faceted nature of wellbeing. This holistic perspective not only enhances service delivery but also ensures that resources are utilised more efficiently, transformational change can be delivered (including by potentially accessing cross-departmental Transformation Funding) ultimately leading to better outcomes for individuals and communities.

Based on discussions, a series of recommendations were made to take forward this agenda in Northern Ireland:

- **Establish an NI-specific, collaborative, cross government strategic framework:** Develop a framework that establishes principles to adopt a 'do with' asset-based partnership approach and to guide change, focusing on shifting mindsets and system/organisational culture rather than replicating existing models.
- **Support and build on 'This is Health':** support and maximise the potential gained from applying a behavioural science and design methodology to change the mindset of the HSC to work with people as partners and to change the relationship that people in NI have with their own health.
- **Quantify the impact of community initiatives to public services:** Explore a mechanism for quantifying the impact of community development and engagement/ CVS activity, in order to understand the potential social value and savings to public services, and seek to strategically build on this work.
- **Build our evidence base and support for shared learning:** establish an evidence bank of initiatives in NI and beyond that work on the basis of asset-based partnership approaches which demonstrate deep understanding, versatile responses and collaborative delivery, and explore scalability and shared learning.
- **Foster interdepartmental collaboration:** Encourage collaboration among various government departments (particularly those concerned with wider social, economic and environmental factors) to align policies and initiatives that collectively support the goal of improving public wellbeing.

- **Listen, reflect and do:** Strengthen and align robust channels for citizen feedback to ensure triangulation of information and insights for continuous improvement of services based on community input and experiences. Review progress across health care and all Government departments to promote transparency and accountability on this agenda, adjusting approaches based on learning in the specific NI context.
- **Promote integrated care as part of a wider approach to wellbeing:** Advocate for holistic care approaches (including a focus on ‘place’ or potentially through ‘neighbourhoods’) that connect health services with social, economic, and environmental factors, ensuring a comprehensive strategy for wellbeing.
- **Encourage citizen activation through education and resources:** Create initiatives, including maximising the potential of digital infrastructure, to understand people’s circumstances (particularly those who experience greatest health inequalities) and promote access to information, choice and control.
- **Embed citizen-centred design methods:** Ensure engagement translates into tangible policy, service and system improvement.

2. PCC Support in the Community Initiative (PENNA Team of the Year Award)

The Neighbourhood Model of Care intends to integrate the provision of care and bring care closer to the community. Sometimes the public need help to express what they require support or assistance with, or how to access supports that may already exist. We suggest that the Neighbourhood Model of Care will need to support and connect people where they are. It will need to reach out to those communities, identify and address barriers and challenges, build upon already existing and trusted networks, establish regular outreach, and address current health inequalities. This will require a new way of thinking, and delivery, including operating in areas affected by rural isolation and deprivation and with vulnerable and hard to reach communities.

In November 2024 we established ‘PCC Support in the Community’, and through this initiative PCC have been able to reach out to members of the public who may not

usually access our services and to help combat health inequalities through the provision of advocacy support. Our service provides:

- Trained Staff at physical locations, to listen to individual's concerns/ issues about health or social care
- Free support, advocacy and advice, to help individuals find a resolution or raise concerns appropriately
- Access to resources tailored to their needs
- Support through a complaints process, which will be always be focused on ensuring the individual's voice is heard and listened to.²

The initiative aims to support those most affected by health inequalities; migrants, LGBTQ+, people experiencing homelessness, those in contact with the justice system, and people with disabilities or neurodivergence. We have also targeted demographics that are less aware of the PCC and our services such as men; 18-34-year olds; Working Class, Retired, students, those not in work, the Belfast and Southern Regions. This initiative covers the whole of Northern Ireland, both rural and urban communities.³

This approach links PCC with established and locally trusted organisations, and other services to enable engagement within local communities. By building trust and relationships within these settings, the PCC have created regular and accessible touchpoints for advocacy and engagement via community-based outreach support services in locations such as local advice centres, migrant support hubs, community and wellbeing centres, men's sheds, primary care MDTs, and organisations within the voluntary and community sector, places where people live, gather, and seek help. This includes collaborations with Healthy Living Centre's, Prisoner Support, Empowerment Programmes, Libraries NI and Migrant Support and many more.

In addition, by operating in areas affected by rural isolation and deprivation, PCC have brought face-to-face support directly into community spaces - empowering individuals to navigate complex systems and speak up confidently. Between

² This paragraph answers questions 3-5, 15

³ This paragraph answers questions 7,9,10, 14, 16

November 2024 and March 2025, seven PCC Practitioners worked across 18 venues, engaging 376 people, creating 224 direct contacts, and opening 43 advocacy cases. Through our approach, PCC Practitioners have built trust and enabled early resolution of issues and concerns raised by members of the public at Support in the Community service days.

Since March 2025, PCC have now embedded this model into our core service delivery. We now have 12 practitioners in 28 venues across Northern Ireland. A zero-budget communications campaign further amplified PCC Support in the Community' reach and visibility. PCC has pioneered a scalable, sustainable, approach to tackling health inequalities, rooted in community knowledge, and localised advocacy support and engagement. PCC regularly monitors initiative through a survey filled out by PCC Practitioners covering themes, barriers experienced by Practitioners and how many members of the public PCC spoke to. Our efforts resulted in the initiative being awarded Team of the Year at the Picker Experience Network National Awards (PENNA) 2025.⁴

Within PCC the data and knowledge is recorded and analysed to identify emerging trends and issues. The importance of understanding existing data and intelligence within a given Neighbourhood area will be vital to providing a based line of experiences, key learning and insights which, can be utilised to promote good practice, identify what is working well and replicate it, as well as identifying opportunities to improve performance and health outcomes.

3. The Big Discussion Initiative

Decision makers can often hold assumptions on what they think the public feel and experience. These assumptions may not always be true. In the development of a Neighbourhood Model of Care this call for evidence, of examples of best practice initiatives, is welcome. There is a need to engage with the public and understand people's experiences.

⁴ This paragraph answers questions 13, 17

Between March and April 2025, the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) convened the 'Big Discussion' workshops across Health and Social Care in NI to design a system approach to addressing 'winter' pressures. The need to engage with the public was a strong and recurrent theme emerging from these workshops. The CNO asked the PCC to consider how a 'Big Discussion' with the public on this issue might be approached.

PCC recommended that the work should be carried out in different phases, with an initial phase focused on generating a regional baseline understanding of the public's beliefs and feelings about health and social care, and their knowledge of winter pressures. PCC designed the first phase and attitudinal survey with the intention that it would have broader applicability to a range of initiatives that are ongoing across health.

PCC commissioned LucidTalk to conduct a Northern Ireland (NI) Attitudinal Poll (survey) to ensure we had a sample that was representative of NI population. With the results from the survey we wrote a key finding report from a key finding report⁵. The findings provide an important regional baseline to inform initiatives such as the '*Big Discussion – Whole System Flow*' led by the Chief Nursing and Chief Medical Officers, and the Minister for Health's '*HSC Reset Plan*'. Key findings include, 51% stating they felt disconnected for HSC services. Results were mixed in relation to how well informed the public feel they are in relation to their health and how to manage it with 53% agreeing or strongly agreeing and 47% stated they were neutral or did not feel informed.

When asked what matters to them when accessing treatment and care, it was most important to people that their care and treatment is safe and high quality, timely, and delivered by the most appropriate and expert healthcare professional. In addition, people significantly prioritised safe, timely and expert care over how far they had to travel or whether the care was delivered in their own home or in the community. People ranked being actively involved, having choice and a sense of control in their

⁵ PCC (2025) '*What the Public Think*' Key findings from a PCC Attitudinal Report on People's Experiences of Health and Social Care and 'winter' pressures, 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](https://www.pcc-ni.org.uk/what-the-public-think-key-findings-from-a-pcc-attitudinal-report-on-people-s-experiences-of-health-and-social-care-and-winter-pressures.pdf)

care and treatment, over the distance to travel for care and whether that care is in their home or local community. Notably, 45% felt they are actively involved in their care with healthcare professionals and staff.

48% did not think any action they took would make a difference to pressures on the health service, compared to 40% that thought it would. Most people knew when to it was appropriate to use an ED, however older people (65+) were more likely to use EDs for different reasons compared to other age categories. 19% of 65+ did not believe that a life-threatening issue was an appropriate reason for attending ED, 45% of 65+ were more likely to say an appropriate reason for attending an ED was to get tests done such as x-rays or blood tests and over 65s were the most likely to consider not being able to access your GP (37%) as an appropriate reason to attend ED. Whilst 58% of people were confident that they knew how to access alternative care pathways, only 38% were confident the alternative care pathway would meet their needs.

This work reflects the case that the PCC has been making for a more strategic approach to public participation, and for building a new relationship with the public, through which healthcare and wider public services, 'does with' (and not 'to') to collectively tackle the challenges we face. This requires a commitment in the first instance to listening to understand public experiences, need and ideas. This report was referenced in the DoH's Overarching Winter Preparedness Plan 2025/26 and its findings will be further progressed by PCC.

4. Remuneration and Reciprocity

The 2018 Department of Health Co-Production Guide⁶ has a section on '*Reciprocal Recognition*'. It notes that at the heart of co-production is a commitment to value, reward and recognise the contribution of all partners, particularly people with lived experience.

Core literature on co-production recognises the principle of reciprocity, which is defined as ensuring that people receive something back for putting something in, and

⁶ Department of Health NI (2018), "*Co-production Guide Connecting and Realising Value Through People*" [126493 H&SCB - Co-Production Guide.indd \(hscni.net\)](#)

builds on the premise of recognising and valuing people's contribution. Examples of Reciprocity include mutual respect, equality of opportunity, joint learning, recognition, flexible rewards, and **remunerating people for their role and contribution**. This can also include benefits in kind, such as 'out of pocket' expenses, and meeting training and development costs.

In 2019 the Patient and Client Council (PCC) through Transformation Funding, was appointed by the Public Health Agency (PHA) to analyse the potential for paid service user and carer involvement⁷. Analysis concluded that the current model for involving service users and carers does not universally recognise or acknowledge the contribution made by them.

This was supported by service user feedback from a workshop hosted by PCC and PHA in 2022 (see section '*PCC and PHA Research*' for further information) which found that Service Users and Carers were unanimous in feeling that their contribution should be recognised in a way that is meaningful to them. There should be a **reciprocal recognition** and remuneration should form a part of how we acknowledge service user and carer involvement. **Creating equality** was also important to Service users and carers. They felt that payment for specific involvement, among other support mechanisms afforded to employees such as personal development opportunities, would have positive impact on creating an environment of mutual respect and true equal partnership.

Reflecting on the need to appropriately recognise and acknowledge the contribution made by service users and carers in co-production work, there is a principled and ethical argument, based on acceptance of the principle of reciprocity, to introduce a regional remuneration policy.

Remuneration as a method to increase diversity and inclusion

Whilst there is limited quantitative data in relation to the diversity of service users and carers in coproduction and engagement activities, throughout, our analysis work and engagement with the public, it was considered that service user and carer

⁷ PCC (2019) '*Exploring Paid Service User/Carer Involvement in Health and Social Care Settings*'

involvement is largely unrepresentative in terms of the age, socio-economic background and ethnicity of those involved.

Work carried out by organisations seeking service user and carer involvement in scientific research echoes this position. For example, research published in the BMJ, when referring to patient involvement in research states that “ensuring diversity—so that the interests of well educated, white, middle class people do not dominate—is challenging. Patients from underserved groups are still excluded from scientific research”⁸. The National Institute for Health and Care Research (NIHR) state that paying people for their involvement in research helps to support more equal partnerships between researchers and members of the public. It helps to support the inclusion of people who might not otherwise be able to get involved, whether for financial or other reasons relating to access. Consequently, it widens the potential pool of people who might influence the course of research⁹.

When we consider documented and recognised health inequalities and access to service issues amongst marginalised groups, it is vital that co-production and engagement activities, which have the potential to help shape future services, are not blind and silent to the issues and concerns of marginalised groups and those already facing health inequalities.

There are numerous barriers to including individuals from marginalised groups in coproduction and engagement activities, including language barriers, capacity, physical ability and wellbeing, however, financial implications for people providing their time without compensation is a significant consideration as an additional and barrier to ensuring diversity and inclusion.

In March 2024, the PCC submitted to the Department of Health a Thought-paper on the need for a regional remuneration policy in Northern Ireland. The paper explored a series of potential implementation options and provided some initial evaluation of those options.

⁸ The British Medical Journal (2018) ‘*Involving underserved patient populations in research*’ [Involving underserved patient populations in research | The BMJ](#)

⁹ NIHR (2022) ‘*Payment guidance for members of the public considering involvement in research*’ [Payment guidance for members of the public considering involvement in research | NIHR](#)

5. The Provision of Independent Advocacy

As set out by the PCC in *'Embracing the public as Assets in HSC: The Role of Advocacy & Engagement'*¹⁰, independent 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 and have their views expressed.

PCC believe that access to appropriate, high quality, Independent Advocacy is an existing need within the HSC system and will be a growing need arising from the delivery of the proposed Neighbourhood Model of Care. The provision of independent advocacy support will be challenging for the proposed model of care given the fragmented approach to advocacy that currently exists. PCC refer to our recent consultation responses, engagement with the Department, and submissions to the Adult Protection Bill in this regard.

Advocacy is vital in cultivating trust and effectively supporting people to ensure their views are considered and heard. It should also provide an environment in which they can confidently raise any concerns they may have with their advocate in the knowledge that there are no conflicts of interest.

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."¹¹

¹⁰ PCC Annual Report 2024 -2025 pcc-annual-report-and-accounts-2023-2024

¹¹ NHS Scotland. (2013) Independent Advocacy Guide for Commissioners. Independent Advocacy Guide for Commissioners

The importance of advocacy services was recognised by the Inquiry into Hyponatraemia-Related Deaths (IHRD) report¹², with its recommendations outlining the need for service users, and families, to **have access to independent advocacy support**. Recommendation 37 (iv) being: *‘Trusts should seek to maximise the involvement of families in SAI investigations and in particular: a fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases’*.

The availability of independent advocacy assists in creating a culture of openness and transparency and plays a fundamental role in governance, assurance and addressing inequality. PCC believe that appropriately supporting independent advocacy services provides a level of assurance that HSC Trusts and organisations are committed to being learning organisations, committed to meeting their Statutory Duty of Quality, are appropriately invested in the Duty of Candour and, most importantly, to protecting patients.¹³

PCC have demonstrated that access to early resolution through independent advocacy saves money and delivers better outcomes for the public, for services and for staff, preventing concerns from escalating¹⁴ and enabling earlier intervention. *“Our drive towards early resolution and a focus on restorative practice is reflected in 60% of cases being resolved prior to formal complaint, an increase from 57% in 2023-24 and 45% in 2022-23.”*¹⁵

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**.¹⁶ Ensuring the integrity of

¹² Inquiry into Hyponatraemia related Deaths (2018) The Inquiry into Hyponatraemia-related Deaths Report Full-Report.pdf

¹³ being-open-framework-pcc-response.pdf

¹⁴ Reference the ICS report which will be forthcoming

¹⁵ Chief Executive’s Summary, page 6, PCC Annual Report 2024-2025 pcc-annual-report-and-accounts-2024-2025-final-with-cert-october-2025.pdf

¹⁶ Independent Advocacy Principles, Standards & Code of Best Practice - Scottish Independent Advocacy Alliance

independence, advocacy service providers' accountability arrangements should be independent of Trusts to ensure freedom to act without potential adverse consequence on the contractual arrangement.

The PCC believes in a Regional Independent Advocacy Model as the most appropriate provision of advocacy, as set out in the consultations referred to above, and in relation to our submission to the call for evidence on the Adult Protection Bill.

The PCC believe that the following aspects should underpin the provision of independent advocacy services within the Health and Social Care system:

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

In relation to current provision, there remains a fragmented approach regionally to advocacy support as commissioned by the Trusts and there are challenges to the operational independence of providers resulting from current commissioning arrangements. This was acknowledged and highlighted by the evidence provided to

the Muckamore Abbey Hospital Inquiry by Ms Marley, retired Director of Bryson Care.¹⁷

The provision of advocacy in its current form may not be sufficient to meet the increase in demand for independent advocacy support, including separate support that may be required for both individuals and carers. PCC believe that this need is likely to increase significantly within the proposed Neighbourhood Model of Care. There is an interdependency between the ongoing consultations, policy programmes, and proposed Adult Protection Bill. The opportunities that exist within the proposed Bill should be carefully considered alongside the Neighbourhood Model of care to make provision to address and to facilitate consideration of a strategic and co-ordinated approach to the provision of independent advocacy, which the PCC considers to be essential.

In order to deliver on improved health outcomes, greater patient and carer satisfaction, a reduction on unplanned hospital admission, and in particular more efficient and sustainable use of resources; the provision of and access to Independent advocacy must be consistent, equal and equitable across the region to deliver appropriate advocacy, for the right person, at the right time.

6. Targeted public education and awareness campaign.

PCC believe that there is a very clear need to develop a public education and awareness campaign to educate the public on the Reset Plan, and the proposed NI Neighbourhood Model of Care.

¹⁷ At paragraph 73 day 84 *“The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which dilutes the true independence of the service”*. Ms Marley stated that it needs *“total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome”*. Further, Ms Marley acknowledged *“..if you’re receiving funding and you’re in a contractual relationship with the Trust, it does make it difficult to feel totally independent of them, and we would prefer to have some kind of arm’s length arrangement where the funder or commissioner is not the Trust”*. She further explained that on occasions the Trust had reminded Bryson House that this was a *“contract with the Trust”* when staff were raising an issue with the Trust”.

This is something new, it is different to how the public have experienced health in the past and currently. The proposals are a lot of change and the public need to understand how health care will be delivered in the future. They need to be a partner in that engagement and development. The campaign will need to ensure that the public understand the avenues of care, and the best, and most appropriate way, to access healthcare. How the public experience information and media coverage are key findings from the PCC What the People think report, referred to earlier. Careful consideration should therefore be given to how any education and awareness campaign is delivered and extends to reach the most rural or marginalised sections within our community, as these will be important factors in whether or not the Neighbourhood Model of Care can deliver on its five key impacts.

Yours sincerely

Peter Hutchinson
Senior Policy Impact and Influence Manger
Patient & Client Council

Appendix 1

The Role of the PCC

The Patient and Client Council (PCC) is a statutory corporate body established in 2009 under the Reform Act¹⁸ to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues within Northern Ireland through:

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

In addition, PCC has an important independent assurance role for the Minister of Health, as set out in the HSC Framework document¹⁹, one of only two organisations that have this role, the other being the RQIA.

The PCC's effectiveness in fulfilling its' functions is partly dependent on building constructive and productive relationships and arrangements with service providers, the third sector and other 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 approach of establishing partnerships and building relationships with others can mean that the PCC is able to exercise a positive influence on the sector – albeit via **soft skills** such as mediation and collaboration rather than through 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.

¹⁸ Health and Social Care (Reform) Act (Northern Ireland) 2009

¹⁹ Department of Health (2011) DHSSPS Framework Document

The PCC is a small Arm's-Length Body with an annual budget in 2024-2025 of £2.1m. £1.8m of this is recurrent funds, £0.3m is non-recurrent funds relating to inquiry related work. PCC employs 31 members of staff, excluding Council members.

The PCC has a Council made up of a Chair and Council Members, recruited from across Northern Ireland under the Public Appointments Process. It currently has 13 members²⁰.

With a budget of £1.8m – equivalent to less than £1 for each member of the public in Northern Ireland that PCC is tasked to serve – it is a challenge to fulfil the statutory functions outlined below, across engagement and support, across the breadth of health and social care services. As such the PCC has to prioritise within this resource where it focuses its efforts to best support the population of Northern Ireland; combining delivering a service to individuals with trying to make a strategic impact; informing Department policy, as well as Department and HSC decisions on HSC structures and decisions on how, when and where services are delivered.

Our vision is for a Health and Social Care Service, actively shaped by the needs and experience of patients, clients, carers and communities, and that in achieving this, the public voice would be influential regionally and locally in planning and commissioning, and that the system responds openly and honestly when things go wrong.

The PCC has developed a Statement of Strategic Intent 2022-2025²¹, setting out the strategic direction of the organisation over the next three years. In the long term we hope to see two big differences:

Strategic Objective One: Through our engagement and impact work, the public voice is influential regionally and locally in the design, planning, commissioning and delivery of health and social care.

Strategic Objective Two: Through our work in advocacy, engagement and impact, the health and social care system responds regularly to people with

²⁰ <https://pcc-ni.net/about-us/our-council/council-members/>

²¹ PCC (2022) Statement of Strategic Intent

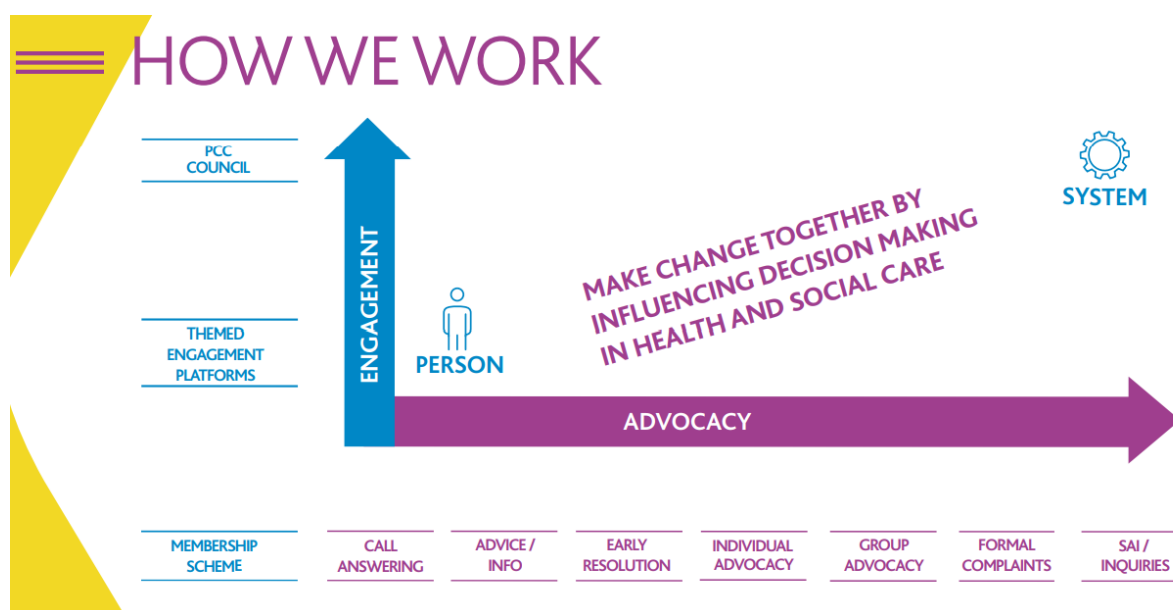
openness, honesty and compassion to address difficulties or failures in standards of care.

PCC provides advocacy services for the public, which range from helpline advice, early resolution of issues, individual advocacy, to supporting people through formal complaints and serious adverse incidents. If we identify a specific need that we cannot help with, we will connect individuals to a partner organisation within the voluntary and community sector or beyond, seeking to ensure people do not fall through gaps in the system.

We also bring members of the public, with common interest and lived experience, together with decision makers from the Department of Health (DoH) and Health and Social Care (HSC) organisations to improve existing HSC services and plan for the future.

PCC Delivery Model

A new practice model, introduced in response to the outcome of the 2019 review, updated and re-designed how the PCC provide support to the public across three core functions; advocacy, engagement and policy impact and influence, see diagram below.



PCC Connect

PCC Connect is about connecting the right person, at the right time, to the right information. Our **PCC Connect Freephone service**, often the first point of entry to the PCC, is the foundation of PCC Support; beginning with the provision of advice and information to the public.

PCC Connect also captures the initial stages of PCC Engage structures; particularly our **Membership Scheme** and our '**Make Change Together**' involvement methodology, which seeks to ensure the public can access involvement opportunities with us, across the HSC and beyond. This is supported by working in partnership with external stakeholders through a '**network of networks**' approach and the development of '**positive passporting**'.

PCC Support

PCC Support is our advocacy and support model.

Our advocacy and support model focus 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.*

PCC advocacy and support begins with the first point of entry to the PCC, which can often involve the provision of **advice and information to the public** over the phone or via email. PCC contact details are widely available across a number of different sources including the NI Direct website (the official government website for Northern Ireland citizens), within the HSCNI Complaints Procedure; within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support; on the PCC website; on social media platforms; and in literature shared by PCC.

Our focus is on seeking **early resolution of issues** through facilitated conversations with parties involved in a particular case. This can include a wide range of other service providers, HSC bodies and individual professionals. Our advocacy and support can include signposting and 'positive passporting' as noted above.

Where immediate early resolution cannot be achieved PCC advocacy and support carries through to **individual and group advocacy casework**. The formal complaints process can be onerous and difficult for members of the public. Therefore, the PCC focus is on assisting members of the public to achieve a resolution to their complaint where possible without invoking the formal aspects of the complaints process.

In some cases, this support and advocacy will however progress to a formal complaint process. The PCC also provides independent advocacy support in relation to serious adverse incidents (SAIs) and Public Inquiries.

PCC Engage

The objective of the PCC is to provide a powerful, independent voice for patients, clients carers and communities on health and social care issues through the exercise of its functions. PCC's new practice model provides the best method of facilitating the conversations, having their voice heard and building relationships between service users, patients, carers and families and the system which serves them. To meet this objective, PCC designed and created a **theme-based engagement platform** model of practice. Themed engagement platforms provide members of the public with a forum for engagement on specific areas of work and connect them with the Department and with representatives across health and social care and voluntary and community sectors. This is critical in fulfilling our statutory functions of **promoting the involvement of the public and representing their interests**.

An Engagement Platform is a space to bring together a group of people, with a common theme or interest and **lived experience**, to work together and make change in health and social care. Engagement Platforms allow participants to communicate their experiences and thoughts, related to a policy programme, with the PCC, as well

as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas under review, development and reform.

Running alongside our engagement and involvement structures is the continuum of **advocacy and support** that the PCC offer in meeting our core statutory function of providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care.

Engagement Platforms can also provide the opportunity for participants to raise their individual issues and concerns with the PCC directly whilst engaging in ongoing theme-based work. This may be in the course of a participation event itself and as part of group discussions. Online technology allows the PCC team to place a participant into a separate virtual room, during these discussions, where they can, in private or on a one-to-one basis, seek advice and discuss concerns with PCC staff. It can also happen after a session or event has concluded when PCC staff are approached by an attendee to raise an issue or complaint they have. In both cases, PCC staff would offer the individual support and advocacy to assist to address the issue they have raised during engagement.

In line with our statutory function to *undertake research into the best methods and practices for consulting and engaging the public*, PCC continues to develop our engagement structures, working alongside the public and our partners, and building on the learning from previous years.

PCC Impact

PCC Impact focuses on measuring and demonstrating the impact of our work, and communicating this externally. Through PCC Impact we seek to bring change on an individual, collective and systems level. PCC has a critical role in securing a '**seat at the table**' for the public. The goal is to connect the evidence gathered through PCC advocacy and engagement work under PCC Connect, Engage and Support to influence change. Under PCC Impact, the aim is to ensure a focus on the best

methods and practices for consulting the public about, and involving them in, matters relating to health and social care.

The PCC policy advocacy role is the process of negotiating and mediating a dialogue through which influential networks, opinion leaders, and ultimately, decision makers take ownership of the ideas, evidence, and proposals, presented by PCC on behalf of the public and subsequently act upon them.

The PCC's approach today is that it will contribute to and seek to influence policy and service developments by the Department and HSC bodies. The PCC will do so by attending and contributing to groups and meetings established to take forward such work; by engaging with service users and members of the public to seek their views; and by submitting evidence. This evidence is based on what those engaging with PCC tell us as well as the practice experience of our staff who provide advocacy and support to the public.