

Codes of Practice for Patient Safety Healthcare Complaints Advocacy

Evidence brief

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Summary

Introduction

This report presents the findings of a brief evidence review conducted by the Evidence Centre in the Health Research Board (HRB) on codes of practice used in healthcare complaints advocacy.

Purpose of the review

Following separate reports in 2015 from the Ombudsman and HIQA (the Health Information and Quality Authority) recommending that a patient advocacy service be established for health services in Ireland, the Programme for Partnership Government (2016) made a number of commitments towards establishing an independent patient advocacy service. The Department of Health's *Statement of Strategy (2016–2019)* reflects these commitments in its plan to establish a patient advocacy service and to examine the statutory provision for the management of complaints. Additionally, under these commitments, the National Patient Safety Office (NPSO) is developing a Patient Safety Complaints and Advocacy Policy for publication in 2018.

Research questions

Question A:

1. What national codes of practice for independent healthcare complaints advocacy are in use in healthcare complaints advocacy services?
2. Who do these codes apply to, for example state-directed services, state-funded voluntary organisations?
3. How were they developed (briefly) and how often are they revised?

Question B:

1. What are the underlying principles/themes of the codes?
2. What guidance is available with regard to the principles/themes?
3. How are they implemented at national level, e.g. statutory, standards, voluntary.
4. With reference to the three codes of practice in Ireland (listed below*), how do these codes compare to the international approach examined?

Countries of interest include England, Scotland, Northern Ireland, New Zealand and Australia.

*Codes from: Mental Health Commission, National Advocacy Service and SAGE.

Note: The term 'code of practice' in this report is taken to mean any written guidelines. These were found to be entitled variously 'guidelines' or 'standards' or 'codes of practice' and all are treated as codes of practice for the purposes of this review.

Methods

Healthcare complaints advocacy services were identified for three countries: New Zealand, England and (Western) Australia, in a previous evidence brief, *Models of Patient Advocacy* (2016). We repeated the grey literature search undertaken in that review by searching online with each country name and the term 'patient advocacy' or 'advocacy code of practice'. We expanded the search to all

five countries of interest, so as to identify additional healthcare complaints advocacy services in Scotland and Northern Ireland and to identify codes of practice published in each country. No codes were found for Australia, Northern Ireland or Scotland. In these cases, the respective healthcare complaints advocacy services were emailed, asking whether a code was in use. All three services responded, but only Northern Ireland's healthcare complaints service confirmed the use of a code of practice.

Findings

Here, the first six parts of Questions A and B are addressed in relation to each of the three countries with codes of practice in use in their healthcare complaints advocacy service. The comparison with Irish codes of practice is addressed separately at the end of this evidence brief document.

New Zealand

The Health and Disability Advocacy Service was established in 1996 under the Health and Disability Commissioner Act 1994. The 1994 Act set up the Office of the Health and Disability Commissioner, who acts as ombudsman for the service. It provided for a code of patients' rights, and required the appointment of an independent statutory officer – the Director of Advocacy. New Zealand operates a no-fault compensation scheme for injuries, and this applies in cases of medical injury. Patients do not have the option of seeking redress through the courts. The National Advocacy Trust is the single independent provider contracted by the Director of Advocacy to deliver the New Zealand Health and Disability Advocacy Service. The Health and Disability Advocacy Service is guided by a code of practice and advocacy guidelines which are applicable to both the service provider and the advocates working within it.

The Minister of Health published the advocacy guidelines in 1996 and these were revised in 2005. A ministerial review of the Act, which took place in 2004, appears to be the antecedent of both the 2005 revised Advocacy Guidelines and the first publication of a Code of Practice, which are referred to in the updated guidelines. Reviews of the Act and, by extension, of the Advocacy Guidelines and the Code of Practice, have been conducted every five years, in consultation with the public and relevant stakeholders. The main themes addressed by the Guidelines and the Code of Practice include: confidentiality, professionalism, clarity of the advocate's role, empowerment/a client-led service, accountability, respect, accessibility, independence, and conflicts of interest. Notably, the Code of Practice and the Guidelines do not offer guidance on dealing with complaints made against advocates or the advocacy service. Under each theme, the Code of Practice details what is expected from advocates and advocacy service providers. By contrast, codes of practice enacted elsewhere adopt a more client-focused approach, detailing the client's expectations and suggesting measures the service might use in order to demonstrate fulfilment of its obligations under each theme heading. The Code of Practice and Guidelines used in New Zealand are implemented under the 1994 Act, and, as such, are statutory codes with which advocates and service providers must comply.

England

The provision of an independent advocacy service for healthcare complaints is a legal requirement under the NHS Act 2006. This service is called the NHS Complaints Advocacy service and is a locally based service, wherein each local authority contracts with independent advocacy groups to provide the NHS Complaints Advocacy service for the region covered by the local authority. This arrangement replaced the existing nationally commissioned service in 2012. Two publications act as codes of practice for healthcare complaints advocacy in England: Healthwatch, the healthcare consumer organisation, published *Independent Complaints Advocacy Standards*, and the Local Government Association published *Practice Guidelines for Independent Health Complaints Advocacy Services*. Both codes are voluntary. However, the *Practice Guidelines* are intended for use in commissioning services and are likely to have been incorporated into the contracts for local services, specifically in order to meet local requirements. The *Standards* were developed by Healthwatch from existing literature on

patients' experiences with complaints services. The Local Government Association used the *Standards* as a starting point to develop its *Practice Guidelines* in consultation with commissioners of advocacy services and advocacy providers. Both codes were published post-2014 and do not indicate whether revisions are planned.

The main themes addressed by the Standards and Guidelines include: confidentiality, professionalism, clarity of advocate's role, empowerment/a client-led service, accountability, respect, accessibility, independence, complaints, and conflicts of interest, thereby covering all of the main themes identified in this report. Each theme details what is expected from advocates and advocacy service providers, along with the client's expectations and measures that the service can use (or the service commissioner can require) in order to demonstrate fulfilment of contractual obligations.

Northern Ireland

Healthcare complaints advocacy in Northern Ireland is provided by the Patient and Client Council, a state body independent of the health service since 2009. Advocates in the Complaints Support Service are guided by the *Advocates Network of Northern Ireland's Code of Practice for Independent Advocates*. This document was commissioned by the Health and Social Care Board in 2014 and developed by consultation with a wide range of advocacy providers. The main themes addressed by the Code of Practice include: confidentiality, professionalism, clarity of advocate's role, empowerment/a client-led service, accountability, and respect. The Code of Practice does not include themes such as accessibility, independence, complaints, training provision and conflicts of interest such as are addressed explicitly in other codes of practice. It was developed to cover all types of advocacy in Northern Ireland and therefore focuses on human and equal rights, and informed decision-making. Each theme presents a list of statements that advocates agree to abide by, but does not address the expectations of clients or responsibilities of the service provider. Nor does it suggest ways of demonstrating that advocates are adhering to the agreement. The Code of Practice is written with the intention of being voluntary and is not implemented officially in the Patient and Client Council Complaints Support Service; rather, it guides the advocates' day-to-day practice.

Comparison between three Irish codes of practice and international approaches

The Irish codes of practice included in this section came from SAGE, an advocacy service for older adults; the National Advocacy Service, an advocacy service for those with disabilities; and the Mental Health Commission, which oversees mental health services in Ireland. The Mental Health Commission Code of Practice is used to guide treatment selection for those engaged with its services, and is not relevant to the practice of advocacy; for this reason, comparison with the international advocacy codes of practice would be inappropriate.

The SAGE Code of Practice was published as its Quality Standards in 2015, and the National Advocacy Service Code of Practice was published in the same year. Both of these codes of practice address all of the main themes common to healthcare complaints advocacy as identified in this report: confidentiality, professionalism, clarity of advocate's role, empowerment/a client-led service, accountability, respect, accessibility, independence, complaints, advocate support/training, and conflicts of interest. In addition, they address themes more relevant to general advocacy, including social inclusion, human rights and informed decision-making. The National Advocacy Service details expectations for advocates and advocacy service providers as defined by the Code of Practice, but the SAGE Code of Practice goes further, to include client expectations and suggesting means by which the service can track or measure overall adherence to the Code of Practice. For this reason, the SAGE Quality Standards may be described as the most complete among the codes of practice.

Conclusion

Healthcare complaints advocacy services have a statutory basis in New Zealand, England and Northern Ireland. Only in New Zealand was a statutory basis for a code of practice identified. In both New Zealand and England, contracts for the advocacy services may also include stipulations around the performance of services specified in the service contracts. The service in Northern Ireland is supplied by an independent state body, which adopts a local code of practice voluntarily as a guide for advocates. There is significant overlap in the themes between codes of practice, both international and Irish, with the main differences apparent in the matter of which parties the codes address. Codes of practice used in England and by SAGE both accommodate the perspectives of all those engaged with the service, while those used by New Zealand and the National Advocacy Service address service providers and advocates only, with the Northern Ireland code having relevance only to advocates.

1 Introduction

This evidence brief was undertaken by Michael O’Sullivan and Deirdre Mongan of the Evidence Centre in the Health Research Board (HRB) at the request of the Department of Health (DoH). An evidence brief provides a summary overview of key sources of selected research evidence. While it provides insight into a topic for a future formal evidence review or primary research study, it is not a comprehensive overview and may therefore miss excellent papers in obscure or low-level journals. An evidence brief is not suitable for peer review because it is not based on a comprehensive search and analysis. Evidence briefs are undertaken as part of a knowledge-brokering service offered to policy-makers in the DoH by the Research Services Division in the DoH, in collaboration with the Evidence Centre in the HRB. The questions were set by the DoH through an iterative process with the Research Services Division and the Evidence Centre. This review was completed over a three-month time frame.

1.1 Purpose of the review

The provision and quality of patient advocacy services provided by the Irish State has been criticised in the Ombudsman’s *Learning to Get Better* report (2015) and HIQA’s *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise*, which was published in 2015. The HIQA report recommended that a national patient advocacy service be established. The Programme for Partnership Government (2016) makes specific commitments to establishing an independent patient advocacy service. On 9 November 2015, the government gave its approval to:

- The establishment of a national patient advocacy service as set out in the *Memorandum to Government on Patient Safety*; and
- A review, in association with the Health Service Executive, the Office of the Ombudsman and the Department of Public Expenditure and Reform, of S.I. No. 652/2006 Health Act (Complaints Regulations 2006), with a view to enhancement of the statutory provisions for management of complaints within the health services.

The DoH’s *Statement of Strategy (2016–2019)* commits to the establishment of a patient advocacy service and to examining the statutory provision for the management of complaints. The National Patient Safety Office (NPSO) is developing a Patient Safety Complaints and Advocacy Policy for publication in 2018 to address the above issues. For the purposes of developing this policy, the establishment of the patient advocacy service will come in the context of a healthcare complaints/advocacy support service, designed to help and empower the service user in the

healthcare complaints process. This may come in the form of offering information or advice on preparing documentation for a complaint, attending meetings with service users to enable them articulate their needs, and/or supporting them after the complaint is made. The establishment of a national patient healthcare complaints advocacy service will be underpinned by a code of practice which is currently absent for healthcare complaints advocacy in Ireland. A code of practice, as described by the DoH for the purpose of this evidence review, is a set of written rules which explains how personnel working in healthcare complaints advocacy should behave. The purpose of this evidence brief is to report on healthcare complaints advocacy codes of practice in current use internationally, as to content, implementation and application, and to compare them with advocacy codes of service in Ireland.

1.2 Research questions

Question A:

1. What national codes of practice for independent healthcare complaints advocacy are in use in healthcare complaints advocacy services?
2. Who do these codes apply to, for example state-directed services, state-funded voluntary organisations.
3. How were they developed (briefly) and how often are they revised?

Question B:

1. What are the underlying principles/themes of the codes?
2. What guidance is available with regard to the principles/themes?
3. How are they implemented at national level, e.g. statutory, standards, voluntary.
4. With reference to the three codes of practice in Ireland (listed below*), how do these codes compare to the international approach examined?

Countries of interest include England, Scotland, Northern Ireland, New Zealand and Australia.

*Codes from: Mental Health Commission, National Advocacy Service and SAGE.

For the purposes of the review, the term 'code of practice' is taken to mean 'a set of written rules which explains how people working in healthcare complaints advocacy should behave', as described by the DoH. In practice, we found that such 'written rules' could be called codes of practice, guidelines or standards and we have treated the term 'code of practice' in our research questions as an umbrella term for these written rules.

1.3 Methods

The questions listed above build on a previous HRB evidence brief for the DoH – *Models of Patient Advocacy (2016)*,¹ co-written by DM. In this evidence brief, definitions and models of advocacy are discussed, in addition to discussing the establishment, functioning and evaluation of advocacy services in England, New Zealand and Australia. Our search strategy, displayed in Figure 1, was informed by the methods used in the previous brief, wherein targeted PubMed searches yielded only one relevant paper for the countries under consideration. It was, therefore, not appropriate to undertake database searches for this evidence brief. As in the previous brief, the authors here examined the first 10 pages returned by a Google search for the term 'patient advocacy' and 'advocacy code of practice' associated with each country name. The healthcare complaints advocacy services arising from the search, and relevant to the report, are listed in Table 1.

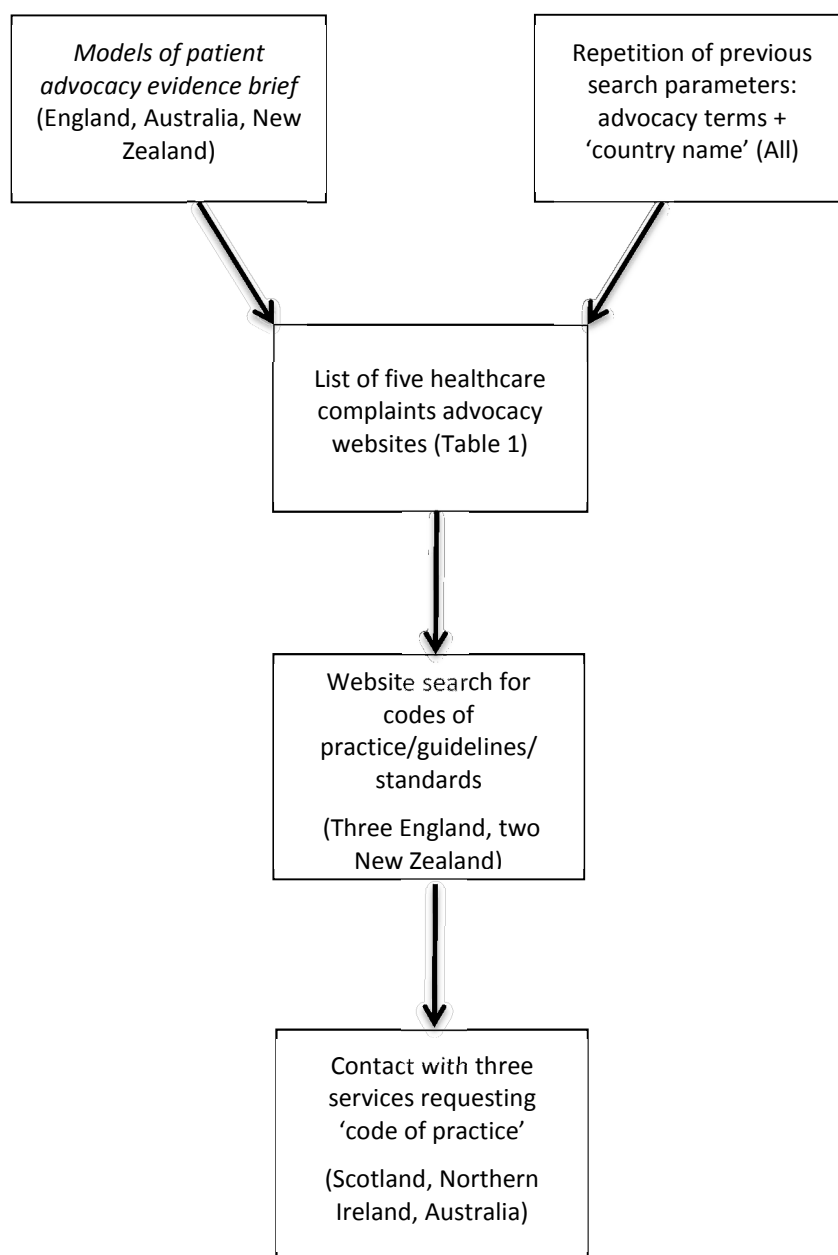


Figure 1: Search strategy for international codes of practice

The search identified no additional healthcare complaints advocacy services operating in New Zealand, Australia or England. One independent healthcare complaints advocacy service operating in each of the two countries not covered by the 2016 brief, namely Northern Ireland and Scotland, were found. General independent advocacy codes of practice, which are seen as advocacy industry standards, including the *Advocacy Quality Performance Mark Code of Practice*² (QPM) in England, and the Scottish Independent Advocates Alliance (SIAA) *Code of Practice for Independent Advocacy*,³ were found. However, as these were not specific to healthcare complaints advocacy, they are not included in this brief. An exception was made in the case of the general independent advocacy code of practice found in Northern Ireland and this is discussed in the next paragraph.

Table 1: Independent healthcare complaints advocacy services arising from the search

Country	Service	Website	Healthcare complaints advocacy	Code of practice
New Zealand	Nationwide Health and Disability Advocacy Service	http://www.advocacy.org.nz/	Yes	Yes
England	NHS Complaints Advocacy	No central website - see https://www.england.nhs.uk/contact-us/complaint/	Yes	No
Australia (Western Australia only)	Health and Disability Services Complaints Office	https://www.hadsco.wa.gov.au/home/	Yes	No
Scotland	Patient Advice and Support Service	https://www.cas.org.uk/pass	Yes	No
Northern Ireland	Patient and Client Council	http://www.patientclientcouncil.hscni.net/	Yes	Yes

Healthcare complaints services were identified for all countries and are listed in Table 1. Website searches resulted in codes of practice being found for two countries mentioned in Figure 1. The complaints services in Northern Ireland, Scotland and Australia were emailed requesting a copy of any code of practice they used. Responses received from the Health and Disability Services Complaints Office in Australia and the NHS Procurement, Commissioning and Facilities in Scotland indicated that no code of practice was used in either the Australian or Scottish healthcare complaints advocacy service. Finally, a response was received from the Health and Social Care (HSC) complaints services in Northern Ireland, indicating that they utilised the Advocates Network of Northern Ireland Code of Practice for Independent Advocates, at least informally, in their practice. This was included in the review to provide a greater international perspective, although strictly speaking it does not amount to a healthcare complaints advocacy code of practice. No response was received from the Scottish service, and follow-up phone calls went unanswered. The codes resulting from the completed search and reviewed in this brief are listed in Table 2.

Table 2: Final search results – international healthcare complaints advocacy codes of practice

	Healthcare complaints advocacy code of practice
New Zealand	New Zealand Health and Disability Advocacy Service Advocacy Guidelines New Zealand Health and Disability Advocacy Service Code of Practice
England	Standards for the NHS Complaints Advocacy Service (Healthwatch) Practice guidelines for NHS complaints advocacy services (Local Government Association) Key performance indicators for NHS England complaints advocacy services (Department of Health)
Northern Ireland	Advocates Network of Northern Ireland Code of Practice
Scotland	None
Australia	None

In the results section we discuss: what codes there are, to whom they apply, their development, their themes, the related guidance, and their implementation (the first six parts of Questions A and B) for each country by turn (2.1 – New Zealand, 2.2 – England and 2.3 – Northern Ireland). The final question in relation to Irish codes of practice is addressed separately at the end of this document (Section 2.4).

2 Results

2.1 Healthcare complaints advocacy services in New Zealand

2.1.1 Background

New Zealand has a nation-wide, publicly funded health and disability advocacy service, the New Zealand Health and Disability Advocacy Service, formally established in 1996 under the [Health and Disability Commissioner Act 1994](#)⁴ (the 1994 Act). This legislation sought to “promote and protect the rights of health and disability services consumers” and to “secure the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights”. In addition, it saw the establishment of the Office of the Health and Disability Commissioner, who acts as an independent ombudsman, and provided for a Code of Patients’ Rights. The Act also requires the appointment of an independent statutory officer – the Director of Advocacy – who is based within the Health and Disability Commissioner’s office and contracts for advocacy services. The National Advocacy Trust (NAT) has been contracted as the single nation-wide advocacy service provider since 2006. Prior to that date the service consisted of an assemblage of 10 initial contract holders, operating since 1996. These later merged into a single body.

2.1.2 What national codes of practice are in use?

Currently, there are two documents which fall under the umbrella term ‘code of practice’. The official statutory guidelines⁵ – issued by the Health and Disability Commissioner and officially approved by the Minister, as provided for in the 1994 Act – are entitled *Advocacy Guidelines* (see Table 8 in Appendix 2). Within the guidelines, advocates are directed to comply with the *Code of Practice*⁶ (see point 3 in Table 8 and Table 7, Appendix 2 for the Code of Practice).

2.1.3 To whom do the codes apply?

The Code of Practice and Guidelines apply to advocates working as part of the National Advocacy Trust (NAT), the state-funded independent advocacy agency. As of 2016, 43 advocates are employed by the NAT and they operate out of 23 community-based offices around the country. The 1994 Act, establishing the service in law, specified that the service must operate independently of the Health and Disability Commissioner, all government agencies, and all health and disability services providers.

2.1.4 Development and revision

2.1.4.1 Advocacy Guidelines⁵

The 1994 Act specifies that guidelines “relating to the operation of advocacy services” may be issued by the Health and Disabilities Commissioner, if so directed and approved by the Minister of Health. This was initially completed in 1996 when the [Notice of Approval of Advocacy Guidelines by Minister of Health Pursuant to section 28 \(5\) \(a\) of the Health and Disability Commissioner Act 1994](#)⁷ was issued. Although the exact process by which these guidelines were formulated is unclear, the 1994 Act states that: “the Commissioner shall, before issuing any guidelines or amendments to guidelines ... consult with, and invite representations from, such persons, bodies, organisations, and agencies, including representatives of health consumers, disability services consumers, health care providers,

and disability services providers, as the Commissioner considers necessary to ensure that a wide range of views is available to the Commissioner to assist in the preparation of those guidelines or amendments.”

2.1.4.2 Code of practice⁶

There is scant information available about the development or publication of, or revisions to, the Code of practice. A review in 2004 by the Health and Disability Commissioner⁸ stated that a code of practice would be published in the future to reflect the movement towards competency-based advocacy; however, the Code of Practice is published online, with no given print publication date. It is unclear whether this document is a legal requirement of the service contract.

2.1.4.3 The review process

According to the 1994 Act, a review may be instigated at the behest of the Minister of Health or the Health and Disability Commissioner.⁴ Periodic reviews of the Act and the *Code of Health and Disability Services Consumers' Rights* have taken place; although the reports published by the Commissioner in 1999, 2004, 2009 and 2014 make no reference to changes in the guidelines or code of practice or to any submissions by stakeholders relating to these. Nevertheless, a revision of the guidelines was published in March 2005, when the notice [Advocacy Guidelines for the Nationwide Advocacy Service: Revised September 2004⁵](#) was issued. As part of this notice it is remarked that: “The Minister of Health approved the revised and updated guidelines on 24 February 2005, following a comprehensive consultation process, where opportunities for comment were extended to a wide range of people and organisations that included representatives of health consumers, disability services consumers, health care providers, disability services providers and professional bodies.”

The most recent Commissioner’s review endorsed a proposal to extend the time span between reviews from 5 to 10 years.⁹

2.1.5 Underlying principles/themes

There is significant overlap in the content of the advocacy guidelines and code of practice. However, the Code of Practice does not include all themes, and we have thus set out the main themes from the advocacy guidelines and Code of Practice in Table 3, with a brief description of each item. The full items are included in Table 7 and Table 8 in Appendix 2.

Table 3: Themes underlying the New Zealand Advocacy Code of Practice and Guidelines

Themes	Brief Summary (See Table 7 and Table 8 for full description)
Code of Practice	
Purpose of health and disability advocates	Clarification of role
Independence and accessibility	Describes relationship with and visibility within the wider community
Confidential and ethical practice	Values central to interactions with consumers
Quality improvement and professional practice	Describes advocate’s practice and commitment to improving quality
Advocacy Guidelines	
Empowerment principle	Consumers are supported in resolving their complaints
Low-level resolution	Escalation of complaints only if resolution cannot occur at lower levels
Code of practice	Compliance with the code is necessary
Interpretation of and comment on rights	Advocates do not offer legal opinions
Quality	Monitoring of advocacy service and improvement based on feedback
Empowered	Advocate may act on consumer’s behalf if appropriate
Protecting the wider body of consumers	Provision to enable advocate’s concerns about a service to be addressed
Priorities	Those least able to self-advocate are prioritised
Consumer interdependence	Advocates encourage consumer to form support networks
Role of advocates	Clarification of role
Advocates’ role with providers	Details the positive relationship required with healthcare providers
Confidentiality	Advocates will never disclose confidential consumer information
Consumers’ needs and accessibility	Individual accessibility needs
Advocate support	Appropriate support for advocates shall be in put place
Relationship of the service provider to consumer	The consumer’s relationship is with the advocacy provider, not the advocate
Referrals to other agencies	Advocate’s relationships with other agencies will support referrals
Information systems	Details use of system for recording information in the service
Publicity and promotion	Describes the Commissioner’s role in promotion and publicity

2.1.6 Guidance available with regard to the principles/themes

Guidance relating to the Code of Practice is available on the Nationwide Health and Disability Advocacy Service [website](#). Guidance for the advocacy guidelines, including ministerial approval, was published, as required by law, as an article in the New Zealand Government’s [gazette](#), and is reproduced here in Table 8, Appendix 1. The Code of Practice is reproduced in Table 7 Appendix 1. Guidance documents address the points in Table 3, stating what is required of advocates or advocacy services, as relevant, and can be seen in full in Appendix 1. They do not address the service user’s expectations or the practical implications of separate parts of the codes for the service, or suggest how the service could measure compliance with each point. Although the New Zealand guidances are

available in full in the Appendices, Box 1 reproduces the guidance around conflicts of interest, primarily to illustrate content, but also to match the presentation of content with this theme from the other codes in this document.

Box 1: New Zealand Code of Practice guidance around conflict of interest for advocates

Confidential and ethical practice (excerpt from)

Health and disability advocates will:

- avoid conflicts of interest, and act honestly and in good faith at all times

2.1.7 Implementation

The advocacy guidelines, and by extension the code of practice which forms part of the guidelines, are statutory guidelines and are provided for in the 1994 Act. The Act states that guidelines may be set from time to time, having been approved and published by the Minister. The consequences for non-adherence are unclear, as is the statutory/voluntary nature of the guidelines. The National Advocacy Trust, employer of the advocates, is contracted by the Director of Advocacy. Contained within the contract are stipulations around performance standards and principles of operation, including the stipulation that advocates must adhere to empowerment guidelines and practise consumer-driven advocacy.¹⁰

2.2 Healthcare complaints advocacy services in England

2.2.1 Background

People who wish to complain about treatment or care received by them from the NHS may receive support from the NHS Complaints Advocacy service. The provision of an independent advocacy service for healthcare complaints is a legal requirement under the NHS Act 2006.¹¹ Since 2009, the framework for complaints involves a two-stage process. First, local resolution involves contacting health service providers, e.g. the nurse or doctor concerned, and engaging with the organisation's complaints manager, where such exists. Most complaints are resolved at this initial stage. Second, the ombudsman investigates complaints not resolved locally. Assistance in making complaints is available at all hospitals through the Patient Advice and Liaison Service (PALS). PALS officers offer confidential advice, support and information on health-related matters to patients, their families and their carers, and this includes information about NHS complaints arrangements and how to get independent help through, for example, the NHS Complaints Advocacy services. Under the Health and Social Care Act 2012, local authorities are obliged to commission a local NHS Complaints Advocacy service. This service evolved from a centrally commissioned service with the advent of the new law. Under the Act, local authorities are required to commission "the provision of assistance for individuals making or intending to make an NHS complaint" (including complaints to the Ombudsman).

2.2.2 What national codes of practice are in use?

A number of organisations have produced documents setting out written guidelines for complaints advocacy.

- In 2015, at the request of the Department of Health, Healthwatch England, the national body representing the views of service users and the public, published proposed **Standards** (Table 9 in Appendix 2) for good complaints advocacy. The Standards represent a service user outcome in relation to a particular theme; each contains a number of 'I' statements, giving the ideal service experience from the user's point of view, as well as 'we' statements detailing promises the service can commit to for each standard/outcome. Finally, the appendix includes the necessary actions that should be taken in order to demonstrate delivery of the service user outcomes.

- In 2015, the Local Government Association (LGA) published **Practice Guidelines** (Table 10 in Appendix 2) for independent health complaints advocacy services. The LGA Guidelines breaks down each guideline into components and details the individual experience, the outcome and the measure associated with each component.

For the purpose of this comparison, the LGA Practice Guidelines and Healthwatch Standards will be used. The LGA Practice Guidelines were developed from the Healthwatch Standards and in this regard may be considered complementary. There are a number of other documents whose relevance to healthcare complaints advocacy we were unable to establish. In 2012, prior to the current situation, where local advocacy contracts are awarded, the Department of Health produced **key performance indicators** (KPIs) for the Independent Complaints Advocacy Service, as the service was then called. The KPIs were intended to inform future contracts. However, as no list of the KPIs currently used exists and they are not implemented at a national level, we have omitted them from the comparison. There have been attempts to create a formal list of a wide range of performance indicators that are sensitive to local demographics and ways of working,¹² but these have not been published. In 2014, the National Development Team for Inclusion published an advocacy code of practice.² This code defines the principles which constitute effective advocacy generally and it is widely used. The Advocacy Quality Performance Mark (QPM) is a quality mark awarded to providers who can demonstrate how they meet the different standards set out in the advocacy code. It is an advocacy industry standard but as it is not a healthcare complaints code of practice it is not reviewed here. However, it may be used as an indicator of quality in the commissioning of advocacy services.

2.2.3 To whom do the codes apply?

The codes above can apply to advocacy service providers and their employees, contracted by Local Government Associations to provide the local NHS complaints advocacy service. The LGA Practice Guidelines were published to offer practical guidance for advocacy providers and commissioning authorities on suitable contractual arrangements. They enable local service requirements, based on the desired outcomes for the people using the service, to be specified. However, it is unclear to what extent these have been incorporated into local contracts. The proposed Standards published by Healthwatch¹³ are intended for independent providers and advocates dealing with healthcare complaints; there is no record of who may have signed up to the Standards.

2.2.4 Development and revision

The 2015 proposed Standards for healthcare complaints were developed by Healthwatch at the request of the Government¹⁴ in its public response to the Francis report into serious failings at Mid Staffordshire NHS Foundation Trust in 2013.¹⁵ Healthwatch drew on existing literature into patients' experiences of complaints handling systems, along with other documents informing the commissioning and delivery of complaints services in its brief to develop and publish proposed standards for complaints handling. No revisions or indications of planned revisions have been published. The 2015 Local Government Association Practice Guidelines were developed by the LGA, local authority commissioners of complaints advocacy services and providers of independent health complaints advocacy. The purpose of the Guidelines is to provide a benchmark for local specifications for the provision of independent health complaints advocacy services. The guidance constitutes a practical tool for local providers and commissioners to use in order to agree local service specifications, based on desired outcomes for those using the service. The Guidelines build upon the Healthwatch Standards as discussed above. No revisions or indications of planned revisions have been published.

2.2.5 Underlying principles/themes

There is much overlap in the themes covered by the Standards and Guidelines, although the Guidelines group some of the themes presented in the Standards under new headings. The main themes from each are included in Table 4 along with a brief description of each theme.

Table 4: Themes underlying standards and guidelines for independent advocacy in England

Themes (published by)	Brief summary (See Appendix 2 for full description)
Standards (Healthwatch)	
<i>The advocacy service</i>	<i>Providers can demonstrate:</i>
is client led	Clients' input and consultation is recorded at all stages
Is independent	Openness, transparency, lack of conflicts of interest
is accessible to everyone who needs a complaints advocate	Proactive promotion and engagement
maintains a clarity of purpose	Referrals to other service when necessary
provides a compassionate response	Acts on feedback, recruits those with specialist skills, meets in a place of the client choosing
works with other networks to achieve systemic change	Monitors trends in its casework
works hard for its advocates	Suitable induction, supervision, support to staff in gaining qualifications
has clear leadership	Adherence to best practice, reports achievements, strives to improve
Guidelines (Local Government Association)	
Known, accessible and responsive	Engaged with whole community and empowering
Professional	Responsive, timely, accountable, well-trained and supportive of staff
Independent	Funding not compromised; clear process for addressing conflicts, committed to a code of practice
Makes a difference	Seeks feedback, is engaged nationally, and promotes systemic change

2.2.6 Guidance available with regard to the principles/themes

In 2015, at the request of the Department of Health, Healthwatch England published [Standards](#) for good independent complaints advocacy (summarised in part in Table 9, Appendix 2). In 2015, the Local Government Association published [Practice Guidelines](#) (summarised in part in Table 10, Appendix 2) for independent health complaints advocacy services. The Healthwatch Standards define what the outcomes of a good complaints advocacy service look like, and represent the ideal service user experience; these are expressed in the form of 'I' statements. Commitments the service providers can make to ensure that their services meet the needs and expectations of the people who use them are expressed as 'we' statements. Possible indicators that may be useful to demonstrate that they are delivering a more user-oriented complaints advocacy service are also provided. The LGA Guidelines aim to benchmark local specifications for the provision of independent health complaints advocacy services. The service specifications detail how the individual should experience the service,

what ‘good looks like’ to them, the outcomes they can expect and the measures that providers and commissioners can use to monitor the effectiveness of the service. Excerpts dealing with conflicts of interest are reproduced in Box 2 to illustrate the content from each aspect of the standards and each aspect of the guidelines.

Box 2: Standards and guidelines around conflicts of interest

<p>(Excerpts from) Healthwatch Standard 1: The advocacy service is client led</p> <p>‘I’ statements (service user outcomes)</p> <p>“My advocate did not have any current professional or personal links to the organisation I was complaining about.”</p> <p>“I felt my advocate was able to raise concerns, submit complaints and support me free from interference from any other organisation.”</p> <p>‘We’ statements</p> <p>“We promise that we will do what we can to avoid conflicts of interest (real and perceived) and ‘protect’ our advocates from external pressures.”</p> <p>Indicator:</p> <p>The advocacy provider demonstrates that they are recording and managing any conflicts of interest (real or perceived) and can demonstrate the steps they have taken to address any conflict.</p> <p>Local Government Association Guidelines:</p> <p>(Excerpts from) Guideline 3: Independent</p> <p>Service specification:</p> <p>3.2 Clear process for identifying, registering and addressing conflicts of interest</p> <p>How do individuals experience this?</p> <p>I am confident that any conflicts of interest will be addressed.</p> <p>Outcome if successful</p> <p>Evidence that policies are implemented and acted on.</p> <p>Measures</p> <ul style="list-style-type: none">• Evidence in terms of reference of provider that conflicts of interest are identified, registered and addressed.• Explicit inclusion in the service specification of the importance of independence of the service
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2.2.7 Implementation

Contracting for all independent advocacy services is carried out at a local level and in accordance with local needs. Thus, each local authority has significant leeway in specifying and agreeing the terms of the advocacy contract. The tools provided in the practice guidelines are voluntary and serve as a starting point in the quest to reach an agreed service with the service provider. Similarly, any KPIs included within a contract reflect local considerations. The Guidelines published in this manner are not enforceable unless included in a contract for a regional service. There are indications that KPIs are routinely included in service contracts and that a national set of KPIs is being developed by the LGA.¹² Some of the recommendations included in the proposed standards for good complaints advocacy by Healthwatch require the implementation of legislative changes, but we found no undertaking by the Minister of Health in this respect. The Standards are currently voluntary, but may be adopted by the 23 complaints services run by Local Healthwatch from some 151 services operating nationally.

2.3 Healthcare complaints advocacy in Northern Ireland

2.3.1 Background

In Northern Ireland, the National Health Service (NHS) is referred to as Health and Social Care (HSC). The Patient and Client Council was established in April 2009 under the [HSC Reform Act 2009](#), with the role of ensuring that the combined voice of service users and the public was heard at all levels of Health and Social Care.¹⁶ The Patient and Client Council Complaints Support Service provides information, assistance and advocacy services for those wishing to make a complaint about HSC services.

The Advocacy Network for Northern Ireland (ANNI) was established in August 2012. The HSC Board has worked with ANNI from its inaugural meeting, as a means of engaging with the advocacy sector. This relationship led to ANNI being commissioned to develop a code of practice for independent advocates, along with a standards framework and a core induction checklist. The Code of Practice¹⁷ was published in 2014.

2.3.2 What national codes of practice are in use?

Under the Reform Act,¹⁸ the Patient and Client Council is not required to adhere to a specified code of practice. The [ANNI Code of Practice for Independent Advocates](#) underpins the operating of, and support offered by, the Patient and Client Council Complaints Support Service.

2.3.3 To whom do the codes apply?

The Code of Practice applies informally to employees of the Patient and Client Council Complaints Support Service.

2.3.4 Development and revision

The HSC Board has worked with ANNI since its inaugural meeting, as a means of engaging with the advocacy sector. This relationship led to ANNI being commissioned to develop a code of practice for independent advocates. The HSC Board provided non-recurrent funding over a defined time period. A project manager was appointed to coordinate the work of ANNI. The code was developed through workshops, email and one-to-one visits conducted by ANNI with a wide range of advocacy practitioners (including non-members of the network) throughout Northern Ireland.¹⁹

The Code of Practice was published in 2014 and it is unclear whether further funding will be provided, or if a review of the code is planned.

2.3.5 Underlying principles/themes

The Code of Practice takes the form of a series of promises to which each advocate commits. There are 2–5 separate commitments under each theme. The main themes are presented in Table 5.

Table 5: Advocacy Network Northern Ireland Code of Practice for Independent Advocates

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

Be open, fair and trustworthy

Put the views of people for whom I advocate first

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

Work with the agreement of the people for whom I advocate

Respect boundaries of confidentiality

Be accountable and seek support

Challenge others

Respect and promote the human rights of those with whom I work

Show respect for others

Practise self-care

Continue my professional development

2.3.6 Guidance available with regard to the principles/ themes

Guidance relating to the ANNI [Code of Practice](#) for Independent Advocates is available online through the HSC website. The guidance addresses advocates only and is written as a series of commitments to which an advocate can agree. It does not address advocacy providers or provide suggestions for measuring compliance with the Code of Practice. The themes are listed in Table 5 and sample commitments from a single theme are listed in Box 3 (in keeping with Boxes 1 and 2, the theme most relevant to conflicts of interest is used, since conflicts of interest are not dealt with directly by the ANNI Code of Practice).

Box 3: Advocate commitments from a single theme of the ANNI Code of Practice.

“As an Independent Advocate, I agree to put the views of people for whom I advocate first.”

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

2.3.7 Implementation

Correspondence with the complaints service indicated that the Code of Practice is used as a guide rather than a formal code of practice to which employees must adhere and there is no published information about how it is implemented.

2.4 Comparisons with existing Irish codes

The international advocacy codes of practice reviewed so far have all focused on the delivery of healthcare complaints advocacy. In this final results section we will focus on specified codes of practice in use in Ireland; namely those adopted by SAGE, and also by the National Advocacy Service

and the Mental Health Commission; although, as noted later, only the SAGE and the National Advocacy Service codes are actual advocacy codes of practice. It is worth noting that there is significant thematic overlap between all of the advocacy codes, whether general or healthcare complaints related, international or Irish, reviewed here. All advocacy codes promote empowerment and autonomy where possible, independence, respect, accessibility, accountability, and avoidance/reporting of conflicts of interest (although independence, conflicts of interest and accessibility are not addressed in the ANNI code). For clarity, these commonalities are mentioned here, but are not addressed as part of each single comparison. How these are interpreted or implemented depends on the particular requirements of the consumers and the area in which the service operates.

2.4.1.1 SAGE²⁰

The SAGE mission statement involves the promotion and protection of the rights, freedom and dignity of older people in the face of age-related challenges. To this end, the SAGE Quality Standards have represented that organisation's code of practice since their publication in 2015. The SAGE Quality Standards appear to be the most complete of the Irish codes of practice (see comparison in Table 6 and summary Table 14, Appendix 7). The guidance includes sections relevant to both advocates and advocacy providers, and addresses client expectations; in addition, it is sensitive to measurement and compliance with the code. While the SAGE service seeks to act as a representative advocacy service, the code of practice promotes empowerment wherever possible. In contrast, the English and New Zealand codes primarily promote empowerment advocacy and allow for non-instructed advocacy as necessary. Thematically, the SAGE service addresses the same areas as the English and New Zealand codes, differing in its focus on social inclusion and the promotion of human rights and equality (as is relevant to its consideration of advocacy beyond healthcare complaints). Having a scope beyond complaints resolution means that the SAGE service considers not just clients with the ability to give their complaint a voice; rather, it seeks to give a voice to the elderly and advocate in areas of treatment and care, as much as complaints. This is reflected in its more explicit statements around autonomy and self-determination, and in its seeking out those who may have trouble self-referring. It contrasts with the New Zealand approach. The English services have a focus on diversity, which varies by locality, and on the inclusion of marginalised social and ethnic groups. SAGE standards, by contrast with New Zealand, but in line with England, feature greater consideration of service management and include suggestions of evidence that would be indicative of compliance with each standard. They both incorporate policies supportive of each standard and practical examples of policy implementation (see Box 4). These differences with New Zealand might arise from the statutory nature of the complaints advocacy in New Zealand country and it is possible that many of the management and performance indicators for the service are included in the national advocacy service contract in New Zealand.

The ANNI Code of Practice is considered separately, as it is generally applicable to all types of advocacy. However, despite overlap with central themes, including accountability, empowerment, competence, autonomy, respect and the rights-based approach, a number of common themes are not mentioned. ANNI does not address accessibility, conflict of interest or independence; nor does it address the service providers' responsibilities. Furthermore, the SAGE Standards are more detailed, in that it addresses advocates, providers, and client outcomes, as well as supporting policy and its practical implementation.

Box 4: The SAGE standard around conflicts of interest

Standard 5: Independence:

5.2 The advocacy service is as free from conflict of interest as possible, both in design and operation.

Advocates: What is expected

- Advocates take all appropriate steps to avoid conflicts of interest occurring in their work with clients.

- Where a conflict of interest does arise, it is declared and dealt with in accordance with organisational protocols on the matter.
- Advocates are aware of their own opinions, prejudices and discriminatory practices and actively work to eliminate these in their advocacy support work.
- The engagement of advocates with clients is never compromised by pressures from outside sources, e.g. service providers or relatives.

Advocacy provider: What is expected

- The advocacy provider ensures ongoing training and support in managing conflict of interest situations is provided to advocates.
- The concept of independence is reflected in all relevant organisational policy documents and codes of practice.
- The principle of advocates not accepting money or gifts is enshrined in the Code of Practice for Advocates.

Older persons: Expected outcomes

- People are aware that only their will and preferences are being promoted by the advocate.
- People are aware that they will not be charged for the service.
- People are aware that advocates are prohibited from accepting money or gifts.
- People are aware that relatives will only be involved if the person himself/herself so wishes – except in cases where a non-instructed advocacy approach is being adopted.

Supporting policies

- Independence statement in handbook
- Governance documents (Constitution, Memorandum and Articles of Association)
- Job description
- Good practice case studies
- Conflict of interest policy and procedures
- Advocacy Handbook
- Code of Practice
- Transparent funding agreements

Policy implementation (excerpts)

- Comprehensive and clear Operational Guidelines for Advocates in place and evidence of adherence
- Record-keeping is monitored and reviewed.

Practical application (excerpts)

- The open disclosure of potential areas of conflict is facilitated.
- Mechanism for evaluation of the service every two years
- Systematic in-house support and supervision for advocates implemented.

* Some further discussion of conflicts of interest under the theme 'accountability' is omitted for clarity.

2.4.1.2 National Advocacy Service for People with Disabilities²¹

The National Advocacy Service for People with Disabilities (NAS) Code of Practice was developed to assist staff in carrying out their work providing independent advocacy for people with disabilities. It is an issues-based representative advocacy service. The NAS Code of Practice addresses many of the same areas as the international codes (see comparison in Table 6 and summary Table 14, Appendix 7).

Within the guidance for the Code of Practice, five core values are identified, each value being broken down into between two and four standards, and with each of these spelling out requirements relevant to management and to advocates separately and explicitly (see conflict of interest example in Box 5). Thematic differences with the international perspectives include a focus in the NAS Code of Practice on overcoming possible communication barriers to enable informed decision-making; a consideration of rights in a wider context, i.e. human rights, and rights relating to participation in society, i.e. rights as a citizen; a proactive seeking out of those who may be marginalised from the service; and an adherence to flexibility in service delivery, promotion, and accessible communication, ensuring that the service is available to all. Service evaluation is not addressed in the code. The Code of Practice cites empowerment as a guiding principle within the representative advocacy, highlighting its importance in a service where empowerment advocacy may not always be appropriate. A similar approach is taken in the ANNI Code of Practice, which is meant for general advocacy purposes; however, the National Advocacy Service Code of Practice is more rigorous in addressing accessibility, conflict of interest, independence, and the responsibilities of service providers.

Box 5: National Advocacy Service for People with Disabilities standards around conflicts of interest

Independence

5.2 Independent, representative advocacy looks out for and minimises conflicts of interest

NAS advocates

- a) Understand the concept of conflict of interest and are vigilant for situations in which a conflict of interest may arise
- b) Clearly and consistently explain their role to all stakeholders, in order to establish clarity of expectations and boundaries
- c) Act in accordance with the NAS Conflict of Interest Policy
- d) Consult with their Regional Advocacy Manager about any potential, or perceived potential, conflict of interest in a timely way and in accordance with the Conflict of Interest Policy
- e) Inform the person seeking independent, representative advocacy about any actual or potential conflict of interest

NAS management

- f) Ensures comprehensive policy and procedures around conflict of interest are in place
- g) Supports advocates to identify and appropriately manage conflicts of interest

2.4.1.3 Mental Health Commission²²

The Mental Health Commission Code of Practice was published in 2009 and issued pursuant to the Mental Health Act 2001. There is no mission statement with the document; instead, it is stated that it provides guidance for “those working in the delivery of a mental health service to people with mental illness and intellectual disabilities”.²² The guidelines note that they might be instructive to advocates working in this area, helping them to better understand the operation of such services. However, as the guidelines were not developed to be applicable to advocacy services, they do not adhere to a model of advocacy. The guiding principles of the Mental Health Commission prioritise the best interests of the person. It is a person-centred approach, which presumes full capacity and espouses a policy of least restrictive intervention. These principles describe how mental health professionals should select treatments and how they should include service users in decisions that affect them. Overall, these principles do not apply to the empowerment advocacy model employed in healthcare complaints advocacy internationally, except in their person-centred approach, which aims to build capacity, resources and the support networks of those engaging with advocates. The guidelines do not offer a framework to evaluate adherence to the Mental Health Commission Code of Practice.

Table 6: Comparison between Irish and international codes of practice

	New Zealand	England	Northern Ireland	SAGE	National Advocacy Service (NAS)
Document name(s)	New Zealand Health and Disability Advocacy Service Advocacy Guidelines and Code of Practice	Local Government Association – Practice Guidelines for independent health complaints advocacy services. Healthwatch – Independent Complaints Advocacy. Standards to support the commissioning, delivery and monitoring of the service.	Advocacy Network Northern Ireland (ANNI) - Code of Practice for Independent Advocates	Six Quality Standards for Support and Advocacy Work with Older People	NAS Advocacy Code of Practice
Purpose of document(s)	To guide healthcare complaints advocacy	To guide healthcare complaints advocacy services' practice and commissioning.	To raise the quality of experience for those who engage with all advocacy services.	To guide all types of advocacy work Organisation works with older adults	To assist independent advocacy for people with disabilities
Model of advocacy¹ format	Empowerment Guidelines – list Code of practice – thematic list	Empowerment Guidelines – thematic list Standards – list of attributes of ideal advocacy service from clients' perspective.	Empowerment (not stated explicitly). Thematic list	Representative advocacy – code applies to all models Six standards (themes) contain four components each.	Issues-based representative advocacy Five core values (themes) comprising 2–4 standards.
Aimed at	Items in guidelines can be relevant to either advocates or advocacy providers.	Guidelines are aimed at local authorities commissioning services looking to benchmark specifications. Standards are aimed at clients, advocates and advocacy providers.	Advocates	Each component is relevant to clients (expected outcomes), advocates and providers (what is expected from them).	Standards detail requirements in relation to management and advocates separately.
Evaluation framework	None	Guidelines include suggested measures for each point. Standards include suggested indicators for each client outcome.	None	Policies supporting each standard are listed with guidance for their implementation and practical use.	None
Role of advocates in education	Advocates engage with healthcare providers to raise awareness of patients' legal rights and the role of advocacy in complaint resolution.	No stated role beyond promoting the service	None	No stated role beyond promoting the service	No stated role beyond promoting the service

	New Zealand	England	Northern Ireland	SAGE	National Advocacy Service (NAS)
Thematic comparison with New Zealand	Not applicable	Not applicable	Not applicable	Both promote professionalism, respect, confidentiality, empowerment, adherence to a code, accessibility, independence, conflict of interest avoidance, accountability, clarity of role, training, collaboration, transparent prioritisation of cases, quality. SAGE has a greater focus on social justice, diversity, proactively engaging marginalised clients, and includes a complaints procedure.	Both promote professionalism, respect, confidentiality, advocate training, accessibility, independence, promotion, relationships with other services, accountability, clarity of role, empowerment, conflict of interest avoidance, and advocate training. NAS has a greater focus on human and equal rights, proactively proactively engaging marginalised clients, eligibility to use the service, facilitating consumers, information sharing, and communication, with less focus on transparent prioritisation.
Thematic comparison with England	Not applicable	Not applicable	Not applicable	The SAGE standards overlap to differing extents with all English guidelines and standards, with the exception of the focus on social justice. SAGE has a greater focus on social justice and proactively proactively engaging marginalised clients.	Similar to the SAGE code, the NAS code overlaps to differing extents with all English guidelines and standards. NAS has a greater focus on human and equal rights (omitted in England), proactively proactively engaging marginalised clients and eligibility to use the service.
Thematic comparison with Northern Ireland	Not applicable	Not applicable	Not applicable	There is some overlap in central themes: accountability, empowerment, confidentiality, professionalism, clarity of role, respect and a rights-based approach. ANNI does not address accessibility, conflict of interest or independence, or service providers' responsibilities or clients' expectations.	There is some overlap in central themes of accountability, empowerment, confidentiality, professionalism, clarity of role, respect and a rights-based approach. ANNI does not address accessibility, conflict of interest or independence. Neither NAS nor ANNI address service providers' responsibilities or clients' expectations.

Note: NAS – National Advocacy Service, ANNI – Advocates Network of Northern Ireland. The Mental Health Commission Code of Practice was omitted from this table as it was found not to be suitable for comparison with the international codes of practice.

3 Conclusion

We examined state-directed healthcare patients' complaints advocacy services in five countries: New Zealand, England, Northern Ireland, Scotland and Australia (Western State only). The complaints advocacy services in New Zealand, England and Northern Ireland all have codes of practice (although the terms 'guidelines' or 'standards' are also used) which inform and guide their advocates' work. These services promote the empowerment of patients to act on their own behalf, with the advocate acting primarily to direct the complaint, identify resources, or mentor the consumer. Advocates can adopt a more representational role, if needed by the consumer, usually within specific limitations. The themes covered by international codes of practice in healthcare complaints advocacy include: confidentiality, professionalism, clarity of advocate's role, empowerment/a client-led service, accountability, respect, accessibility, independence, complaints, and conflicts of interest.

Of the three countries with codes of practice, New Zealand has the longest-established service (since 1996). Its complaints and advocacy services are provided by a single statutory service that is independent of the health service. The legislation underpinning the advocacy service requires the Commissioner to review the Act and the Code periodically, and this has been done every five years since its inception. Advocates are employed by a single service provider, the National Advocacy Trust, and are guided by both the Advocacy Guidelines (statutory) and a Code of Practice. The themes covered in the New Zealand codes compared well with other healthcare complaints codes, although a procedure for addressing complaints made about the advocacy service was not set out. The content of these codes applies to the advocacy service provider also, but does not address client expectations or suggest measures that might be used to check compliance with the codes. However, the national contract for the advocacy service does include stipulations around the advocacy service's performance and operation which are unavailable. It is worth noting that New Zealand operates a no-fault system of compensation for accidental injury, including medical injury, and therefore complainants are not required to prove negligence in order to receive compensation. It is only through the Health and Disabilities Commissioner's Office that a complaint may be made – not through the court system, as in Ireland.

England has a long-established independent patient advocacy service, operating on a statutory basis since 2006. Since 2013, the local authorities have the responsibility of contracting with independent advocacy groups to provide a local NHS complaints advocacy service. Two codes of practice, whose use is voluntary, were produced to guide the commission and operation of healthcare complaints advocacy services: the Local Government Association's Guidelines and the Healthwatch Standards. The content of these codes of practice addresses all themes listed above and includes clauses relevant to client expectations, advocates and service providers, as well as indicating useful measures of compliance with the code. Both codes of practice were published post-2014 and have not indicated whether revisions are planned. The Guidelines are designed to allow local services to be benchmarked and are intended to be used in the commissioning of services; however, the extent to which individual contracts adhere to the Guidelines is unknown.

Northern Ireland's Patient and Client Council has been in operation since 2009. As an independent statutory body it provides healthcare complaints advocacy for users of the Health and Social Care Board's services. Advocates' practice is guided by the Advocacy Network for Northern Ireland's Code of Practice, although it is unclear the extent to which the code is formally used. The code applies to general advocacy and, as such, it is not a healthcare complaints code. This is reflected in its themes, which do not directly address accessibility, independence, conflicts of interest or inclusion of marginalised groups, advocacy support or complaints. It does focus more on informed decision-making and human rights, reflecting its more general purpose. The content of the code is addressed solely to advocates.

This brief identified three Irish codes of practice currently in use, among which the Mental Health Commission's was found to guide treatment selection in its services and was thus not applicable to advocacy. Codes of practice in use by SAGE, a service for older adults, and the National Advocacy Service, which advocates for those with disabilities, were compared with the international codes of practice discussed above. Both SAGE and the National Advocacy Service address all themes raised by the international healthcare complaints advocacy codes; in addition, they address informed decision-making and human rights, reflecting their general advocacy role with people who potentially have impaired decision-making. Each identifies its service as a representative advocacy, but one that includes empowerment as a basic aim enshrined in its Code of Practice. While the National Advocacy Service includes content relevant to advocates and providers, the SAGE Code of Practice was found to be more comprehensive, given that it includes content relevant to service providers, as well as suggested measures of compliance.

Appendix 1 – New Zealand’s codes of practice

Table 7: New Zealand Health and Disability Advocacy Code of Practice

Code of Practice – Full Guidance

Purpose of health and disability advocates

Advocates aim to help consumers achieve consumer-centred health and disability services and resolve complaints by:

- Providing advocacy services that focus on the resolution of consumers’ concerns and complaints
- Promoting respectful relationships and communication
- Empowering and supporting consumers/complainants to take their own action to improve health and disability services
- Educating both providers and consumers on consumer rights.

Independence and accessibility

Health and disability advocacy services will:

- Be easy to contact
- Be well linked to their community and local networks
- Provide advocacy that is free and independent
- Provide independent information about consumer rights and options for dealing with concerns, including how an advocate can assist.

Confidential and ethical practice

Health and disability advocates will:

- Be trustworthy, act in a non-judgemental way and treat others with respect
- Listen, encourage and validate the consumer’s views, taking into account cultural values, beliefs and the unique place of *tangata whenua*
- Avoid conflicts of interest, and act honestly and in good faith at all times
- Provide consumers with access to their advocacy record, keep information confidential and not disclose information without the proper authority unless safety is compromised
- Be reliable and follow through on actions agreed between the consumer or the consumer’s representative; and provide a level of stability, safety and clarity in meetings and other resolution processes.

Quality improvement and professional practice

Advocates will:

- Work to continuously improve quality of service to consumers through ongoing training, professional development and quality improvement activities
 - Use appropriate support, such as mentoring, peer support and supervision
 - Be accountable, seek consumer feedback, take part in regular review of their practice and participate in monitoring and evaluation of their work, and
 - Demonstrate commitment to the vision, values and standards of the Nationwide Advocacy Service and the principles of the Code of Health and Disability Services Consumers’ Rights.
-

Table 8: New Zealand health and disability advocacy guidelines

Full guidance for the Health and disability advocacy guidelines
<p>1. Empowerment principle – Advocacy is committed to the belief that consumers already have skills and experience on which to draw in order to help them resolve their concerns. Working in an empowering way is based on the belief that it is better to equip and support consumers to solve their own problems than to take over their problems and fix them on their behalf. The empowerment principle supports the consumer to resolve the current issue with assistance, and to learn skills and knowledge to develop confidence to self-advocate if and when similar issues arise in the future.</p>
<p>2. Low-level resolution – The intention of the Health and Disability Commissioner Act and the Code of Health and Disability Services Consumers’ Rights (the Code) is to promote resolution of complaints at the lowest appropriate level. Often, the fastest and most satisfactory way of resolving grievances is for the consumer to deal directly with the actual provider of the service. The advocacy service established under the Act is fundamental to this aim of low-level resolution.</p>
<p>3. Code of Practice – Advocacy service providers and advocates shall comply with the Code as if they were providers for the purposes of the Code, except where such compliance is inconsistent with these guidelines.</p>
<p>4. Interpretation of and comment on rights – Advocacy service organisations and individual advocates shall refer any request for interpretation of the Code to the Commissioner. Advocacy service organisations and individual advocates shall not offer opinions about the interpretation of the Code or other rights, except to refer consumers, providers or media to any relevant decisions or statements by the courts, Human Rights Review Tribunal or the Health and Disability Commissioner, and to assist consumers or providers to understand those decisions and statements.</p>
<p>5. Quality – It is important that the quality and effectiveness of the advocacy service is monitored and evaluated regularly and that improvements to the service are made on the basis of feedback from consumers, complainants, providers and advocates.</p>
<p>6. Empowered – Consumers remain in control and take responsibility for their issues, concerns and rights. If the consumer is unable to act on his or her own behalf, or it is culturally inappropriate for the consumer to speak on his or her own behalf and requests the advocate to do so, the advocate may accept instructions to act or assist on behalf of the consumer.</p>
<p>7. Protecting the wider body of consumers – Advocates may have concerns about a provider’s practice or any other matter that relates to the rights of health or disability consumers. These concerns may have arisen through an advocate working with a consumer who is unwilling or unable to complain, or from trends identified by the advocate in the course of his or her work, or from concerns raised by others in the community. In order to protect the wider body of consumers and ensure the proper accountability of providers, an advocacy service may contact providers directly about the concerns raised, or draw the matter directly to the Health and Disability Commissioner’s attention. The advocacy service can contact the provider directly when concerns can be appropriately resolved at a low level. An advocate shall refer systemic and non-systemic concerns that cannot be dealt with appropriately with low-level resolution directly to the Health and Disability Commissioner. A referral shall also be made where the concern has been raised previously by the advocacy service, and the provider has not responded or taken appropriate action.</p>
<p>8. Priorities – Persons who are least able to self-advocate, and those persons whose welfare is most at risk and who do not have an appropriate support person, are the priority for all inquiry and complaint advocacy services to consumers. Those considered as having their welfare most at risk are likely to be consumers who may experience two or more of the following:</p> <ul style="list-style-type: none"> • Very little social contact • Little or no family support • Difficulty in communicating and being understood • Living in a situation where physical, emotional, mental or financial abuse by an informal or formal caregiver is threatened or has occurred • Mental illness and/or drug or alcohol addictions that may impede their ability to reason and/or be understood or taken seriously.
<p>9. Consumer interdependence – When working with consumers, advocates assist and encourage them to develop their own support networks. This enables them to remain in control and take responsibility for their own issues, concerns and rights. Ongoing support networks may include family, extended family, friends and</p>

neighbours, other consumers, paid professionals or advocacy groups, in order to meet their ongoing advocacy needs and to assist in the resolution of their issues. Health and disability consumer advocacy may be used in conjunction with a consumer's network of support people.

10. Role of advocates – An advocate provides information and facilitates the consumer to pursue and resolve their issues with advocacy support. An advocate assists a consumer to develop knowledge and skills so that the consumer is supported to resolve the current issue and is able to resolve future issues, where possible, using the skills and knowledge gained through working alongside an advocate. When assisting a consumer, advocates shall not offer opinions as to whether there has been a breach of the Code. An advocate shall not investigate or adjudicate on issues raised, nor act as an impartial mediator. If resolution is not achieved, the advocate shall, if requested by the consumer, assist in finding an appropriate forum where issues raised may be mediated or complaints may be investigated. This can involve the advocate in supporting a consumer through the Health and Disability Commissioner complaint processes and/or the Director of Proceedings processes.

11. Advocates' role with providers – Advocates are on the side of the consumer and may present some challenging situations to the provider, but this does not prevent them from being fair, considerate and professional in all their dealings with providers. Advocates give free presentations to provider groups, on advocacy services, the Health and Disability Commissioner role, the Code, and the complaints processes available to consumers.

12. Confidentiality – Advocacy services and advocates shall not make statements to the media, or in presentations, or in personal communications that identify individual consumers or providers, nor comment whether specific actions by providers, either real or hypothetical, are or would be in breach of the Code.

13. Consumers' needs and accessibility – Advocacy services shall take positive steps to ensure that they are able to meet the needs of any particular person or groups of persons for whom they have contracted with the Director of Advocacy to provide services. Advocacy service providers shall therefore take positive steps to ensure that advocacy services are equally accessible to all groups of consumers. Specialist nationwide advocacy services may be contracted with the Director of Advocacy to provide consumers with specialised advocacy.

14. Advocate support – Advocacy service providers shall ensure that appropriate support systems are in place for individual advocates. This may include induction, training, performance management, peer supervision via support and review, risk management procedures, physical safety and appropriate specialist support.

15. Relationship of the service provider to consumer – Advocacy service providers, rather than individual advocates, are contracted to provide services to the consumer. Consumers shall be advised that the advocate is providing the service as an employee of the advocacy service provider.

16. Referrals to other agencies – Advocacy service providers shall establish and maintain effective links with relevant agencies, including community groups, and refer consumers to those agencies as and when appropriate.

17. Information systems – The collection, accurate recording and transfer of information pertaining to advocacy services, including trends in consumer issues, assists in the efficient and effective management of these services. It provides valuable information as to the present and future needs of consumers and the need for any improvements to the service. Reporting requirements in line with contractual obligations shall be facilitated by the use of information systems approved by the Health and Disability Commissioner.

18. Publicity and promotion – The integrity of the advocacy service is maintained by ensuring consistency in all publicity provided about the advocacy service. The Health and Disability Commissioner will provide all generic promotional and educational material, about the Code and the role of the Commissioner, directed to consumers and providers. Promotional and educational material will, where possible, be in accessible formats for consumers. Any specific promotional and educational information produced by individual advocacy service providers will be sent to the Director of Advocacy, prior to publication, for comment. Formal public speaking engagements and papers for publication by advocacy service providers and individual advocates will be notified in advance to the Director of Advocacy for comment.

Appendix 2 – England’s codes of practice

Table 9: Standards to support the commissioning, delivery and monitoring of the NHS Complaints Advocacy Service (Healthwatch England)

Standards for the NHS Complaints Advocacy Service (Healthwatch)

Standard 1: The advocacy service is client-led

‘I want to be in control of the advocacy process at all times. I don’t want the advocate to push their own agenda or tell me what to do. I want them to listen to me and only act on my instructions.’

Standard 2: The advocacy service is independent

‘I want my advocate to offer me the full range of advocacy support without being worried, restricted or limited by the health and care provider, commissioner or anybody else.’

Standard 3: The advocacy service is accessible to everyone who needs a complaints advocate

‘I want it to be easy to find my local advocacy service and get an advocate. I want the advocacy service to respond to my needs.’

Standard 4: The advocacy service maintains a clarity of purpose

‘I want to understand precisely how the advocacy service can help me. When I want other types of support I want help to find out about other services and support in accessing them.’

Standard 5: The advocacy service provides a compassionate response

‘I want to be treated with kindness and be shown compassion by an advocacy service that understands my needs. I want the service to understand I may be experiencing a whole range of difficult emotions that may affect my complaint and the ability to complain.’

Standard 6: The advocacy service works with other networks to achieve systemic change

‘I want the advocacy service to make sure it takes action to improve the way health and social care services are delivered, so no one else will have to go through the experiences I went through.’

Standard 7: The advocacy service works hard for its advocates

‘I want a service that looks after its staff. I want to know my advocate is trained, supervised and maintains professional standards.’

Standard 8: The advocacy service has clear leadership

‘I want a service that I trust will deliver the very best quality of complaints advocacy support. I want to know that the people running the advocacy service are good leaders and are committed to excellence.’

For each of the above standards, the guidance describes the ‘I’ statements included above as representing the ideal complaints service. In addition, a ‘we’ series is included in the complete guidance, representing promises the service provider can make.

Table 10: Practice guidelines for NHS complaints advocacy services

Practice guidelines for NHS complaints advocacy services (Local Government Association)

As a minimum, the core characteristics of an effective service are:

1. Known, accessible and responsive

- 1.1 Clear communication strategy, based on specific characteristics of the community.
- 1.2 Proactive engagement of all sections of the community – in particular seldom-heard groups – and removing barriers to access.
- 1.3 Focused on empowerment and the promotion of self-advocacy, wherever appropriate.
- 1.4 Part of and knowledgeable about the local landscape for complaints, information and signposting.

2. Professional

- 2.1 Clear purpose and description of service.
- 2.2 All staff, including volunteers, are appropriately trained, supported and managed to recognised professional standards.
- 2.3 Staff understand the policy framework and statutory responsibilities for confidentiality, safeguarding and consent, and information management in line with current guidance from the Department of Health.
- 2.4 All staff are accountable, with a clear and accessible complaints procedure.
- 2.5 Clear standards for timeliness and responsiveness.
- 2.6 Clear understanding of best use of resources.

3. Independent

- 3.1 Commissioning and funding arrangements do not compromise provision of independent advocacy to clients.
- 3.2 Clear process for identifying, registering and addressing conflicts of interest.
- 3.3 Demonstrable commitment to the principles of the Advocacy Charter or local equivalent.

4. Makes a difference

- 4.1 Measure and report on outcomes from a client and system perspective and can demonstrate what difference the service has made.
- 4.2 Proactively seeks and acts on client feedback.
- 4.3 Identifies systemic issues and trends and takes action to promote systemic change.
- 4.4 There are robust systems to share information with local and national organisations involved in complaints and service improvement.

For each of the above 17 guidelines, the guidance explains how it relates to clients' experiences, the outcome for the service if each point is implemented and what documents or other evidence provides a measure of the guideline.

Appendix 3 – Northern Ireland’s Code of Practice

Table 11: Advocacy Network Northern Ireland Code of Practice for Independent Advocates

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

Be open, fair and trustworthy.

Put the views of people for whom I advocate first.

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

Work with the agreement of the people for whom I advocate.

Respect boundaries of confidentiality.

Be accountable and seek support.

Challenge others.

Respect and promote the human rights of those with whom I work.

Show respect for others.

Practise self-care.

Continue my professional development.

Advocates can sign a statement of commitment agreeing to the following statements, which are further broken down in the official guidance.

Appendix 4 – SAGE Quality Standards

Table 12: Six overarching standards and related components (SAGE)

Standards	Components
1. Respect for the inherent dignity and worth of persons	<ul style="list-style-type: none"> • People treated with dignity and respect • Respect for people’s autonomy and right to self-determination • All personal information , whether obtained directly or indirectly, treated in strict confidence • Empowerment of individuals as a core value
2. Promoting social justice	<ul style="list-style-type: none"> • An underpinning human rights perspective • A focus on social inclusion • Each person respected as having equal rights before the law • Recognising and respecting diversity
3. Diligence and competence in practice	<ul style="list-style-type: none"> • Advocates adequately trained, supported and supervised in their advocacy work • Adherence to agreed codes of practice • Advocates working consistently to high quality standards • Total clarity of advocacy role and boundaries
4. Accessibility	<ul style="list-style-type: none"> • Available in an equitable and timely manner for those who need it • Promoted so that potential users become aware of it • Proactive in seeking out hard-to-reach people and those who might have difficulty self-referring to the service • Information about the service fully accessible
5. Independence	<ul style="list-style-type: none"> • Structurally and operationally independent • Free from conflict of interest • Clear boundaries between advocates and health/social care services staff • Collaboration with other health/social care provider
6. Accountability	<ul style="list-style-type: none"> • Accountable to the people who use the service • Service effectively managed • Adherence to all legal requirements • Underpinned by human rights provisions and equality legislation

For each component, the guidance discusses what is expected from the advocate, what is expected from the advocacy provider and the expected outcomes for older adults. For each standard, the guidance provides a list of policies which support the standard.

Appendix 5 – National Advocacy Service for People with Disabilities Code of Practice

Table 13: Core values and standards of the National Advocacy Service for People with Disabilities

Values	Standard
Independence	<ul style="list-style-type: none"> Independent, representative advocacy is led and guided by the views, wishes, rights, needs and interests of the people who use the service. Independent, representative advocacy looks out for and minimises conflicts of interest.
Autonomy	<ul style="list-style-type: none"> Independent, representative advocacy aims to support people to have greater control over their lives and to maximise their involvement in decisions which relate to their advocacy goals.
Equality/Citizenship	<ul style="list-style-type: none"> Independent, representative advocacy tries to ensure that people’s rights are upheld. National Advocacy Service, and all its publications and communications, are accessible to the people who may wish to use the service. Independent advocacy is available to those who need it and services are allocated in a fair way. The Service is proactive in seeking out people who have difficulty in getting a service and who may not be able to enquire or seek advocacy support.
Respect	<ul style="list-style-type: none"> Independent, representative advocacy values the people who use the service and always treats them with dignity and respect. Independent, representative advocacy is accountable to the people who use the service. Independent, representative advocacy is accountable under the law. Independent, representative advocacy is effectively managed.
Empowerment	<ul style="list-style-type: none"> National Advocacy Service aims to facilitate the person to be an active participant in the advocacy process to the degree that they wish.

Each standard in the guidance includes details of the responsibilities of advocates and managers in relation to the service.

Appendix 6 – Mental Health Commission Code of Practice

Guiding principles (abridged) of the Code of Practice:

- The **best interests** of the person should be the principal and overarching consideration when making a decision.
- A **person-centred approach** to care and treatment should be adopted.
- A person who has reached the age of majority (i.e. 18 years of age) should be **presumed to have full capacity** to make a decision affecting him or her until the contrary is established.
- Any intervention employed should be the **least restrictive** to the person's freedom while remaining appropriate to the person's needs and the need to protect the safety of himself/herself and others.

Good practice is outlined around the issues of: governance, care and treatment, and decision-making and consent; and is discussed in terms of the expectation/experience of the user, the service provider's responsibilities and the responsibilities of those working in a mental health service.

Appendix 7 – Summary table comparing codes

Table 14: Summary of comparison between Irish and international advocacy codes of practice

	SAGE	National Advocacy Service	New Zealand	England	Northern Ireland
<i>Purpose of advocacy</i>					
Healthcare complaints			✓	✓	
General	✓	✓			✓
<i>Empowerment advocacy</i>					
<i>Content applicable to</i>					
Client expectations	✓			✓	
Advocates	✓	✓	✓	✓	✓
Service providers/managers	✓	✓	✓	✓	
Measures of compliance	✓			✓	
<i>Main themes</i>					
Confidentiality	✓	✓	✓	✓	✓
Professionalism	✓	✓	✓	✓	✓
Clarity of advocate’s role	✓	✓	✓	✓	✓
Empowerment/client led	✓	✓	✓	✓	✓
Accountability	✓	✓	✓	✓	✓
Respect	✓	✓	✓	✓	✓
Accessibility	✓	✓	✓	✓	
Independence	✓	✓	✓	✓	
Conflicts of interest	✓	✓	✓	✓	
Proactive inclusion	✓	✓			
Human rights	✓	✓			✓
Advocate support/training	✓	✓	✓	✓	
Complaints about service	✓	✓		✓	
Safeguarding	✓	✓	✓	✓	✓

Note: Main themes adapted from the Advocacy Charter²³

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