PATIENT & CLIENT COUNCIL

Learning Disability and Autism Unit

Department of Health Room

D2 Castle Buildings

Stormont

Belfast

BT4 3SQ

22 December 2025

BY EMAIL ONLY

Dear Sir/Madam

Ref: Learning Disability Service Model Consultation

A welcome consultation

1. The Patient and Client Council (PCC) welcomes this consultation and the opportunity to respond to the Learning Disability Service Model Consultation.

2. PCC is not an organisation that specialises in learning disability and our response should be considered in this context. In developing this response, we have considered our statutory role, experience - through what we have heard from people's lived experience, through our Learning Disability Engagement Platform, advocacy work and our general policy work.

The role of the PCC

3. The PCC is a statutory corporate body established under the Health and Social Care (Reform) Act (2009). The HSC Framework Document (2011), produced by the Department, describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. The document stipulates that ‘the overarching objective of the PCC is to provide a powerful and independent voice for patients, clients, carers and communities on health and social care issues through the exercise of its legislative functions’[1], which are:

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

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

5. Paragraphs 6.40 to 6.42 of the HSC Framework Document (2011) further outlines the independent challenge function the Department conferred on the PCC and the RQIA.[2]

6. Further information on the role of the PCC, our delivery model and services can be found at **Appendix 1**.

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[1] DHSSPS Framework Document - September 2011 | Department of Health
[2] DHSSPS Framework Document - September 2011 | Department of Health

Introduction

7. The Learning Disability Service Model is an overarching review and as stated is a strategic framework that defines what good support should look like – including the values, outcomes, and service approaches that should shape how care is designed, commissioned and delivered, which began as far back as 2018.

8. The implementation of the Learning Disability Service Model as proposed will be a system-wide undertaking and this will, in itself, PCC believe, present both opportunities and challenges that will need to be clearly articulated to the public. People with learning disabilities have the same rights as everyone else that should be respected and protected – to live with dignity, to be included in their communities and to access the support they need to lead full meaningful lives. Their voice, and that of their families, carers, and supporters, is a vital component in the decision-making that affects their lives.

9. The Proposed Learning Disability Service Model sets out a focus with 6 key ambitions:
    - Life Changes – ensuring people receive the right support through key transitions and life stages.
    - Health & Well Being – Tackling avoidable health inequalities and improving access to care.
    - Families and Carers – Strengthening emotional, practical and respite support for those who care.
    - Meaningful Lives and Citizenship – Expanding opportunities for education, employment and Community inclusion.
    - Home – Supporting people to live in their own homes, with the right support around them.
    - Mental Health and Behaviours of Concern – Delivering timely, specialist and integrated support, including alternatives to hospital admission.

10. The plan proposes that these will be supported by a clear set of outcomes and that a 3-year Delivery Plan will identify the actions needed, responsibilities, and that progress will be measured through a Regional Outcomes Dashboard and a cross-departmental Memorandum of Understanding and joint governance structures.

11. The need for a review and new approach to the provision of Learning Disability Services is long overdue and the extent of the current reform spanning a number of years and including stakeholder engagement, engagement platforms, workshops and roadshows is welcome, but it now requires action and implementation.

12. Page 19 to 22 of ‘We Matter Report’ estimates up to 42000 people could potentially meet the criteria for a diagnosis of learning disability, however, not all of these would require support from HSC services. In 2025, at page 22, it states that there are “approximately 9000 adults with learning disability accessing specialist and community learning disability HSC services with a current growth rate of 1.6% per annum.” However, the report does not provide an analysis of the demand, and future demand, for services. Nor does it outline an analysis of the breadth of need across the learning disability spectrum or a recognition of the complexity of need and specialised support for those with complex communication requirements and/or specialised advocacy support. PCC consider it important that this analysis is undertaken and that projected forecasts on need, demand and proposed response are included in the costed implementation plan, including a breakdown of provision of LD services across the range of service need anticipated and consideration of how this will be prioritised.

13. PCC considers that the public are the experts, by their experience in the care they or someone they care for receives. This experience and expertise should not be lost to the system and if appropriately utilised the public can add significant value to delivering on HSC reform.

14. PCC welcome the manner in which the public have been engaged within the development of the Learning Disability Service Model via roadshows across NI, and in engaging with the PCC Learning Disability engagement platforms, as a positive step in the right direction towards greater public participation, ensuring a person-centred approach and to enabling the public voice to be represented in the design, commissioning and delivery of future services.

15. It is PCC's position that a strategic approach to public participation and engagement builds a culture of shared responsibility and accountability and that two-way engagement fosters trust and transparency, which are essential components for building strong relationships between citizens and public institutions. This engagement ensures that policies and services can be tailored to reflect the realities of people's lives, leading to more effective interventions, improved health outcomes, and more efficient government through strengthened community agency. A strategic whole system approach to the delivery of the Learning Disability Services Model will be essential to break down silos and create the integrated approach that will be necessary to deliver the multi-faceted and holistic nature of care, health and well-being support that will be necessary to achieve better outcomes for individuals, carers, family members and their communities.

16. PCC recently published our People to Partners[3] report which outlines the systemic thinking and changes that we consider are fundamental to meaningfully embed the necessary cultural shift across the HSC and with the public, to deliver this change on a system wide basis.

17. We would encourage the Department to meet people where they're at, continuing to seek out opportunities to engage with marginalised groups and those perceived to be hard to reach. This would maximise the engagement of those who may not usually be heard, or who ordinarily would not seek out or access services, in order help address health inequalities.

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[3] people-to-partners-final-for-print-081025.pdf

PCC Learning Disability Engagement Platform

18. A PCC Engagement Platform is a space to bring together a group of people, with a common theme or interest and lived experience, to work together and make change in health and social care. PCC Engagement Platforms allow participants to communicate their experiences and insights, related to a policy programme, with the PCC, as well as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas or policies under review, development and reform.

19. The PCC Learning Disability Engagement Platform has operated since 2021. It brings together the lived experiences of those caring for individuals with learning disabilities. The Platform have regularly met with the Department of Health (DoH) and have had the opportunity to contribute to the Learning Disability Service Model directly.

What We Heard – Insights from the PCC Learning Disability Engagement Platform

20. At the latter part of 2024 the Engagement Platform were provided with the draft Refreshed Learning Disability Service Model. The Department has directly received feedback from the platform, however a summary of their main concerns can be outlined as such:

- The service model is geared towards those with loved ones who do not require as much “hands-on” care.
- They felt the service model did not adequately represent the spectrum of learning disability and focused on individuals with less complex needs with the ability to consent.

- The Platform Members expressed concern that the HSC Trusts will continue to work in silo’s even with a new model in place.
- The Learning Disability Service Model proposes that individuals will have access to activities and services in the community that are meaningful and purposeful. They will have a choice and control over the activities in which they participate. There are real concerns expressed at the roadshows and that the PCC Engagement Platforms have highlighted that day centre provision will be replaced with day opportunity provision. These provide both opportunities for the individual with learning disability while also providing respite for carers and families.
- There is a genuine concern that this will benefit those adults with Learning Disabilities that have lesser complex needs and provides only limited provision. Greater detail is required on the provision for those with more severe and profound learning disabilities and how this will appropriately meet the objectives outlined whilst meeting their needs.
- There is a fear that those with the greatest complex needs may lose out on day centre placements that currently provide a range of experiences, training and skills opportunities as well as providing social hubs for engagement that they would otherwise struggle to avail of. This may impact social integration, socialising opportunities, and personal relationship building which are necessary to enable individuals with learning disabilities to live safe, active and valued lives.
- Day opportunities that are hourly based may increase the dependence requirements on families and carers, who may have to give up work due to timeframe requirements and to facilitate transportation to and from provision, which may create a further negative financial impact on the family home. Greater scoping and engagement on individual care plans will be required to address and reflect the best needs of the person with a learning disability and also their carers’ in relation to the provision of care that will best meet their needs at that time.
- A further concern is that of transport provision. At present opportunities at day centres can and does include transport provision but it is not clear if this will be included in day opportunity provision. This may result in an

additional financial burden, vehicle requirement/driver availability, on already stretched or working families to facilitate this provision.

- Respite Care/short break provision is a key concern. Respite provision for persons with learning disability and their carers has been significantly scaled back and, in some areas, has been unavailable.

21. The Top four priorities for the Learning Disability Engagement Platform in a Learning Disability Service Model were:

    A. Better respite and short breaks;
    B. Transport to Day Centres;
    C. Better communication between staff & families;
    D. Better medical services (GP, hospitals etc)

22. The Platform further expressed concern that there is no new money for implementation and to put the model into action and they felt without appropriate funding the Service Model development may be somewhat of a pointless action.

Independent Advocacy Services

23. PCC welcomes under *Key Ambition 3 - Carers and Families,* that families and carers can access a single point of contact for all advice and information about services, carer’s assessments and independent advocacy services and that carers will have local access to an independent advocacy service, when required.

24. Advocacy plays an important role in supporting people to express their views and in providing a source of support which gives them confidence to speak out. Advocacy is vital in cultivating trust and effectively supporting people to ensure their views are considered and heard. It should also provide an environment in which they can confidently raise any concerns they may have with their advocate in the knowledge that there are no conflicts of interest. There is an additional need to provide independent advocacy for service users *and* at the same time be commissioned to provide direct services to people with learning disability. This poses an actual or perceived conflict of interest and strengthens the need to

consider how independent advocacy, understood in structural, psychological and financial terms, is commissioned and delivered. We say more on this in our response below.

25. Independent Advocacy:
    - Safeguards people who can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social and environmental circumstances that make them vulnerable.
    - Empowers people who need a stronger voice by enabling them to express their own needs and make their own decisions.
    - Enables people to gain access to information, explore and understand their options, and to make their views and wishes known.
    - Speak up on behalf of people who are unable to do so for themselves[4].

26. The PCC expects, and we believe the public expect, that organisations providing advocacy services should be independent of service providers i.e. **structurally, financially and psychologically** independent. Ensuring the integrity of independence, advocacy service providers' accountability arrangements should be independent of Trusts to ensure freedom to act without potential adverse consequence on the contractual arrangement.

27. The PCC believes the following aspects should underpin the provision of advocacy services within the Health and Social Care system:
    - Advocacy services should be commissioned as regional services;
    - Advocacy services should be commissioned independently of HSC Trusts;
    - Advocacy services should be commissioned on the basis of agreed standards which include addressing the role of these advocacy services in dealing with complaints and concerns raised by clients, responding to safeguarding issues, and systems of regulation of services and the workforce;
    - The service specification with providers commissioned to provide advocacy services should specify how these service providers relate to the Patient and

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[4] NHS Scotland. (2013) Independent Advocacy Guide for Commissioners. Independent Advocacy Guide for Commissioners

Client Council in the discharge of its statutory roles (where the PCC is not the provider or commissioner of the service);

- The same specification should specify a minimum data set to be collected by the service provider both for the purposes of monitoring the provider's performance and for the purpose of identifying issues of service quality and safety with services provided by HSC Trusts; and
- Access to these advocacy services should be client-led and not solely dependent on a referral by HSC Trust.

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

29. The availability of independent advocacy assists in creating a culture of openness and transparency and plays a fundamental role in governance, assurance and addressing inequality.

30. PCC believe that appropriately supporting independent advocacy services provides a level of assurance that HSC Trusts and organisations are committed to being learning organisations, committed to meeting their Statutory Duty of Quality, are appropriately invested in the Duty of Candour and, most importantly, to protecting patients and service users.

31. PCC have demonstrated that access to early resolution through independent advocacy saves money and delivers better outcomes for the public, for services and for staff, preventing concerns from escalating and enabling earlier intervention. "Our drive towards early resolution and a focus on restorative

practice is reflected in 60% of issues being resolved early, an increase from 57% in 2023-24 and 45% in 2022-23."

32. The PCC's interest is in having systems and structures which promote and maximise openness, patient outcomes, purpose, quality and safety of services and governance and assurance. PCC recognises the expertise and contribution of a wide range of voluntary sector organisations which provide specialist knowledge-based advocacy services and the PCC itself avails of those services. The PCC is not seeking to displace or replace those providers. It is critically about how to "connect the system to more of itself "(Myron's Maxims) and to deliver better outcomes for the public.

33. There are similar models of independent advocacy currently in operation, for example, the Scottish model - SIAA.

34. In relation to current provision, there remains a fragmented approach regionally to advocacy support as commissioned by the Trusts and there are challenges to the operational independence of providers resulting from current commissioning arrangements. This was acknowledged and highlighted by the evidence provided to the Muckamore Abbey Hospital Inquiry by Ms Marley, retired Director of Bryson Care, at paragraph 73 day 84 "*The challenge function of advocates was impacted by the commissioning approach to procurement in that the Belfast Trust funds and sets priorities for the service which dilutes the true independence of the service*". Ms Marley stated that it needs "*total independence from the Trust to challenge more robustly where the Trust disagrees with a process or outcome*". Further, Ms Marley acknowledged "*..if you're receiving funding and you're in a contractual relationship with the Trust, it does make it difficult to feel totally independent of them, and we would prefer to have some kind of arm's length arrangement where the funder or commissioner is not the Trust". She further explained that on occasions the Trust had reminded Bryson House that this was a "contract with the Trust" when staff were raising an issue with the Trust*".

35. It is clear that the provision of advocacy in its current form is insufficient to meet the growing need and demand for independent advocacy for adults-at-risk, for those with Learning Disabilities, for those accessing Mental Health services and for those transitioning into adult services. There are a range of other current proposals and policy development from the Department and within Health and Social Care e.g. in relation to the Mental Health Strategy, Neighbourhood Health Model and on the Mental Health Codes of Practice which will inform and provide guidance to advocacy practitioners. PCC considers the Department needs to appropriately develop a regional advocacy model to ensure further fragmentation does not take place and that minimum independent advocacy standards are met.

36. Whilst the intention regarding access to independent advocacy in the strategy and model is welcome, PCC would like more information on what the Department understand the underlying principles of ‘independent’ advocacy are and how a delivery model will be established to meet those principles. PCC is concerned that key evidence and learnings from public inquiries are not being adequately assessed by the Department as it makes proposals in a number of policy areas relating to independent advocacy

37. In the context of the points outlined above PCC asks if the Department has considered regional standards and quality assurance for independent advocacy as described in the Strategy. In addition, PCC would like more information on the role of independent advocacy to support a person with Learning Disability to express wants and needs, which may at times at odds with their families/carers wishes.

Shared Decision Making and Involvement

38. PCC welcomes the commitment to families and carers being involved in planning and decision-making, as well as the commitment that families and carers will be offered support by HSC staff to plan for future life changes for themselves and their family member.

39. As outlined above, PCC has been making the case for the need to shift the relationship between the public and the HSC from one where the public are recipients of care, to a partnership model. PCC considers that fully delivering on the commitment outlined in the Strategy will require a cultural and mindset shift. It will be important to have a standardised approach to training and support for HSC staff to effectively implement this approach. This must embedded within an appropriate quality assurance and governance framework in which the voice of those with lived experience is effectively incorporated.

40. As noted above, the PCC's Learning Disability Engagement Platform consider that the new service model does not adequately represent the spectrum of learning disability. They felt it was focused more on those with less complex needs and with the ability to consent. How will the commitment to involving families and carers be met in circumstances where there is limited or no capacity, and what provision will be given for specialist advocacy support, to ensure effective participation in shared decision making.

Patient Safety, Quality Assurance, Learning and Oversight

41. PCC welcomes the proposed establishment of a Learning Disability Collaborative Leadership Board to ensure HSC oversight of the Model against the key ambitions of the strategy. PCC welcomes that there will be people with lived experience and carers represented on the board. PCC suggest that these representatives should be connected to a broader network of lived experience to ensure diversity of representation and of voice.

42. The PCC considers that the board has a critical role in relation to quality assuring the delivery of the service model and within this role is a clear responsibility in respect of patient safety and safeguarding. The PCC seeks clarification as to whether the remit of the Leadership Board will consider quality assurance and patient safety issues in the new service delivery model and if not where these key elements will be considered. PCC would ask how the Board will engage with the proposed Adult Protection Board and the Children's Safeguarding Board in this

regard. The Board must seek out and listen to concerns of people with lived experience and carers and be in a position to act upon them.

43. Learning Disability exists on a spectrum. It is crucially important that the Board has access to a diversity of lived experience that represents the range of needs within the learning disability community, including those with less and more complex needs.

Triangulation of data and intelligence

44. PCC welcomes the Regional Outcomes Dashboard and the intention to publish baseline data and track annual progress across areas such as service access, transitions, supported living and hospital admissions. PCC suggests that this data should be triangulated with anonymised data and intelligence from Independent Advocacy providers, the complaints system and Care Opinion to provide a more wholistic picture to the Board of service delivery and potential patient safety and safeguarding issues. PCC suggests the value and benefit of establishing a regional advocacy model that incorporates clear data collection requirements, is clear in this regard.

45. PCC notes that part of the delivery model will require each HSC Trust to develop Local Action Plans and that these plans will be developed by ‘multi-agency multi spread’ representatives. PCC would ask what consideration has been given to how this Service Model will integrate with the commitment to develop a Neighbourhood model of care in Northern Ireland?

Yours faithfully

Ruth Sutherland M. Monaghan

Ruth Sutherland, CBE
Chair

Meadhbha Monaghan
Chief Executive

Appendix 1

The Role of the PCC

The Patient and Client Council (PCC) is a statutory corporate body established in 2009 under the Reform Act[5] to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues within Northern Ireland through:

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

In addition, PCC has an important independent assurance role for the Minister of Health, as set out in the HSC Framework document[6], one of only two organisations that have this role, the other being the RQIA.

The PCC’s effectiveness in fulfilling its’ functions is partly dependent on building constructive and productive relationships and arrangements with service providers, the third sector and other statutory bodies who have powers to investigate and take enforcement action where there are problems with the quality and availability of health and social care services. The approach of establishing partnerships and building relationships with others can mean that the PCC is able to exercise a positive influence on the sector – albeit via ***soft skills*** such as mediation and collaboration rather than though hard statutory obligation. However, this approach requires a significant commitment of time and resources for a small organisation like PCC and can take longer to reach a point when results are being achieved.

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[5] Health and Social Care (Reform) Act (Northern Ireland) 2009

[6] Department of Health (2011) DHSSPS Framework Document

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

The PCC has a Council made up of a Chair and Council Members, recruited from across Northern Ireland under the Public Appointments Process. It currently has 13 members[7].

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

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

The PCC has developed a Statement of Strategic Intent 2022-2025[8], setting out the strategic direction of the organisation over the next three years. In the long term we hope to see two big differences:

> **Strategic Objective One:** Through our engagement and impact work, the public voice is influential regionally and locally in the design, planning, commissioning and delivery of health and social care.
>
> **Strategic Objective Two:** Through our work in advocacy, engagement and impact, the health and social care system responds regularly to people with

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[7] https://pcc-ni.net/about-us/our-council/council-members/

[8] PCC (2022) Statement of Strategic Intent

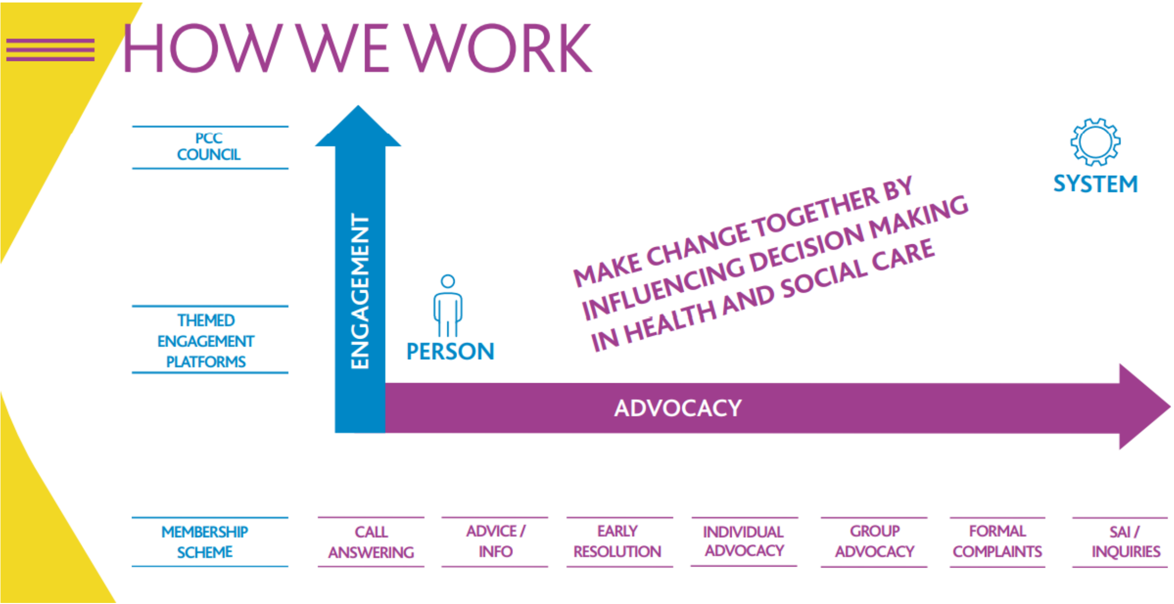
openness, honesty and compassion to address difficulties or failures in standards of care.

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

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

PCC Delivery Model

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



PCC Connect

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

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

PCC Support

PCC Support is our advocacy and support model.

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

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

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

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

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

PCC Engage

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

An Engagement Platform is a space to bring together a group of people, with a common theme or interest and **lived experience**, to work together and make change in health and social care. Engagement Platforms allow participants to communicate their experiences and thoughts, related to a policy programme, with the PCC, as well as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas under review, development and reform.

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

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

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

PCC Impact

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

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

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