

Advocating for Children

January 2008

Royal College of Paediatrics
and Child Health



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prepared for members of the
Royal College of Paediatrics and Child Health
by the Advocacy Committee



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www.rcpch.ac.uk

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A longer, more detailed version of this document is available at: www.rcpch.ac.uk/policy/advocacy

Foreword

Advocacy on behalf of children and young people is an essential part of the work of the College and the work of every individual Paediatrician. Most of us do this in some shape or form as part of our working lives, but clearly there are always opportunities for us to do more, and ways in which we can do it differently and more effectively.

This document is an updated version of our previous successful guide to advocacy and I urge you to read it and to keep it bookmarked on your electronic desktop, so that you can refer to it when need be.

You will find useful advice and ideas for delivering and encouraging advocacy on behalf of children, young people and their families and also how to enable them to become self advocates. There is advice on the always difficult and sensitive topic of using the media effectively and how to persuade decision makers and funders to put more resources and imperatives into the delivery of services for children and young people.

Many people have worked hard on this document, both in its original form and now in this revision and we thank Rachel Hodgkin, the members of the Advocacy Committee and of the Media Department of the College who have brought it to completion.

I hope that each of us who has read this document will be able to say that, as a result, we have been a more effective advocate on behalf of either an individual child or young person, or on behalf of young people generally.

Dr Patricia Hamilton
President, RCPCH
January 2008

1. Strategy of the Royal College of Paediatrics and Child Health on Advocacy and Equality

The College has adopted as an overall aim: “To advocate the rights of children and young people in society and to promote their health needs and services”, with four more specific objectives:

- to integrate, in association with other bodies, the opinions of children, parents and their representatives in improving child health services.
- to lobby for national policies to ameliorate the effects of poverty and disadvantage on children’s health.
- to work with other bodies to publicise key issues relating to the health of children.
- to ensure that paediatricians are trained and have access to guidance that will allow them to be advocates for children.

Projected activities of the RCPCH for seeking these objectives include:

- promoting implementation of the UN Convention on the Rights of the Child throughout the College and in all areas of society and institutions.
- identifying and prioritising issues where the College has a significant role in advocacy for children.
- ascertaining children’s views (for example by publishing surveys) and promoting their rights to information and participation in health care and research.
- to work with other bodies to publicise key issues relating to the health of children.
- setting priorities for and commissioning research into inequalities that are measurable and amenable to intervention.
- supporting effective interventions which promote the health of children including guidance on diet and exercise, sex education and injury prevention.
- promote the special needs of asylum seekers, looked after children and other disadvantaged groups.
- actively educate opinion formers in issues relating to child health.
- communicate effectively with the public through the media.

Within the context of this overall strategy, the College’s Advocacy Committee adopts an annual work plan, with specific priorities for action. Updating this handbook is one outcome of the Advocacy Committee’s work.

This guide covers some of the methods and techniques for effective advocacy. It does **not** address direct action which is unlawful, or any activity which involves the promotion of party politics.

2. What do we mean by advocacy?

Advocacy is commonly understood as speaking up for someone else, in particular someone with little power. There are two quite different types of advocacy-related activity for children. First, **direct advocacy**, in which the interests of individual children or specific groups of named children are represented to decision-makers (either by an advocate or through self-advocacy). Second, “**public policy advocacy**”, in which the advocate is seeking changes to an aspect of the system to benefit children generally, or particular groups of children. Paediatricians take part in both types and examples are given throughout this guide.

Direct and public policy advocacy are of equal importance. Indeed each supports the other. You will have greater credibility as a public health campaigner, if you can show a detailed understanding of the difficulties facing individual children and local communities. Advocacy on behalf of individual children will be more effective if you have a clear understanding of the underpinning administrative and legislative structures.

3. Why do children need advocacy?

Children need effective advocacy for the following reasons:

- Failures in services for children are now well documented, but children are usually not able to advocate for themselves - not only because they lack knowledge and experience but also because adult procedures are not structured to accommodate children's circumstances;
- Children's needs are often eclipsed by adults' - not least because children are politically disenfranchised - so that services and resources are not delivered equitably;
- Children also tend to suffer disproportionately if their needs are not met. Because they are in process of maturation their development may be blighted by circumstances which an adult can survive or overcome.
- Under international law, ratified by the UK, children have a right to have their best interests considered whenever decisions affecting them are taken.

Until recently, a legitimate question would have been: "But who decides the best interests of children?" Though "best interests" continues to be a subjective and relative term where individual children are concerned, the world now has arrived at near-global consensus on the broad parameters of children's 'best interests'. These are enshrined in the UN Convention on the Rights of the Child; the most widely accepted international treaty ever - now ratified by all but two of the world's countries (Somalia and the USA). The Convention covers all aspects of children's lives and the United Kingdom is legally required, albeit not enforceably, to implement its provisions. Any advocacy undertaken by a member of the College would be expected to conform to the principles of the Convention. (See text at: www.unicef.org/crc or obtain free copies from UNICEF UK, address in Appendix).

Methods and techniques for effective advocacy (both direct and public policy) include:

- Taking direct action on behalf of individual children by writing letters, making telephone calls, giving evidence, attending meetings, arranging expert assistance or second opinions.
- Facilitating self-advocacy by children and their families or local groups.
- Securing effective advocacy services for children.
- Undertaking strategic research and data collection.
- Securing a cost-analysis to show the financial benefits of the goal being advocated.
- Piloting innovative models of practice.
- Disseminating proven models of good practice.
- Building up coalitions, alliances and action groups seeking a common end.

- Using the media to publicise the issue and to inform and influence opinion.
- Using the law to claim rights.
- Disseminating the message through publications, training materials, conferences and so forth.
- Cultivating relationships within local and central government and other decision-making bodies.
- Joining committees, task groups and other such bodies.
- Responding to consultations on proposed changes.
- Lobbying local and national politicians, administrators and decision-makers.

4. Direct advocacy for children

The benefits of advocacy by paediatricians

Advocacy on behalf of individual children can have two benefits. First, the advocate helps solve the problems of the child in question. There are many children who are not receiving the services they deserve and require the 'clout' of a paediatrician to remove the blocks. Second, individual cases provide vivid evidence for the need to change systems. A single case history may change a politician's views faster than twenty pages of research; the media will often only run stories if they contain 'real-life cases'; public attitudes can be quite irrationally swayed by personal anecdote. Individual cases should always be carefully documented and, where appropriate, the child and/or parents asked if they are prepared to be publicly identified to help other children in the same situation. However, advocates should always be mindful of potentially negative consequences that can unintentionally arise from publicising individual cases and should be satisfied that the family has fully considered this possibility, and given consent to appearing in the press.

Paediatricians are in a position to provide children with very effective advocacy. They are held in high regard as respected professionals. They are highly trained and generally have no other axe to grind than the welfare of the child concerned.

Paediatricians encounter many opportunities for helping individual children in difficulties, such as giving evidence for disability or other benefit appeals, assisting abuse investigations, helping families get better housing, securing specialist treatment or community-based facilities, supporting children's claim for special education services, child protection and so forth. As can be seen from the examples in the box, much of this advocacy involves sectors outside the health system.

- A paediatrician, who was the medical adviser to an adoption panel, was concerned that insufficient information about the children was given to prospective adopters. She thought this might contribute to placement break-downs and increase the possibility of litigation. When she analysed the information she had been given, she discovered that over half the necessary documents had not been provided at the time she wrote the medical reports. She consulted British Agencies for Adoption and Fostering, looked at practice in other panels and brought the problem to the attention of her panel manager and chair. As a result a secretary was appointed to co-ordinate the documentation and the social workers were advised on how to improve the availability of reports.
- Another paediatrician was concerned about the poor toilet facilities for primary-school girls who had reached menarche. Her audit of local schools found that over half required girls and boys to change for PE together in the classroom, and that over 40% of schools

required menstruating girls to use the staff toilets. Focus groups held with the girls revealed that they were unhappy with this situation. She discovered that there were no guidelines on acceptable practice either locally or nationally. The education department agreed to draw up local good practice guidelines and involved the healthy schools initiative officer in developing these. These guidelines, which included toilets with locks and sanitary disposal facilities for girls in Year 5 and 6, received a healthy schools award and funding was made available to implement them. The guidelines were then applied nationally.

The limitations on direct advocacy by paediatricians

Paediatricians are not qualified advocates, nor is the profession designed with advocacy in mind. While this may not prevent them from delivering high-quality advocacy, it does mean that there are unavoidable constraints on paediatricians. The following should always be made clear at the outset to the child or child's family:

- You cannot guarantee to argue in favour of the child's or parents' wishes if this conflicts with your own professional judgement of the child's best interests;
- You have responsibility to other children as well. Sometimes what is good for one child, or one group of children may end up disadvantaging other children and you must be careful to avoid unintended negative consequences from your advocacy;
- You are not entirely independent or disinterested. Circumstances may arise where you will need to consider the effects of your advocacy on relationships with professional colleagues or on the institution, or the possibility of disciplinary proceedings by senior staff;
- You may not be able to devote adequate time to the child's case;
- In *certain* circumstances you may have to breach confidentiality.

“Best interests” advocacy on behalf of young or incapacitated children

Advocacy for young or incapacitated children, like advocacy for mentally impaired or mentally ill adults, sometimes means that you will be representing the child's perceived “best interests” rather than his or her expressed wishes.

While the “best interests” of individual children can often be highly contentious, the UN Convention on the Rights of the Child (and other internationally ratified treaties) now set down broad standards defining this concept. **The RCPCH expects all members to act within the framework of this Convention when undertaking any form of advocacy for children.** The College is also happy to advise members who are confronted with ethical or professional dilemmas when undertaking direct advocacy (contact the Registrar at the RCPCH on 0207-307-5600).

The role of parents

Parents are almost always their children's first, best and fiercest advocates. In addition, many children's rights can only be claimed through their parents. It is rarely in children's interests to enter into direct conflict with their parents. It is important to work collaboratively with parents wherever possible, to enlist their support for your actions, discuss the case with them and generally treat them like advocacy colleagues.

Remember, however, that the child, not the parents, must be the ultimate beneficiary of your advocacy. Always withdraw if you feel that you are representing parents' views which contradict your perception of the child's best interests. It is also highly inadvisable to advocate on behalf of the parents against the expressed wishes of the child, even where you think the child is not competent or is below the age of "sufficient understanding". In such circumstances it would be sensible to seek advice and backing from a higher professional body, or refer the matter to an impartial source of help.

Tips for effective direct advocacy on behalf of children:

- Be realistic about what you can achieve. Do not promise more than you can deliver. Make clear at the outset to the children and families concerned the limitations of your advocacy.
- Try to identify solutions to the problem with the child/family, rather than just raising a complaint. Preferably work out beforehand first, the ideal solution and second, any alternative options which may be offered. Discuss what are acceptable compromises and what are not.
- Make sure that the child/family fully understands and supports all that you propose to do;
- Be clear about possible consequences. For example, they may be asked to disclose private details of their medical or social history; or the advocacy may worsen their relationships with key professionals.
- Be reasonably sure that you are the best person to undertake the advocacy. If someone else has more expertise and more time, for example, use your energies persuading them to take on the case.
- Get on top of the facts. Refusal of your proposals will almost always be explained on a technical basis so come prepared with counter arguments. Acquaint yourself with the relevant law, guidance, complaints procedures, official policies, administrative procedures, available budgets and so forth.
- Support the child and/or family to speak for themselves wherever possible;
- Decide your strategy. In particular, identify who is the best person or body with whom to initiate first contact. When in doubt, always go to the highest feasible level.

- Use your advantages. Paediatricians are almost always treated with respect; disabled and ill children are almost always regarded with sympathy. Public opinion, the media and independent arbitrators are likely to be on the child's side, even though this usually need not be put to the test.
- Do not try and polarise the case into goodies and baddies. Assume that everyone wants to be the good guy and manage events so that the decision-maker takes the credit for doing the right thing.
- Be prepared to change tactics as circumstances change.
- Remember, it is the child you are primarily advocating for, not the parents.

5. Encouraging advocacy services for children

Paediatricians may feel they do not have the time to undertake direct advocacy for individual children. Alternatively, they may assume that their parents will act as sufficient advocates. However, children often need advocates who understand the system and who can give the child energetic representation and a high level of confidentiality. There are now advocacy services in the health sector, such as PALS and ICAS, which paediatricians can encourage children to use. There are also similar services in other sectors, such as children's rights officers for children in need of social services; independent advocates for special education problems; disability advice and advocacy services, and publicly-funded solicitors under contract with the government who specialise in children's matters. As well as referring children to these services, paediatricians can also help develop them - for example by offering to help as an expert witness.

6. Self-advocacy

Self-advocacy is arguably the most effective form of advocacy because it also empowers the child or vulnerable person concerned, enhancing their self-esteem and providing them with skills, information and confidence to look after themselves. Of course self-advocacy is not always possible for children anymore than it is for adults: there will always be a need for expert or professional advocacy by third parties.

You should always be on the lookout to encourage and facilitate individual children and their families to take on their own advocacy - for example providing them with all the relevant arguments and rehearsing them through all contingencies so that they have the confidence to go to the meetings, write letters, engage the decision-maker and so forth without you.

In addition, NHS policy is now helpfully in favour of “user involvement”. Health authorities, hospital trusts, primary care trusts and practitioners have been formally encouraged to consult and involve the consumers of health services. Children should not be excluded from that process. Even if you personally disagree with the views of the child or believe they stand no chance of succeeding, any decision that fails to give these views serious consideration is likely to be poor decision-making. Our first responsibility is to ensure that children have sufficient information, since the more information children have the more likely they are to make sound decisions.

Mostly self-advocacy by children and young people occurs through the formation of a self-advocacy group. They are only possible where there is a degree of continuity hence children with permanent disabilities or chronic illnesses, or any children who have to spend long periods in hospital are prime candidates for a self-help group. Such groups usually welcome the practical assistance of adults, so long as they do not try to “take over”. In the initial stages it is usually essential that adults do a great deal of facilitating and organising.

The box shows some examples of effective self-advocacy by children and young people.

RCPCH *Coming out of the shadows*

The Royal College recently funded an initiative to increase the participation of children in the work of the College which included hearing from healthy children, children with multiple and complex health needs and those with experience of acute and chronic illness. This made a number of recommendations for improving both the receptiveness of the College to the views of children and the work of the health system generally in this respect. This work is now being taken forward by the RCPCH Child Participation Project Manager (in addition, see <http://www.rcpch.ac.uk/Patients—Carers/participation-guide>).

Kids count at the Newcastle Royal Victoria Infirmary

In 1996 a project was launched at the Royal Victoria Infirmary to ascertain young patients views and ensure that that had appropriate information when coming into hospital. Through questionnaires, suggestion boxes and a young forum facilitated by the hospital's radio presenters, the children raised a number of concerns and suggestions to which the hospital was happy to respond.

Children First for Health

A website designed to encourage children to share with each other their experience of illness and the health services, as well as giving them information in child-friendly language. (<http://www.childrenfirst.nhs.uk>)

Children consulted over hospital design

A children's board was consulted on every feature of the new Evaline Children's Hospital in London, resulting, for example, in the provision of fold-away beds next to every patient's bed to allow parents to stay overnight and a helter-skelter for children to play on while they wait to be seen.

7. Public policy advocacy

Public policy advocacy means advocacy which seeks to change the system to help children generally, rather than an individual child or group of named children. This can be done at the **local** level or **nationally**. This booklet gives advice relating to both levels of advocacy; however most of the techniques and strategies are common to both (and of course successful local projects may lead to national advocacy).

Strategies for effective public policy advocacy (local and national):

- Do not work on anything you don't feel personally committed to or don't fully understand.
- Find out the facts. Is there existing relevant research or data? What is the relevant legislation, policy, professional practice or administrative framework? What have others have done already? Who are the key 'stakeholders'?
- Collect any individual cases or examples that illustrate the message.
- Identify people to collaborate with. Speak to, and work in partnership with, children and families affected by the problem. Seek the support and collaboration of the appropriate voluntary organisations, professional associations and community leaders. Set up action groups, alliances and consortia, or, at the least, get people to agree to exchange information and not to be played off against one another.
- Identify clear, achievable targets. Ideally these should include proposed solutions for a perceived problem, although the target may just be to highlight the existence of an unrecognised problem.
- Develop an action plan, e.g. a research project or a media strategy. Generally adopting a range of different tactics is most effective. Change is usually brought about by keeping the issue alive over a period of time, seizing whatever chances arise to make the case for change.
- Agree clear time-tabled responsibilities for tasks, allocated to the people best able to carry them out.
- Identify the main obstacles to change - people, systems, vested interests and then develop strategies for surmounting these but do not be antagonistic - someone on the opposing side one day might be your supporter on another issue!

Public policy advocacy at the local level

You are unlikely to become involved in advocacy at a national level without working at a local level. You will certainly have greater influence with government and national policy-makers if

you can demonstrate a close understanding of the lives of children in your local community and how the underpinning systems work in practice.

The principles of the strategies involved are the same as previously discussed above. The RCPCH's **Advocacy Committee** will be interested to hear of any advocacy initiative and it may be appropriate to seek the College's formal support for it.

Trusts and other managers

Your employing Trust may not look favourably on your advocacy work and sometimes you may find yourself in conflict with management decisions. This is one reason for trying to find professional colleagues and others to share involvement in the advocacy initiative. It is sensible to alert the Clinical Director of your Directorate, the Trust's Clinical Director and publicity officer to your advocacy intentions. They may agree to contact you when the issue becomes topical, and may foresee possible conflicts of interest.

The General Medical Council advises in *Management in Healthcare - the Role of Doctors*:

Management involves making judgements about competing demands on available resources. If managerial concerns conflict with your primary duty to the extent that you are concerned for the safety or well-being of your patients, you should declare the conflict, seek colleagues' advice, and raise your concerns formally with senior management and external professional bodies as appropriate. [p11, 2006]

It thus appears easier to justify advocacy initiatives which involve children who are or have been your patients, rather than advocacy on behalf of children not known to you personally. In such circumstances it is sensible to act in alliance with others, rather than try to go it alone.

Political activity

It is certainly wise to keep within the limits on campaigning or lobbying that are currently permitted under charitable law. The Charity Commission has made clear that charities - which includes all the main voluntary organisations acting for children - may seek to influence government, the media and decision-makers, so long as the intended aim is clearly of benefit to their beneficiaries and:

- Their lobbying activities are lawful and based on information-dissemination and reasoned argument (for example, no demonstrations or strikes)
- The advocacy is strictly non-**party**-political. While, obviously, your primary focus will be

on those who have the power to change things, always ensure you inform members of other political parties about the cause you are advocating.

Legal actions

A legal action, or often just threat of legal action, may be the most effective way of securing change for children. Sometimes this is a fairly straightforward matter of claiming undisputed legal rights. On other occasions it may be necessary to test whether rights exist or not, for example by a judicial review or an application under the Human Rights Act or by making a children a ward of court. While paediatricians will not have the expertise to lead on legal actions, they can play a very important role in initiating a legal strategy - for example, by exploring the possibility of a legal right, or by persuading lawyers to give their services *pro bono*.

The box illustrates some examples of public policy advocacy.

Challenging official decisions

In 1999 a social services-run nursery was earmarked for closure. The nursery provided flexible care for families in difficulty, children at risk of abuse and children with special needs. The Child Development Centre (CDC) often referred children after assessment while awaiting educational provision. Social Services said they wished to re-provide care with families and child-minders, on the grounds that such provision was more appropriate to children's needs. Neither parents nor professionals agreed with this view. One of the CDC's former managers and a community paediatrician agreed to the parents' request to address the County Council in support of their campaign. They explained how the special needs system worked and provided persuasive and detailed information on the impact of the closure. The Council meeting reversed the decision to close the nursery: a very unusual move at such a late stage in the decision-making process.

Protecting play in Cardiff

Paediatricians were concerned that children were being injured unnecessarily in playgrounds throughout the United Kingdom and that parental concern at the risk of injury had reduced play opportunities for children. They argued that playground studies had been developed in the laboratory rather than looking at real children having real accidents on real playgrounds. They teamed up with the Cardiff City (now the County) Council and the Accident and Emergency Department. Analysis of data revealed that a

number of children sustained arm fractures falling from play equipment, particularly the monkey bars. The Council replaced monkey bars with a rope ladder and increased bark surface depth in five major playgrounds. This reduced injuries.

8. Strategic Research

Of all advocacy strategies, research is probably the one where paediatricians can make the most powerful impact. Through daily routines paediatricians are likely to encounter cases where they believe children's health and well-being is needlessly being damaged - where the cause is not physiological and the damage would not have occurred if the system had been different. Some kind of research or audit will almost always be needed to demonstrate that this is indeed the case, and to discover the scale of the problem, what the causes are, and what might be the possible solutions.

Tips for effective research:

- Keep it simple and focused. Try to design research which can be completed reasonably quickly and where all the results will be of direct relevance.
- Do a small pilot before embarking on the full research project.
- Discuss the proposed research with your advocacy collaborators, particularly children and families.
- Make sure that you are not duplicating existing research. For example, investigate what local government data collection units have done already.
- Advocacy research is usually about persuading others that there is a case for action, rather than being able to provide scientifically conclusive proofs. Nonetheless, all facts must be meticulously checked and its presentation must be carefully designed to make a persuasive case and withstand hostile analysis.

The College has a Research Division which may be able to advise on research initiatives. In addition, the BMJ publication *How to Read a Paper: The Basics of Evidence Based Medicine* by Trisha Greenhalgh gives de-mystifying advice on the essential elements and pitfalls of medical research; similar information can be found on www.jr2.ox.ac.uk/bandolier

9. Using the media

Media coverage is a vital tool for advocacy. The College has produced Media Guidance Information available from the Press Office.

The College press office is also able to advise on how to take forward your particular concern. There may also be College material such as policy statements which will provide vital support. These can be found on the RCPCCH website, or from the press office.

The point for advocacy of getting media coverage is to influence the readers, viewers and listeners. Your media strategy will therefore depend on the intended audience. Some examples of media relations:

- to reach the general public/opinion leaders and policy makers, use national newspapers, weekly journals and radio news.
- to target the national newspapers, television/radio magazine programmes and local press.
- professionals, target specialist journals and professional magazines.
- local decision-makers, use local media;

Journalists may ask you to supply them with the names and details of children and their families who have had first-hand experience. This should not be done unless you have the **full consent** of the family. It is very easy to be misrepresented and this can have a negative effect.

Some media activity will be favoured by employing Trusts, but at other times this may be a cause for concern. It is usually sensible to give employers forewarning of any media coverage in which you might be involved, whether it concerns them or not. Take opportunities for media training, which may give you a sense of your skills in this area as well as tips for effective tactics.

Ways of getting media coverage:

- **Informal** - cultivating informal relationships with individual members of the press can be an extremely effective way of securing coverage and gaining influence. Remember however, that if you say: "*this is off the record*" it does not always guarantee this to be the case.
- **Press releases** - these are the most usual method of communicating with the media. They can be used to advertise a future event, or describe a past one; they accompany press conferences and launch reports and research; they can publicise your reaction to government policy or topical events, and can be used tactically to put pressure on politicians or other decision-makers (for example, press-releasing a letter of protest to a Minister). Information on how to prepare a press release is available from the College press office.

- **Remember local media** - obviously you will target local press for local issues, but with national issues it is worth circulating regional print and broadcasting media, or alerting the press agencies which feed them.
- **Letters to editors** can be used to raise particular points and provide free advertising for your campaign. Letters editors reserve the right to cut, so keep letters as short as possible.

Television and radio appearances are excellent ways of reaching a mass audience. News programmes will also be noticed by policy-makers. Always check before agreeing to go on a programme:

- Where it is and how you will get there (taxis can normally be provided).
- How long you will be there for and how long the interview will be.
- What the first question will be.
- Whether it will be live or pre-recorded.
- What its style is (e.g. news item, part of a documentary, phone-in, debate).
- Who will be interviewing.
- Whether someone from the 'other side' will be taking part, and who they are.

News items are usually edited down to under a minute. It is therefore essential to prepare beforehand. Rehearsing on your own usually helps, though avoid sounding like you have learned your words by heart. Reduce your message to three key points and ensure that these points are made. If you can précis the message into a sound-bite or can tell a story which illustrates your point in a few lines, these will be the parts which will be used.

For advice on doing interviews, please contact the College press office, or your own organisation's press office.

10. Writing to and meeting decision-makers

Whether you are contacting a local councillor or the Prime Minister, the rules are much the same:

Writing

- Make sure that you have got the correct spelling and title of the recipient. If you are writing the same letter to a number of officials or politicians make this clear.
- Always include your name, address (including email), telephone number and position. If an alliance, consortium or action group has been mobilised, indicate this somewhere in the letter (for example, after your signature “on behalf of...”).
- Refer briefly to any personal or official relationship with the recipient (e.g. that you are a constituent, that you met at a conference or you have mutual friends).
- Give a heading to indicate the main issue.
- Get to the point as quickly as possible. Keep the letters short, including the main points in summary and any specific request. Attach detailed arguments or evidence in a separate briefing paper.
- Try to end with something that will elicit a reply - ask for a meeting or comments on your proposals or for relevant facts.
- If you are going to press-release the letter, say so in the letter and make sure it is delivered to the recipient before it goes to the press.
- Send a copy of any letter to a politician to the responsible officials. Officials hate being surprised more than anything, and will appreciate the courtesy.

Meetings

You may be meeting a decision-maker alone or with other colleagues. Try not to take more than three or four people. If you go as a group you are likely to be met by a group. Informal meetings are usually only possible between two people.

- Prepare beforehand what you want to say and what results you are seeking. Discuss this plan with your colleagues, deciding who will deal with which point.
- Check who is going to be at the meeting. Politicians usually like to be flanked by officials, whose views may be known or who may give helpful information beforehand.
- Make sure you have facts and figures to back up your arguments. If you do not, where possible, promise to find them out and send them after the meeting.
- Bring briefings and proposals in writing to leave behind.
- Decision-makers sometimes take up all the given time by making speeches, leaving you frustrated that you haven't been able to make your case. On the other hand they sometimes

leave you to do all the talking, leaving you ignorant of their views and intentions. Try to make sure that the meeting is not a one-way event.

It is always worth inviting decision-makers to experience the issue first-hand. Invite them to visit the family centre, the ward, the estate and so forth in a way which allows them to see the issue through the children's eyes.

Government and Parliament – Influencing the Formation of Government Policy

The schematic diagram, opposite, provides an overview of the stages involved in forming Government policy in England, some primary law in Wales and non-devolved laws for the whole of the UK. Potential points for action by paediatricians to advocate at are shown on the left hand side of the diagram. In short, the best time to influence Government is as early on as possible. Seize all informal and professional opportunities for meeting with Ministers, their advisers or civil servants. Get involved by attending Government run seminars/ consultation days, advisory groups, task forces and so on. Further information about the process, latest Government bills and main Government departments can be found at www.parliament.uk, and www.direct.gov.uk/D11/Directories/fs/en respectively.

UK

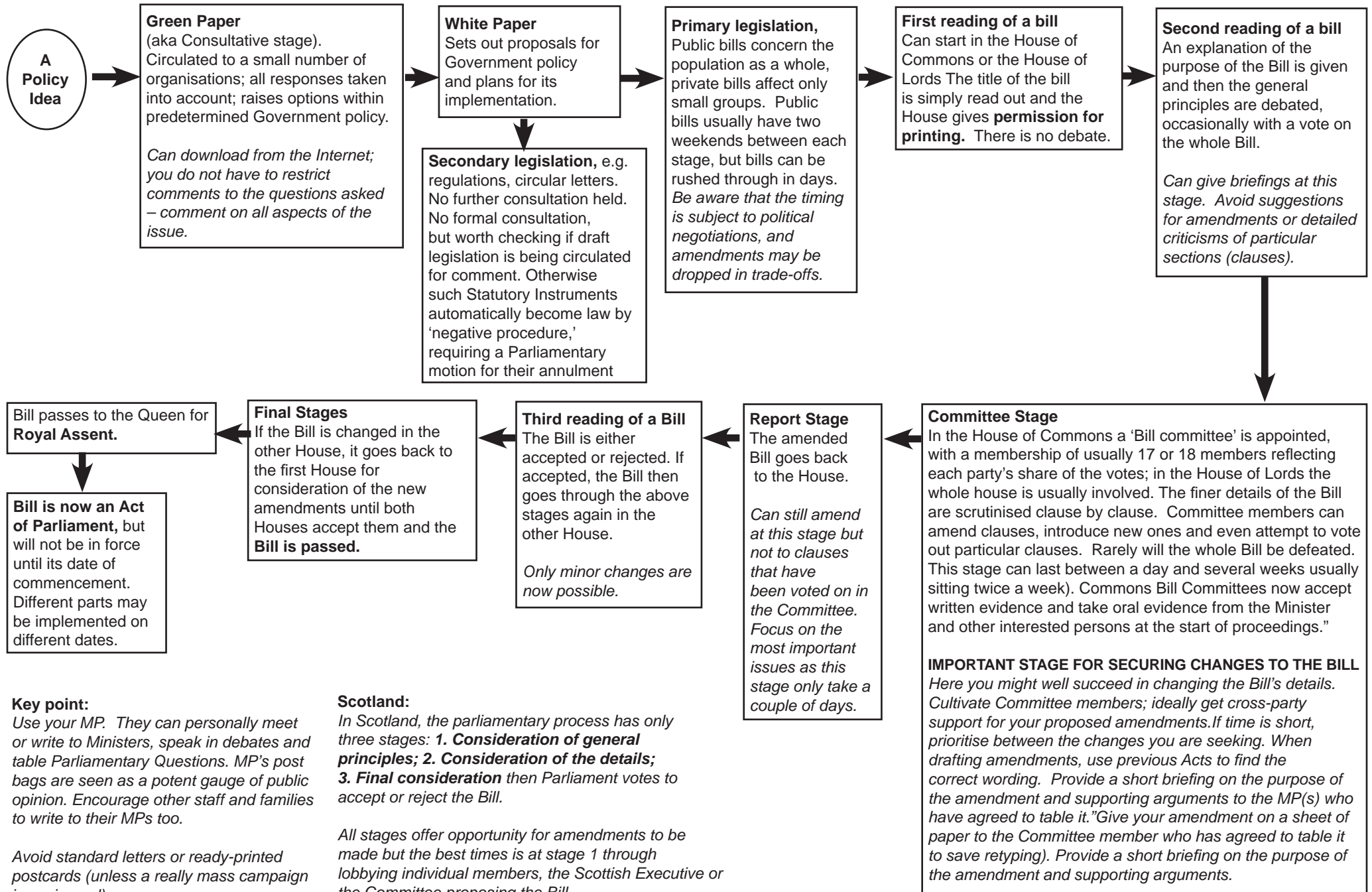
Private Members' Bills: At the beginning of Parliament a ballot is held in the House of Commons, which determines priority for Bills sponsored by back-benchers. The first 20 are published, the first six have a faint chance of passing through all their stages. The successful MPs are heavily lobbied by campaigners, and are likely to favour Bills which are already drafted and stand some chance of being accepted. If you have a reasonably uncontroversial cause, with no large resource implications, it is worth drafting a Bill to tempt MPs who have good ballot draw.

Ten Minute Rule Bills, Standing Order Bills and Early Day Motions: These are all procedures which can be used to make a point in Parliament, and to attract support of other Parliamentarians.

Parliamentary Questions (PQs): Sympathetic MPs and Peers are almost always happy to put down questions, and this is a useful way of discovering the progress of Government policy, future intentions and relevant statistics. Some questions are answered orally, allowing for brief debate, and others are written.

Select Committees: shadow the functional departments of state (ie health, which includes social services, home affairs, education etc.). They have investigatory powers and can be asked to look into controversial aspects of administration. Their composition mirrors the representation of parties in the House, and they are made up of back-benchers. While having no executive force, their reports and interventions are useful for lobbying

Influencing the formation of Government Policy



Scotland

The powers and procedures of the Scottish executive and Scottish Parliament broadly correspond to those of the UK government and Parliament. There are some key differences as well - for example in the use of committees during the passage of a Bill - but most of the advice on tactics given above applies equally to Scotland.

Devolved powers

The Scottish Executive has responsibility for all devolved matters, which are all areas apart from 'reserved' matters which have a UK-wide or international impact (like defence or immigration). Health, education and children's private and public law are all devolved matters.

The Scottish Parliament

This is made up of 129 Members of the Scottish Parliament (MSPs), who represent their constituents on devolved matters. Most are on at least one parliamentary committee. The role of the Parliament is to pass laws and scrutinise the work of the Executive. The Parliament is serviced by officials who are independent and politically neutral, and an MSP is nominated to act as a politically impartial Presiding Officer, with two Deputies.

The Scottish Government

This is formed from the party or party holding the majority of MSP seats. The First Minister appoints Scottish Ministers and determines their areas of responsibility. The Ministers are served by civil servants working in eight main departments of state (Justice, Health, Environment & Rural Affairs, Development, Education, Enterprise & Lifelong Learning, Finance and Corporate Services).

Effective lobbying often depends on building up close relationships with Parliamentary officials (who are key to accessing Committees), the Executive civil servants, the relevant Ministers and with MSPs from all parties.

How a Bill becomes law

Bills may be proposed by the **Executive**, a **Committee** or by an **MSP**. As the Executive commands the majority of votes, its support for a Bill is usually crucial.

Because the Scottish Parliament is committed to accountability and accessibility, there are usually good opportunities to influence Bills before they start their formal stages, either when the policy is being developed or when the Bill is being drafted.

The parliamentary process has three stages:

1. Consideration of general principles. The Bill is accompanied by a policy memorandum outlining what consultation occurred on the Bill, and an MSP is nominated as 'Member in Charge of the Bill'. The lead Committee considers and reports on the general principles of the Bill and the Parliament then debates them. If Parliament does not agree, the Bill falls.

These all offer opportunities for getting your views across, either by written or oral evidence to the Committee, or by lobbying individual MSPs, or by putting pressure on the Executive or the Member in Charge of the Bill.

2. Consideration of the details Each section is considered either by the Committee or by the whole Parliament and amendments may be made, though these must conform to the agreed general principles. Do not be afraid of drafting amendments: the language can be adapted from other parts of the Bill or other Acts, and Parliamentary officials will usually be helpful.

3. Final consideration Further amendments can be made by Parliament at this stage, and Parliament then votes either to pass or reject the Bill.

After four weeks the Bill receives Royal Assent and either comes into force immediately or at a later specified date.

Northern Ireland

Since May 2007 the Northern Ireland Assembly and its Executive Committee of Ministers have resumed control over devolved matters, including health, social services, education and public safety. The Northern Ireland Assembly has 108 elected Members whose role is primarily to scrutinise and make decisions on the issues dealt with by Government Departments and to consider and make legislation.

The Executive Committee of Ministers, led by the First Minister and Deputy First Minister (representing both main parties), plans a programme of government with an agreed budget. Ministers are advised by the appropriate statutory committee – health, education, environment etc – composed of Assembly members (MLA), in proportion to the party strengths within the Assembly. These Committees are more powerful than those in Westminster. They scrutinise the work of each department, consider secondary legislation and deal with primary legislation at Committee stage as well as initiate legislation or inquiries.

Legislative bills can be proposed by Ministers, Committees or individual Members. Once the Speaker confirms that a Bill is within the Assembly's competence, it is introduced and debated in the Chamber, scrutinised by the statutory Committee which reports back to the Assembly as a

whole. Members consider the detail of the Bill and propose and vote on amendments (passed on a simple majority). The Bill is then reconsidered by the Assembly and a final vote is taken. The Bill then receives royal assent as an Act of the Northern Ireland Assembly.

A 60-member Civic Forum, representing business, trade union, voluntary and other sectors of the Northern Ireland community, acts as a consultative mechanism on social, economic and cultural matters.

Wales

There are sixty elected Assembly Members. The Welsh Assembly Government is its executive arm, comprising First Minister and up to twelve Ministers or Deputy Ministers responsible for specific matters.

They are accountable to the rest of the Assembly, which scrutinises all decisions and actions, as do the cross-party committees on their subject areas. The Assembly also has powers to intervene when local authorities are failing to discharge their education or social services duties to children.

Until very recently the Welsh Assembly did not have powers to legislate, but was able to introduce secondary legislation (regulations and orders) and administrative policies in Wales. This limited form of devolution had a significant impact on the lives of children, for example in health, education and the environment, putting the Welsh Assembly in the vanguard of promoting children's welfare and rights within the UK.

Under the Government of Wales Act 2006, the Assembly is now empowered to pass primary legislation, known as Assembly Measures, in specified areas - including health, health services, social welfare and education – which are set by legislative competence orders agreed by the Assembly and Westminster (currently set out in Schedule 5 to the 2006 Act, which may be extended by further agreements)

Measures may be introduced by the Welsh Assembly Government; an Assembly committee; an individual Member, if their name is drawn from a ballot, or the Assembly Commission (the administrative body). A proposed Measure passes into law through a four stage process:

1. Consideration of the general principles by a committee and the agreement of those general principles by the Assembly;
2. Detailed line-by-line examination by the Committee of the proposed Measure and any amendments tabled;
3. Detailed line-by-line consideration by the Assembly;
4. A vote by the Assembly to pass the final text.

11. Levers of change

To keep this document brief, practical and reader-friendly, the examples which follow below are only a few of the large list available in the appendix to this document on the RCPCH website: <http://www.rcpch.ac.uk/Policy/Advocacy> . Readers are advised to consult the web version for an extensive list of useful addresses and further background information on how policy is formed

International

United Nations

1. Convention on the Rights of the Child (CRC)

www.unicef.org/crc

The most ratified treaty in history, the Convention covers most aspects of children's lives both in terms of specific areas, such as health, disability, poverty and protection, and general principles, such as children's rights to be heard, to have their 'evolving capacities' respected and to have their potential fulfilled. The next report is due in 2008-9; an audit of the UK's failings in respect of the Convention are comprehensively mapped and continually updated by the Children's Rights Alliances.

UNHCR Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum (1997) and UNHCR's Strategy and Activities concerning Refugee Children and Adolescents (2000) emphasises refugee children's entitlement to special care and protection.

Europe

2. European Convention on Human Rights

conventions.coe.int/Treaty/en/Treaties/Html/005.htm

It is hard to overestimate the effect this Convention has had on the development of children's policy in the UK over the past few decades, given how many reforms in children's policy have been driven by judgements by the Court of Human Rights in Strasbourg. Although not written with children in mind, it is arguably the most powerful lever for change available at present for an issue that is politically unpopular.

National

England and Wales

3. Statutes and statutory instruments: enforceable Acts and Regulations

All Acts after 1989 can be accessed on www.opsi.gov.uk/acts. They include:

- Human Rights Act 1998
- Children Act 1989
- Disability Discrimination Acts 1995
- Education Act 1996
- Local Government Acts 1999 and 2000
- Carers and Disabled Children Act 2000
- Health and Social Care Act 2001
- Adoption and Children Act 2002
- Children Act 2004

4. Guidance, Standards, Codes of Practice

These include:

- National Services Framework (NSF) for children, young people and maternity services <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>
- Special Education Code of Practice <http://www.teachernet.gov.uk/doc/3724/SENCodeOfPractice.pdf>
- National Healthy School Standard <http://www.wiredforhealth.gov.uk/cat.php?catid=842>

5. Local bodies and processes

Children's Services authorities are the new structures in England and Wales set up by the Children Act 2004 which must make arrangements with the local Strategic Health Authorities and PCTs to improve the well-being of children. They must publish a children and young people's plan setting out its strategy. This plan will be part of the local strategic partnerships – collaborative groups to co-ordinate community strategy; councils encouraged to involve children and young people.

Patient Advice and Liaison Services (PALS) are available in all trusts. They support, advise and inform patients, mediate on their behalf and represent their views to health service www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PatientAndPublicInvolvement/PatientAdviceAndLiaisonServices

Independent Complaints Advocacy Service (ICAS) locally based, supports people making complaints about the NHS

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/NHSComplaintsProcedureArticle/

Appendix 1

Strategy of the Royal College of Paediatricians and Child Health on “Advocacy and Equality”

The following pages outline international and national instruments, administrative structures and independent bodies which have been used by advocates to achieve change for children, or have potential to change things (for example, at the time of writing the Children Act 2004 was at an early stage of implementation and so largely untested). It is not a comprehensive list, and does not go into detail: the aim is to signpost avenues for advocates to explore. Websites are provided here, contact details in the last section.

International

1. United Nations

Convention on the Rights of the Child (CRC) (1979)

The most ratified treaty in history, the Convention covers most aspects of children’s lives both in terms of specific areas, such as health, disability, poverty and protection, and general principles, such as children’s rights to be heard, to have their ‘evolving capacities’ respected and to have their potential fulfilled. You will almost certainly find support for your cause in its comprehensive provisions.

Despite the fact there are no domestic or international mechanisms to enforce its implementation in the UK, the Convention is a useful advocacy tool. The UN-based Committee on the Rights of the Child, which reports on nations’ progress under the Convention, has twice issued strong recommendations to the UK government for reform in a number of areas. The next report is due in 2008-9; an audit of the UK’s failings in respect of the Convention are comprehensively mapped and continually updated by the Children’s Rights Alliances. In addition, the Convention is increasingly seen as the internationally agreed measure for defining children’s interests and needs.

See www.ohchr.org/english/bodies/crc/ for text, UK reports, Committee’s concluding observations on UK, Committee’s General Comments (these are authoritative interpretations and include General Comments on adolescent health and on children affected by HIV/AIDS) etc.

International Covenants on Civil and Political Rights and Economic, Social and

Cultural Rights (1966)

Principal human rights treaties for adults, with the same monitoring and reporting systems as the CRC. The Committees have produced authoritative General Comments, including on health and disability.

See www.ohchr.org/english/bodies/, which covers both Covenants and their Committees.

Convention on the Elimination of All Forms of Discrimination against Women (1979)

Although not focused on children the remit covers girl-children; CEDAW's Committee has produced a number of General Comments on health; it also has a process for individual complaints which the UK has – uniquely – ratified (2004), giving it greater potential for enforcement.

For text see: www.un.org/womenwatch/daw/cedaw/ and for advice on how to make a complaint: www.bayefsky.com/complain/37_cedaw.php

UN-based Rules and Guidelines:

See: <http://www.ohchr.org/english/law/index.htm> for complete list. These are not binding treaties but nonetheless represent internationally recognised standards of best practice, and therefore can be usefully quoted by advocates.

Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993).

Aimed at securing equality and full rights for disabled people, including children; initially monitored by a Special Rapporteur.

Standard Minimum Rules for the Administration of Juvenile Justice (1985), Guidelines for the Prevention of Juvenile Delinquency (1990), Rules for the Protection of Juveniles Deprived of their Liberty (1990).

Sets out humane and constructive measures based on prevention and treatment rather than punishment; requires adequate health and mental health services for children in custody.

UNHCR Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum (1997) and UNHCR's Strategy and Activities concerning Refugee Children and Adolescents (2000)

Emphasises refugee children's entitlement to special care and protection.

UN Special Session on Children

May 2002 - the Special Session's Outcome Document includes 25 specific health goals,

many relevant to the UK as well as developing countries, and an obligation to produce a National Plan of Action, still to be drafted in the UK) (www.unicef.org/specialsession/)

2. Europe

European Convention on Human Rights (1950)

It is hard to overestimate the effect this Convention has had on the development of children's policy in the UK over the past few decades, given how many reforms in children's policy have been driven by judgements by the Court of Human Rights in Strasbourg. Although not written with children in mind, it is arguably the most powerful lever for change available at present for an issue that is politically unpopular.

Strasbourg judgements have made clear that articles 2 (right to life) and 3 (no torture or inhuman or degrading treatment) includes state obligations to protect and safeguard children from risk of death or harm by others, to inform of health risks, and where the state might bear responsibility for a death, to hold an effective inquiry. Children are protected from institutional or professional abuse under articles 3 and 8 (right to private and family life). 'Voluntary' detentions of children for mental health reasons may be a breach of article 5 (right to liberty). Breach of confidentiality could be an article 8 violation; the Court has also held that a healthy environment is an implicit part of article 8.

The Convention has now been incorporated into UK law (see Human Rights Act below).

Text: conventions.coe.int/Treaty/en/Treaties/Html/005.htm;

Court judgements: www.echr.coe.int

European Charter of Social and Economic Rights (1961)

This Charter largely deals with employment rights, but **Articles 11 to 17** cover health and welfare, including the State's duty to prevent ill-health (particularly by securing healthy environments) as well as provide accessible and effective health provision for the whole population. Children and mothers are especially singled out as requiring social and economic protection, and the State must support family unity.

Unlike the ECHR, the Charter does not deal with complaints from individual victims but instead, since 1995, has heard 'collective complaints' on any alleged breach of the Charter's obligations. Unfortunately the UK has not yet signed up to the complaints procedure, so UK breaches would have to be addressed tangentially through complaints against other countries with similar failings. The Committee on Social Rights also monitors states' compliance and will now regularly report on progress and difficulties in each country: this

process can also be used in advocacy. (www.coe.int/T/E/Human_Rights/Esc/)

European Union

The draft Constitution has some provisions relating to the rights of children and to health care, but at the time of writing was a long way from being ratified.

National: England and Wales

3. Statutes and statutory instruments: enforceable Acts and Regulations

All Acts after 1989 can be accessed on www.opsi.gov.uk/acts.

Human Rights Act 1998

This brought the European Convention on Human Rights (see above) into domestic law, though Strasbourg remains the final court of appeal.

All public authorities must act compatibly with the Act unless following primary legislation which requires them to do otherwise. 'Public authorities' include health trusts and individuals working for the NHS, as well as government departments. Legal action in the courts has to be taken by the victim of a rights violation, i.e. by the child, not a doctor or organisation on behalf of the child, and it is obviously important to find the 'right' individual case. Courts can order remedies within their powers, but cannot change the law itself, though a court declaration of incompatibility will put the same pressure for legal reform as a ruling from the European Court. It is up to the Government to change legislation, but the Act enables a speedy Parliamentary procedure for doing so.

Children Act 1989

This Act establish the basic framework of children's law in civil and public care. Important principles include: the paramountcy of children's welfare in court cases affecting children; court and local authorities' obligation to consider children's views ; local authorities duty to safeguard the welfare of children in their area who are deemed to be in need, if necessary by providing services, and their duty to investigate and take action if the child is at risk of significant harm. The 1989 Act also expresses in statute the principles of the *Gillick* case – that under-age children of 'sufficient understanding' have a right to control medical treatment and examination.

These Acts are the bedrock of children's domestic rights, and have been effective in enforcing them - for example a recent case ruled that social services are responsible for the protection and welfare of children in young offender institutions in their area.

Education Act 1996

This Act contains most education law including special education law: Part IV, together with its regulations (Education (Special Educational Needs)(England)(Consolidation) Regulations 2001) sets out the very strong rights of children with special needs, a group which covers children with behavioural problems as well as sick and disabled ones, whose statements of educational needs *must* be met by the education authority, which *must* take account of an independent medical expert's view as well as its own educational experts. Paediatricians thus have great potential power to secure provision for individual children with special needs. Special education law is one of the strongest levers in this country for securing provision for children because it imposes duties rather than discretionary powers to provide.

Disability Discrimination Acts 1995 and 2005

Gives disabled children access and equality of opportunity rights in, for example, housing, schools and play as well as all health services – again, because it contains less room for the exercise of discretion in providing services these Acts may be more effective than other legislation governing statutory services.

Local Government Acts 1999 and 2000

Local authorities are required to review their services in terms of their economy, efficiency and effectiveness and to produce a community strategy on improving economic, social and environmental well-being of the area, in consultation with others.

Carers and Disabled Children Act 2000

Gives carers of disabled children, and 16 and 17 year-old carers, the opportunity to receive money, services and short-term break vouchers from the local authority. Paediatricians can undertake the necessary assessments.

Health and Social Care Act 2001

Places a duty on the government to provide independent advocacy services (including representation) for those making a complaint about health services.

Adoption and Children Act 2002

Gives children in care and care leavers a right to an independent advocate in complaints procedures against social services.

National Health Service Reform and Health Care Professions Act 2002

Requires Patients Forums for NHS trusts, foundation trusts and primary care trusts (PCTs) to set up Patients' Forums; the PCT Patients' Forum must also provide an independent advocacy service to patients and people in the trust's area.

Children Act 2004

Sets out five desired 'outcome goals' for children: health, protection, education, civic responsibility and economic well-being; makes administrative changes to consolidate or strengthen partnerships between local children's services, for example by pooled resources and shared databases on children and by the publication of strategic plans for children. Also introduces the English children's commissioner (see below).

Northern Ireland

Before devolution most Acts affecting children used to be directly translated into Northern Ireland Orders. However during the suspension of the Northern Ireland assembly this has tended not to be done, and therefore some of the rights gained for children in the rest of the UK in recent years do not yet apply to Northern Irish children.

Northern Ireland Act

The Human Rights Act 1998 (HRA, see above) came into force in Northern Ireland in October 2000. Section 6 of the Northern Ireland Act 1998 invalidates any provision of an Act of the Northern Ireland Assembly which is incompatible with the HRA, and subordinate legislation may not be passed if it is incompatible with the HRA.

Children Act

The Children (NI) Order 1995 is equivalent to the Children Act 1989 (see above).

Special Education legislation

The equivalent to the Education Act 1996 is:

- 1) The Education (NI) order 1996,
- 2) Special Educational Needs Tribunal Regulations (NI) 1997
- 3) Education (Special Educational Needs) (Amendment) Regulations (NI) 1997
- 4) Special Educational Needs and Disability (NI) Order 2005 – which combines rights for children with special educational needs to attend mainstream schools and rights for children with a disability. However there is no equivalent in the Northern Ireland legislation to the requirement that the independent medical experts view must be taken into account, and the Northern Ireland Special Educational Needs and Disability Order does not cover as wide a range of disability rights as the English/Welsh equivalent in that it only deals with education and not housing and play etc. The Equality Commission Northern Ireland has the responsibility for dealing with the Order's implementation.

Scotland

Scotland Act 1998 – creates the Scottish Parliament and Administration, requiring both Ministers and Parliament to act in accordance with the convention rights set out in the Human Rights Act (see above).

Children (Scotland) Act 1995 – provides the framework for public and private child law. It sets similar key principles to the English/Welsh Children Act 1989 (see above) but places additional duties on parents, such as promoting children’s health, development and welfare and consulting children about major decisions. It also covers the operation of local authorities and the children’s hearing system in Scotland.

Age of Legal Capacity (Scotland) Act 1991 – establishes in law the Gillick principle that under-16 year-olds can consent to treatment if a qualified medical practitioner decides they have the capacity to understand the nature and possible consequences of the treatment.

Education (Scotland) Act 1980 and Standards in Scotland’s Schools etc. Act 2000 – provides legal rights of children to education and to have their views taken into account over significant decisions.

Education (Disability Strategies and Pupils’ Educational Records) (Scotland) Act 2002 and Education (Additional Support for Learning) Act 2004 – These Acts set out the strong rights Scottish children with disabilities have to access mainstream education and to adequate provision from both education and health services in order to overcome any barrier to learning. The Disability Discrimination Acts (see above) also apply in Scotland.

Regulation of Care (Scotland) Act 2001 – ensures the independent regulation of care services against a set of national standards.

Community Care and Health (Scotland) Act 2002 – extends the rights of carers (including young carers or carers of disabled children) to have their needs assessed and views taken into account.

Breastfeeding etc (Scotland) Act 2005 – makes it an offence to prevent breast feeding in a public place, and encourages promotion of breastfeeding.

Local Government in Scotland Act 2003 – integrates children’s services, including an

integrated local plan for children including social services, youth justice, education improvement, local health and child health strategies, on which the local authority must make annual progress reports. These plans must also be cross-referenced to other plans affecting children (e.g. local drug action or domestic abuse strategies).

4. Guidance, Standards, Codes of Practice

These do not have legal force, but authorities are obliged to follow them unless they can show it would be unreasonable to do so.

National Services Framework (NSF) for children, young people and maternity services

Ten-year plan for improving children's health services linked to a wider 'Change for children' programme; applicable to NHS Trusts, PCTs, SHAs but also to all other statutory services dealing with children. Contains eleven standards each with a vision, standard to be met, markers of good practice, rationale and interventions:

- 1) Promoting health and well-being, identifying needs, intervening early
- 2) Supporting parents/carers
- 3) Child and family-centred services
- 4) Growing up into adulthood
- 5) Safeguarding and promoting welfare
- 6) Children who are ill
- 7) Hospitals
- 8) Disabled children and those with complex needs
- 9) Mental and psychological well-being
- 10) Medicines
- 11) Maternity services.

The NSF emphasises the need to involve children in the delivery of services, improve access, tackle health inequalities, and to ensure staff with concerns about children are able to act. The Government is committed to the fulfilment of this plan and is therefore likely to respond favourably to advocacy which makes explicit reference to it.

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

Special Education Code of Practice

Implemented in 2002, guides SENCOs (Special Educational Needs Coordinator), LEAs and allied professionals through the tiered process of securing children's statutory right to have their special educational needs met. Case law (most fully in the 1999 case *London*

Borough of Bromley and Special Educational Needs Tribunal and Others) has confirmed that occupational, speech and physiotherapies are a mandatory part of education. <http://www.teachernet.gov.uk/doc/3724/SENCodeOfPractice.pdf>

National Healthy School Standard

Every LEA (England) is supposed to be working in partnership with PCTs to implement a local healthy schools programme, with particular focus on schools with most socially deprived populations.

<http://www.wiredforhealth.gov.uk/cat.php?catid=842>

Scotland

Vision for Children and Young People – The Scottish Executive’s ambitions for children set out under seven headings: that they should be safe from harm, nurtured within a caring setting, healthy, achieving, active, respected and responsible, and included. Advocacy for children aimed at Scottish Ministers or civil servants can usefully draw on this framework.

Supporting Children’ Learning: Code of Practice - Guidance on functions and duties regarding children with special educational needs.

www.scotland.gov.uk/Resource/Doc/57346/0016754.pdf

Health for all children 4: guidance on implementation in Scotland - supports implementation in Scotland of recommendations on child health screening by the RCPCH.

www.scotland.gov.uk/Resource/Doc/37432/0011167.pdf

Delivering for health – sets out what action will be taken by the Scottish Executive’s to implement its vision, building on the NSF (see above).

www.scotland.gov.uk/Resource/Doc/76169/0018996.pdf

Birth to three: supporting our youngest children – aimed at those involved in caring babies and young children, including health practitioners; sets out key features of effective practice.

www.ltscotland.gov.uk/Resource/Doc/76168/0018996.pdf

Protecting Children and Young People: The Children’s Charter and Framework for Standards – the Charter contains 11 pledges to children at risk, including, for example, their rights to be safe, to be taken seriously and to have their privacy respected. The Framework for Standards addresses practice in relation to children at risk, their parents, other concerned adults and all the professional agencies involved in child protection.

5. English and Welsh Bodies: contact details in final section

Children's Commissioner for England

Professor Sir Al Aynsley-Green, previously National Clinical Director for Children at the Department of Health, was appointed Children's Commissioner for England in July 2005. Much will depend on his interpretation of his role, set out in the Children Act 2004, which, broadly speaking, is to promote awareness of the views and interests of children by means of research and investigations. Although he cannot arbitrate on individual complaints, he can pursue such cases if they have wider implications. He is likely to be interested in health-related topics.

Children's Commissioner for Wales

A new Commissioner is to be appointed, following the death of Dr Peter Clarke in January 2007. The office has three teams: Legal and Administrative (deals with cases), Policy and Service Evaluation (promoting better services) and Communications (for contact with children and dissemination of children's rights).

Commission for Health Audit and Inspection (CHAI or the Healthcare Commission, replacing the Commission for Health Improvement under 2003 legislation)

Encourages "improvement in the provision of health care by and for NHS bodies" and has powers to review and investigate failings by health authorities and bodies, including considering complaints about health services, and has a duty to inspect and assess the quality and performance of all trusts and healthcare provision.

Parliamentary and Health Services Ombudsman

Investigates complaints about poor service or unfair treatment by public bodies, including the NHS – complaints about non-health bodies are lodged via a Member of Parliament, after an unsatisfactory attempt to complain to the body concerned; complaints about health services does not require an MP's involvement but must include an unsatisfactory complaint to CHAI/Healthcare Commission. The Ombudsman has no enforcement powers but its recommendations for change or compensation are often followed.

Commission for Social Care Inspection (CSCI, replacing the National Care Standards Commission and the Social Services Inspectorate)

This is the independent inspectorate of all social care; includes a **children's rights director** who audits the Commission's work from children's perspective and oversees complaints relating to children.

Disability Rights Commission

An independent body set up by statute in 2000, which gives advice, supports legal test

cases, provides a conciliation service, campaigns and disseminates information on rights and good practice. It has already secured some case victories.

Commission for Patient and Public Involvement in Health

Sets up PPI Forums (see below)

Northern Ireland

Northern Ireland Commissioner for Children and Young people (NICCY), currently Patricia Lewsley. Her role is to promote the rights of children under the CRC, review and monitor legislation and conduct research or inquiries into issues adversely affecting NI children. She also operates a complaints service which supports and advocates for individual children. www.niccy.org.

The Northern Ireland Ombudsman is the popular name for the Assembly Ombudsman and the Commissioner for Complaints, covering maladministration by government departments and public bodies in Northern Ireland. His powers cover doctors, nurses, dentists, pharmacists and optometrists and other health professionals and he can look into the exercise of clinical judgment. Health and Personal Social Services Regulation and Improvement Authority (HPSSRIA). This inspects and regulates health and social care services issues; it also has a complaints function.

Scotland

Scottish Commissioner for Children and Young People – currently Kathleen Marshall. Her function is to promote and safeguard the rights of children and young people, by reviewing law, policy and practice. She has powers to hold formal inquiries but she does not become involved in individual cases. www.sccyp.org.uk

National Clinical Lead for Children and Young People's Health in Scotland –Morgan Jamieson, a paediatric cardiac surgeon appointed to this post in March 2005, provides the the Scottish Executive with advice to support NHS boards in the redesign of children's health services.

Scottish Public Services Ombudsman – provides a 'one-stop shop' for the public to make complaints about public services, including the Scottish Parliament and Executive, health services, education institutions and local government. www.scottishombudsman.org.uk

Care Commission (Scottish Commission for the Regulation of Care) oversees care

services by registration and inspection and investigation of complaints.

www.carecommission.com

SWIA (Social Work Inspection Agency) an 'arm's length' agency which inspects and reports to Parliament on social work services in Scotland www.swia.gov.uk

Cabinet Delivery Group on Children and Young People – is the cross-government group responsible for ensuring the Executives commitments to children are met and for setting objectives and targets in its work programme; it includes the First Minister, Deputy First Minister and ministers for health & community care, education & young people, tourism, culture & sport, justice, communities and finance & public service reform. Some information can be found on: www.scotland.gov.uk/About/Ministers/14944/13387

Child Health Support Group – expert advisory group to drive forward improvements in child health. It includes representatives from medicine, nursing, other health professionals, local authority social work and education; it meets quarterly. www.show.scot.nhs.uk/chsg

6. Local bodies and processes

Children's Services authorities

Are the new structures in England and Wales set up by the Children Act 2004 which must make arrangements with the local Strategic Health Authorities and PCTs to improve the well-being of children; and must publish a **children and young people's plan** setting out its strategy, including priorities based on an accurate assessment of need in the area. This plan will be part of the **local strategic partnerships** – collaborative groups to co-ordinate community strategy; councils encouraged to involve children and young people.

Public Health Observatories (PHO)

There are ten PHOs in England and Wales. These exist for information-exchange on public health data and dissemination of good practice, but also to be 'advocates for users of public health information'. Each PHO takes a different set of priorities in order to avoid duplication – for example children and young people in Yorkshire and Humberside; mental health in the North East PHO, drugs/alcohol/violence/crime in the North West, obesity in the South East, accident, injury and sexual health in the South West, teenage pregnancy in East Midlands; health inequalities in London etc.

Patient and Public Involvement (PPI) Forum

One in each English NHS Trust but independent, aiming to involve the public in health service development.

Patient Advice and Liaison Services (PALS)

PALS are available in all trusts. They support, advise and inform patients, mediate on their behalf and represent their views to health service. www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PatientAndPublicInvolvement/PatientAdviceAndLiaisonServices

Independent Complaints Advocacy Service (ICAS)

Locally based, supports people making complaints about the NHS. www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/NHSComplaintsProcedureArticle/

Scrutiny reviews

When a small group of elected councillors examine one area of work by the local authority and make any necessary recommendations for change. Such reviews can be requested by action groups.

Joint Area Reviews (JARs)

New combined OFSTED, CSCIE, Audit Commission and Healthcare Commission integrated inspections of the new children's services under the 2005 Act, with a specific emphasis on the degree to which the area is improving outcomes for children and involving children.

Appendix 2

Useful Addresses

Action for Sick Children

NCB, 8 Wakley Street, London EC1V 7QE ; tel: 0207 843 6444;

<http://www.actionforsickchildren.org>

Scotland: 172 Leith Walk, Edinburgh EH6 5EA; tel: 0131 553 6553

Wales: A.W.C.H.(Wales), 31 Penyrheol Drive, Sketty Swansea SA2 9JT;
tel: 01792 205 227

Provides a parent help line, disseminates information, guidelines for health professionals and advocates improvements to the delivery of children's health services

Advisory Centre for Education (ACE)

1C Aberdeen Studios, 22 Highbury Grove, London N5 2DQ, tel: 020 7354 8318 (admin), 0808 800 5793 (freephone advice); <http://www.ace-edu.org.uk>

Gives parents and others confidential advice on education law and procedures, also undertakes training, public advocacy and disseminates information.

Association of Public Health Observatories

Wolfson Research Institute, University of Durham Queen's Campus, University Boulevard, Stockton on Tees, TS17 6BH tel: 0191 3340398; fax 0191 334 0391; <http://www.apho.org.uk>;
Susan.Panrucker@durham.ac.uk

Barnardo's

Tanners Lane, Barking, Essex IG6 1QG, tel: 020 8550 8822; <http://www.barnardos.org.uk>

Northern Ireland: 542-44 Upper Newtownards Road, Belfast BT4 3HE;
tel: 028 9067 2366

Scotland: 235 Corstorphine Road, Edinburgh EH12 7AR; tel: 0131 334 9893

Wales: 11-15 Columbus Walk, Brigantine Place, Atlantic Wharf, Cardiff CF10 4BZ; tel: 029 20 49 3387

Runs local projects for disadvantaged children and families; campaigns for improvements to social policy

British Medical Association

BMA House, Tavistock Square, London WC1H 9JP; tel 020 7387 4499; <http://www.bma.org.uk>

Northern Ireland: 16 Cromac Place, Cromac Wood, Ormeau Road, Belfast BT7 2JB
tel: 028 9026 9666

Scotland: 14 Queen Street, Edinburgh EH2 1LL tel: 0131 247 3000
Wales: 5 Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff
CF10 4DQ tel: 029 2047 4646

Advises members on most aspects of advocacy, including media, research, ethics, parliament and supporting information

British Association of Community Child Health

50 Hallam Street, London W1N 6DE tel: 020 7307 5601 bacch@rcpch.ac.uk;
<http://www/bacch.org.uk>

Child Poverty Action Group

94 White Lion Street, London N1 9PF tel 020 7837 7979; staff@cpag.org.uk *Scotland*
Unit 9, Ladywell, 94 Duke Street, Glasgow G4 0UW tel: 0141 552 3303;
staff@cpagscotland.org.uk

Provides information, campaigns, researches and takes test-cases on poverty and welfare benefits.

ChildLine

45 Folgate Street, London N1 9PF; tel: 0207 650 3200; Freephone 0800 1111
info@childline.org.uk

Northern Ireland: 1st Floor, Queen's House, 14 Queen Street, Belfast BT1 6ED
tel: 0870 336 2945

Scotland: 18 Albion Street, Glasgow G1 1LH, tel: 0870 336 2910; 2 Poynerook
Road, Aberdeen AB11 5RW, tel: 0870 336 2900

Wales: Royal Alexandra Hosp, Marine Drive, Rhyl LL18 3AS,
tel: 0870 336 2930 , 9th Floor Alexandra House, Alexandra Road,
Swansea SA1 5ED tel: 0870 336 2910

Free 24-hour telephone helpline for children in trouble or seeking confidential counselling. ChildLine also researches and pursues policy implications of their work. Detailed reference list of helpful organisations obtainable on website www.childline.org.uk

Children's Legal Centre

University of Essex, Wivenhoe Park, Colchester, Essex CO4 3SQ Tel 01206 872466 (admin/pubs), 873820 (advice line) 873466; <http://www.childrenslegalcentre.com>

Scotland: Scottish Child Law Centre 54 East Cross Causeway, Edinburgh,
EH8 9HD tel: 0131 667 6333, freephone for under 18s: 0800 328
8970; enquiries@sclc.org.uk

Northern Ireland: Children's Law Centre, 3rd Floor, Philip House, 123-137 York Street,
Belfast BT14 1AB Tel 02890 245 704; advice 02890 434242, free
advice to children 0808 808 5678

Legal advice on law and policy on children (in England this is limited to education law and children in need in Essex); disseminates information on legal rights.

Children's Rights Alliance for England

94 White Lion Street, London N1 9PF tel:020 7278 8222 info@crae.org.uk

<http://www.crae.org.uk>

The alliance of voluntary, statutory and professional organisations (including the RCPCH) seeking full implementation of the UN Convention on the Rights of the Child. Undertakes and co-ordinates public advocacy.

Children's Rights Officers and Advocates (CROA)

Suite 5J, North Mill, Bridgefoot, Belper, Derbyshire DE56 1YD, tel 01773 820100 ;

<http://www.croa.org.uk>

Membership organisation that promotes and develops locally-based children's rights and advocacy services in England and Wales.

Children's Society

Edward Rudolf House, Margery Street, London WC1X 0JL; tel: 020 7841 4436;

<http://www.childrensociety.org.uk>

Runs local advocacy projects, and projects for children in difficult circumstances (including failure to thrive) develops policy relating to public health and children

Commission for Racial Equality

St Dunstan's House, 201-211 Borough High Street, London SE1 1GZ,

tel: 0207 939 0000; info@cre.gov.uk

Scotland: The Tun, 12 Jackson's Entry, off Holyrood Road, Edinburgh EH8 8PJ, tel: 0131 524 2000; Scotland@cre.gov.uk

Wales: 3rd Floor, Capital Tower, Greyfriars Road CF10 3AG tel: 029 20 729 200; informationWales@cre.gov.uk

Promotes implementation of the Race Relations Act, disseminates information, facilitates equal opportunities policies, advises and takes cases

Commissioners for Children and Young People

England: 11 million, Office of the Children's Commissioner, London Bridge, London, SE1 9BG

tel: 0844 8009113, E-mail: info.request@childrenscommissioner.org ;

www.11million.org.uk

Northern Ireland: NICCY, Millennium House, 17-25 Great Victoria Street Belfast, BT2 7BN,

tel: (028) 9031 1616; info@niccy.org (for general enquiries) or
yourshout@niccy.org (for complaints/concerns)

Scotland: Scotland's Commissioner for Children and Young People, 85 Holyrood Road, Edinburgh EH8 8AU, Tel: 0131 558 3733, Fax: 0131 556 3378; www.sccyp.org.uk

Wales: Children's Commissioner for Wales, Oystermouth House, Charter Court, Phoenix Way, Llansamlet, Swansea. SA7 9FS tel: 01792 765600 fax: 01792 765601; post@childcomwales.org.uk

Commission for Patient and Public Involvement in Health

7th Floor, 120 Edmund Street, Birmingham, B3 2ES. tel 0845 120 7115; fax 0121 222 4511; enquiries@cppih.org

Commission for Healthcare Audit and Inspection

Finsbury Tower, 103-105 Bunhill Row, London EC1Y 8TG, tel: 0207 448 9200;

Commission for Social Care Inspection

33 Greycoat Street, London SW1P 2QF; tel: 020 7979 2000 enquiries@csci.gsi.gov.uk

Community Practitioners and Health Visitors Association

33-37 Moreland Street, London EC1 8HA, tel: 0207 780 4080; <http://amicus-cphva.org>

Contact-a-Family

209-211 City Road, London EC1V 1JN; tel: 0207 608 8700, freephone for families: 0800 808 3555; info@cafamily.org.uk

Northern Ireland: Bridge Community Centre, 50 Railways Street, Lisburn, BT28 1XP; tel: 028

9262 7552; nireland@cafamily.org.uk

Scotland: Norton Park 57 Albion Rd, Edinburgh EH7 5QY; tel: 0131 475 2608; scotland@cafamily.org.uk

Wales: Room 1535, 1st Floor, The Exchange Building, Mount Stuart Square, Cardiff, CF10 5E13; tel: 029 2049 8001; wales@cafamily.org.uk

Provides advice and information for families who care for disabled children

Council for Disabled Children

8 Wakley Steet, London EC1V 7QE tel: 0207 843 1900; <http://ncb.org.uk/cdc/>

Multi-disciplinary consortium to promote collaboration between professionals and families; national forum for policy and practice relating to disabled children

Disability Alliance

ERA, 1st Floor East, Universal House, 89-94 Wentworth Street, London E1 7SA Rightsline:

0207 247 8776; office.da@dial.pipex.com

Gives advice on welfare benefits for disabled people

Disability Rights Commission

Grey's Inn Road 7th floor 222, WC1X 8HL tel: 020 7211 3000. Helpline: 08457 622 633/ 644 for texting (any time between 8am and 8pm, Monday to Friday); Fax: 08457 778 878; DRC Helpline ,FREEPOST MID02164 Stratford upon Avon CV37 ; <http://drc-gb.org>

Promotes implementation of the Disability Discrimination Act, disseminates information, advises and takes cases

Equal Opportunities Commission

Arndale House, Arndale Centre, Manchester M4 3EQ, tel: 0845 601 5901;

info@eoc.org.uk

Scotland: St Stephen's House, 279 Bath St, Glasgow G2 4JL, tel: 0845 601 5901;

scotland@eoc.org.uk

Wales: Windsor House, Windsor Lane, Cardiff CF10 3GE; tel: 0845 601 5901;

wales@eoc.org.uk

Promotes implementation of the Sex Discrimination and Equal Pay Acts, disseminates information, facilitates equal opportunities policies, advises and takes cases

Equality Commission for Northern Ireland

Equality House, 7 - 9 Shaftesbury Square, Belfast BT2 7DP, tel : 028 90 500600;

information@equalityni.org

Promotes anti-discrimination rights in race, gender, sexual orientation, religion and disability, through assisting complainants, dissemination of information, investigation and research

Parliamentary and Health Ombudsman

Millbank Tower, Millbank, London SW1P 4QP tel 0845 015 4033;

phso.enquiries@ombudsman.org.uk

Scottish Public Services Ombudsman

4Melville Street, Edinburgh EH3 7NS, tel: 0870 011 5378;

enquiries@scottishombudsman.org.uk

Northern Ireland Ombudsman

Freepost BEL 1478, Belfast BT1 6BR, tel:

0800 34 34 24 (freephone) or 028 9023 3821; ombudsman@ni-ombudsman.org.uk

Public Services Ombudsman for Wales

1 Ffordd Yr Hen Gae, Pencoed, Bridgend, CF35 5LJ, tel: 08456 010987;
ask@ombudsman-wales.org.uk

Investigates complaints made by the public about the National Health Service or government departments or agencies (including local administration in Scotland, Northern Ireland and Wales).

IPSEA - Independent Panel for Special Education Advice

4, Ancient House Mews, Woodbridge, Suffolk IP12 1DH. tel England and Wales (freephone):
0800 0184016;

Scotland (ISEA): 0131 454 0096; 0131 454 0144

Northern Ireland: 02890 705654

Provides parents with professional second opinions on special educational needs, also represents parents at tribunals.

Law Centres Federation

Duchess House, 18-19 Warren Street, London W1T 5LR; tel: 020 7387 8570;
info@lawcentres.org.uk

Will provide contact details of your nearest law centre.

Local Government Ombudsman

Millbank Tower, Millbank, London SW1P 4QP, tel: 020 7217 4620 ; <http://lgo.org.uk>

Investigates complaints of maladministration by English local authorities

MIND

15-19 Broadway, London E15 4BQ, tel: 020 8519 2122; contact@mind.org.uk;

<http://mind.org.uk>

Information helpline: MindinfoLine

Northern Ireland Association for Mental Health

80 University Street, Belfast, BT7 1HE tel: 02890 328 474 ; <http://www.niamh.co.uk/>

Scottish Association for Mental Health

Cumrae House, 15 Carlton court, Glasgow G5 9JP el: 0141 568 7000; enquire@samh.org.uk

Wales Mind

Cymru, 3rd Floor, Quebec House, Castlebridge, 5-19 Cowbridge Road East, Cardiff CF11
9AB; tel: 029 2039 5123; <http://www.mind.org.uk/About+Mind/Mind+Cymru/>

Provides information and advice for people with mental distress and campaigns for a better life for them.

National Children's Bureau

8 Wakley Street, London EC1V 7QE tel: 0207 843 6000 www.ncb.org.uk

Children in Scotland

Princes House, 5 Shandwick Place, Edinburgh EH2 4RG tel: 0131 228 8484;
info@childreninscotland.org.uk

Children in Wales

25 Windsor Place, Cardiff CF10 3BZ tel: 02920 342434; info@childreninwales.org.uk
Supports a multi-agency membership; library and information service (NCB); promotes good practice; hosts specialist forums on drugs, sex education, violence, play etc.

NCH - Action for children

85 Highbury Park N5 1UD tel: 020 7226 2033; <http://www.nch.org.uk>
Northern Ireland: 45 Malone Road, Belfast, BT9 6RX, tel: 028 9068 7785
Scotland: City Park, 368 Alexandra Parade, Glasgow, G31 3AUm
tel: 0141 550 9010
Wales: St David's Court, 68A Cowbridge Road East, Cardiff CF11 9DN tel:
02920 22 21 27

Runs a large number of locally-based projects, including statutory services and services relating to disabled children and young carers and sexual abuse treatment. Undertakes research and policy development.

National Institute for Health and Clinical Excellence (NICE) National Institute for Clinical Excellence

MidCity Place, 71 High Holborn, London WC1V 6NA; tel: 0207 067 5800; nice@nice.org.uk
Provides national guidance on the promotion of good health and the prevention and treatment of ill health, including health technologies, public health and clinical practice.

National Society for the Prevention of Cruelty to Children (NSPCC)

42 Curtain Road, London EC2A 3NH tel: 020 7825 2500; <http://www.nspcc.org.uk>
24 hour helpline: 0808 800 5000
Northern Ireland: Jennymount Business Park, North Derby Street, Belfast BT15 3HM
tel: 0289 035 1135
Wales: Capital Tower, Greyfriars Road, Cardiff CF10 8AG 02920 267 0000
Scotland: Children 1st (a separate organisation) 83 Whitehouse Loan, Edinburgh
EH9 1AT, tel: 0131 446 2300

Undertakes casework (with statutory powers), produces information, runs projects and develops policy in this area

National Youth Advocacy Service

99-105 Argyle Street, Birkenhead, Wirral, CH41 6AD; tel 0151 649 8700 Freephone 0800 616101; <http://www.nyas.net>

Independent, confidential advocacy for children and young people who have family or social services problems.

DIAL UK (National Association of Disablement Information and Advice Lines UK)

St Catherine's, Tickhill Road, Baldy, Doncaster DN4 8QN; Tel: 01302 310 123; infoenquiries@dialuk.org.uk

Source of useful referrals on disability

A National Voice

Central Hall, Oldham Street, Manchester M1 1JQ, tel: 0161 237 5577; info@anationalvoice.org

Wales: Voices from Care

39 The Parade, Roath, Cardiff CF24 3AD, tel: 029 2045 1431; info@vfcc.org.uk

Young people's self-advocacy organisation representing children in and leaving care

Office for National Statistics

Customer Contact Centre, Room 1.015, Office for National Statistics, Cardiff Road, Newport NP10 8XG tel: 0845 601 3034; enquiries in Welsh: 01633 813381 info@statistics.gov.uk; www.statistics.gov.uk

Queries on statistics should be answered within ten working days.

Patients' Association

PO Box 935, Harrow, Middlesex HA1 3YJ, tel 0208 423 9111 (admin), helpline: 0845 6084455; mailbox@patients-association.com

Advises, represents and campaigns on behalf of patients.

Save the Children Fund

1 St. John's Lane, London EC1M 4AR, tel: 0207 012 6400; <http://www.savethechildren.org.uk>

Northern Ireland: Popper House, 15 Richmond Park, Belfast BT10 0HR tel: 028 90 431123

Scotland: 7th Floor, Haymarket House, 8 Clifton Terrace, Edinburgh EH4 52R
tel: 0131 527 8200

Wales: Phoenix House, 2nd Floor, 8 Cathedral Road, Cardiff CF11 9LJ tel: 02920 396 838

Works with local agencies and government in developing policy and good practice; supports research and advocacy to implement children's rights.

Shelter

88 Old Street, London EC1V 9HU; tel: 020 7505 4699, housing advice 0808 800 4444;

info@shelter.org.uk

Campaigns on homelessness and bad housing, provides housing advice.

Young Minds

48-50 St John Street, London EC1M 4DG, tel: 020 7336 8445; enquiries@youngminds.org.uk

Works to promote the mental health of children and young people; training and consultancy services; policy development and information service.

United Kingdom Public Health Association (UKPHA)

Suites 3 & 4, 1st Floor, Lion Court, 25 Procter Street, London WC1V 6NY, tel: 0870 010 932;

info@ukpha.org.uk

Promotes public health and reduction of health inequalities, mainly through information and networking. Secretariat to the All Party Group on Primary Care and Public Health.

Voice for the Child in Care

Unit 4, Pride Court, 80/82 White Lion Street, London N1 9PF; tel: 0207 833 5792; info@vcc-uk.org

Provides advocacy services to looked after children, campaigns for improvements in their lives.

UNICEF UK-Committee

Africa House, 64-78 Kingsway, London WC2B 6NB, tel: 0207 405 5592;

helpdesk@unicef.org.uk

Provides copies of the UN Convention on the Rights of the Child and related briefings.

Royal College of Paediatrics and Child Health

5-11 Theobalds Road, London, WC1X 8SH

Tel: 020 7092 6000

www.rcpch.ac.uk

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