

Draft Advocacy Guide for Commissioners

Consultation questions

1. Since the publication of the Guide for Commissioners by SIAA in 2010 there have been several developments. For example the publication of the NHS Healthcare Quality Strategy in 2010; the introduction of the Patient Rights (Scotland) Act 2011; the publication of the Patients Charter of Rights and Responsibilities in October 2012; publication of the Carers and Young Strategy in 2010, and the provision of joint Scottish Government and COSLA Guidance on Procurement of Support and Care Services in 2010.
2. The guide has been updated to incorporate these and other relevant developments.
3. Sections 5 and 6 of the Guide explain commissioner's statutory responsibilities under the Mental Health (Care and Treatment) Act 2003 which are further explained in the Code of Practice Volume 1. Based on the definition taken from the legislation the guide provides the following Principles and Standards for Independent Advocacy:

Principle 3

Independent advocacy is as free as it can be from conflicts of interest.

Standard 3.1 - Independent advocacy providers cannot be involved in the welfare, care or provision of other services to the individual for which it is providing advocacy.

Standard 3.2 - Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

Standard 3.3 – Independent advocacy looks out for and minimises conflicts of interest

Please note:

- Standards 3.1 and 3.2 associated with Principle 3 above reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003 and differ from the standards used by the advocacy movement in the SIAA Principles and Standards.
- The remaining Principles and Standards i.e. Principles 1, 2 and 4 and the associated standards set out in Appendix 1 are consistent with the Principles and Standards given in the SIAA Principles and Standards.

Question 1: Are you content with the level of detail given in relation to the statutory responsibilities and that the information is clear? Yes No

If no, what additional information do you think should be included?

We welcome the clarity provided by Standards 3.1 and 3.2 by reflecting the definition of independent advocacy used in legislation. We believe that this is exceptionally useful, and will allow for more productive discussions in the future.

There is other legislation and guidance that includes a duty to consider or advise on the availability of advocacy.

(For example, the Adult Support and Protection (Scotland) Act 2007, the Children's Hearing Act 2011, the Patient's Rights (Scotland) Act 2011, and the Guidance on Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007.)

While such legislation does not include a statutory duty to provide advocacy services, it does include statutory responsibilities in relation to advocacy services. We believe that it would be useful to highlight this within the Guide.

4. Section 10 covers commissioning of independent advocacy. This is a much shorter section than in the previous guide as it refers to the Guidance on the procedures for Procurement of Care and Support Services given in the joint Scottish Government and COSLA guidance issued in 2010 and available at:

<http://www.scotland.gov.uk/Resource/Doc/324602/0104497.pdf>.

Question 2: Are you content that the level of detail given in Section 10 on the Commissioning of Independent Advocacy is appropriate?

Yes No

If not, why not?

Commissioning can be carried out in several ways, including procurement (purchasing a service) or through grant-funding (by way of a Service Level Agreement). Grant-funded commissioning often allows for a more "grass roots" approach in the development of services to meet local need, and for services to be developed on a partnership basis.

However, Section 10 refers to the *Procurement of Care and Support Services* guidance document. This guidance document clearly states (p.5, para 1.1) that it only applies to the procurement of services, and not for services secured through grant funding.

If the Draft Guide is recommending that Advocacy Services must be procured (and not commissioned in any other way), we believe that this should be made more explicit in the Draft Guide.

(Please note that NHS Fife and Fife Council would not support such a recommendation. We consider that grant funding several small local groups to provide advocacy is both effective and fully in line with the principles of the Christie Commission.)

However, if the Draft Guide wants Commissioners to follow the procurement guidance – *even when securing services through grant funding* – then this should also be made more explicit, and should include more clarity over which specific parts of the guidance should be followed.

5. Both commissioners and the advocacy groups have a responsibility to ensure that the advocacy being provided is of good quality and is effective. Section 12 of the guide covers Monitoring and Evaluation and mostly reflects the arrangements currently set out in the 2010 guidance. However we understand that the cost of independent evaluations is high and is not always undertaken. In relation to this we are currently exploring a pilot for evaluation of advocacy projects with the SIAA. This will involve the recruitment of independent sessional evaluators to undertake evaluations based on the Principles and Standards within this guide over an 18 month period. SIAA will facilitate the appointment and training of the evaluators. The report of the evaluation will be prepared by the evaluators and will go to the commissioners and the advocacy group. The SIAA will be in a position to offer support to the advocacy group in the event that improvements are required. An evaluation of the pilot will be conducted prior to any decision on whether to proceed with this model. The evaluations will not be restricted to SIAA member organisations.

Question 3: Would you support a programme of evaluations based on the pilot model of evaluation set out at 5 above?

Yes No

If not, why not?

NHS Fife and Fife Council are very keen to ensure that all advocacy organisations provide good quality, effective services. We approve of the concept, although we would require more information before we could definitely support the idea.

E.g. would such a programme follow the concepts set out in the SIAA publication *Independent Advocacy – An Evaluation Framework*? What commitment (in terms of staff time) would be required by the NHS/ Council and the individual advocacy organisations?

We currently monitor and evaluate Advocacy services through contract monitoring (for procured services) or through Fife Council's Monitoring and Evaluation Framework (for organisations with Service Level Agreements).

Any evaluation by SIAA would need to take cognisance of existing monitoring arrangements to avoid duplication of effort. Prior to the pilot evaluations, there would also need to be a period of time to allow services to consider how they can evidence their ability to meet the Principles and Standards, as not all advocacy organisations will be working within the current SIAA guidance (as this has been voluntary to date).

These considerations would obviously become even more important if any form of mandatory evaluation of advocacy services was introduced at a later stage.

6. Examples of situations that can potentially cause a conflict of interest which might impact on the person receiving the advocacy support, the advocate, the advocacy organisation or a service provider have been included at Appendix 2.

Question 4. Do you think it is useful to highlight situations (such as those given in Appendix 2) that commissioners should be mindful of in order that consideration is given to how these would be avoided/handled/resolved? Yes No

Are there any others you would add/remove?

We would welcome your thoughts on what the impact of each of these situations would be and also your views on what action should be taken to minimise conflict. We will consider the responses and add as part of the guidance.

We note that the majority of these situations concern a single principle – a potential conflict of interest caused by additional services provided by the organisation supplying advocacy services. Many of these scenarios appear to involve organisations that are in breach of paragraph 6.8 of the Draft Guide.

All advocacy organisations should have a robust conflict of interest policy, as required by the Code of Practice on the Mental Health (Care & Treatment) (Scotland) Act 2003 (page 111, para. 109). Where necessary, we would expect this policy to be discussed and agreed with the relevant Commissioners. Within Fife, most such policies state that any potential conflicts should be referred to another advocacy organisation to prevent the conflict from arising in the first place.

Where a conflict of interest arises after the advocate has established a relationship with the advocacy partner, the Code of Practice recommends (para. 110) that the advocacy service should withdraw from acting for the patient / service user. However, we would suggest that consideration should also be given to the views of the person receiving advocacy.

There is also a duty for Commissioners to ensure that either they commission services where such conflicts of interest will not arise, or that they ensure they provide other appropriate services who can receive referrals when necessary.

We also feel that some of the issues raised in Appendix 2 could also usefully be highlighted within Section 8, *Planning for Independent Advocacy*, not just in an appendix.

7.The layout of the guide has been changed to provide information and direct links to a list of relevant policy and guidance documents in Appendix 3.

Question 5: Do you find the information on additional reference material/useful links in Appendix 3 helpful?

Yes

No

Are there any others you would add?

We would add the Guidance on the Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007

(<http://www.scotland.gov.uk/Publications/2011/03/10110037/0>). This states that children should have the opportunity to access an independent person to help them articulate their views. This may an independent advocate (but could also be e.g. a Council-employed Right's Officer). However, Commissioners will need to ensure that they have considered such provision.

In addition, the Christie Commission, and the Scottish Government response to the Christie Commission, *Renewing Scotland's Public Services*, sets out a vision of working in partnership with local communities and organisations, involving local people, and a focus on prevention, not cure. (See <http://www.scotland.gov.uk/Publications/2011/06/27154527/0> and <http://www.scotland.gov.uk/Publications/2011/09/21104740/0>.) We consider these principles to be relevant when commissioning advocacy services.

Are there any you would remove?

No

General Comments

We would welcome any further general comments you may wish to offer here.

NHS Fife and Fife Council welcome the general principles and direction of travel set out in the Draft Guide for Commissioners. We particularly welcome the clarity over the definition of independence.

We note that the "Part 1: Background" section (p.4) states that you will be considering separately the provision of advocacy for children and young people and the principles and standards and special considerations that should apply. This information is not incorporated within the Draft Guide itself, and we feel that it would be useful to reference this forthcoming work, particularly e.g. highlighting areas of the Draft Guide where you feel special considerations are likely to apply.

Paragraph 2.1.1.2 states that Citizen Advocacy is based on a long-term relationship. This is usually the case, but we note that citizen advocacy can also be successfully delivered on a short timescale (i.e. a few months).

Paragraph 3.4 states that the Mental Health (Care & Treatment) (Scotland) Act 2003 identifies a need for independent advocacy organisations to have conflict-of-interest policies in place. While this requirement is set out in the Code of Practice, we are unaware of this specific requirement being incorporated within the actual 2003 Act.

Paragraph 5.2 states that people “do not have to have a medical diagnosis to access independent advocacy”. However, the legal right to advocacy under the 2003 Act is based on the person having a mental disorder. We are unaware of how determination of a mental disorder may be made without some form of medical input, and would appreciate clarification.

We would recommend that Section 11 (possibly in paragraph 11.9.1) includes a reference to ensuring advocacy organisations fully understand their responsibilities in terms of Adult and Child protection.

It would also be useful if the Guide considered (perhaps in Section 10 or 11) any minimum qualifications or training requirements for independent advocates. Currently, this differs from one organisation to another, and there are no set minimum standards. However, any such guidance would have to consider the fact that independent advocates can be volunteers as well as paid members of staff.

We believe that Section 12 (Monitoring and Evaluating Advocacy) needs to highlight the importance of considering both outputs and outcomes in relation to the advocacy provided.

We also feel there should be a stronger distinction between good quality advocacy (advocacy where the person's view is clearly and appropriately expressed), and advocacy that gets the result the person is looking for. In practice, these are not synonymous, which can make it hard to evaluate advocacy services (e.g. when considering complaints received by an organisation).

We are grateful for your response. Thank you.