

## 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 (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  X                  No

Overall yes, however we would make the following points:

The Adult Support and Protection legislation also has advocacy as a right for people and this should be included. Not everyone is aware that the right to advocacy is in this Act.

It is unclear in the document whether access to advocacy support is to be made available for all or only those who meet the criteria in relation to the legislation for mental health. If it is concerned with the general principles for independent advocacy, this should be clearly stated - the same if it is solely for mental health.

In addition, the language used in the guidance should be consistent if only patients of mental health services are covered as the later appendix refers to a number of possible advocacy relationships and legislation that may apply. There are other groups of people who may have a need to access advocacy and if they are not to be included in this guide, this should be clearly stated.

There should also be a link to the dementia standards.

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 X                  No

Overall, the Care Inspectorate is satisfied with the level of detail, however we suggest the information is strengthened by making reference to how strategic and local priorities will be set out in an advocacy strategy and in a jointly developed strategic commissioning strategy.

Whilst this section of the guidance is focussed on the involvement of people in commissioning advocacy, it may be helpful to make some reference to arrangements that support the involvement of people using the service to have the opportunity to give feedback on the quality of their experience.

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

Overall, the Care Inspectorate supports the programme of evaluations. However, the guidance states that methods used for monitoring and evaluating the work of independent advocacy organisations must be credible, both to the advocacy organisations themselves and to funders, and should not impose a disproportionate burden on a small organisation.

All organisations will be familiar with the need to monitor, evaluate, measure and report on their performance as an integral part of strategic aims and operations. This supports a climate of continuous improvement relevant to all organisations, particularly when direction from Scottish Government is focused on outcomes-based services.

We suggest this section is re-worded to reflect the above. In particular, we would recommend replacing the words “impose a disproportionate burden” with “ensure a proportionate, risk and intelligence based approach across all services”.

Although it is evident that the document is aiming to use plain language to be easy to understand, we would suggest that (12.6.2) be re-worded to reflect the fact that evaluation should assess how “effective” (rather than how “good”) a service is at meeting needs. The paragraph needs to reflect how quantitative and qualitative information is analysed and used to measure outcomes.

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

The Care Inspectorate believes that a useful example to include would be a scenario in which a social worker accesses advocacy for someone who disagrees with the social worker’s views, whilst being funded by the same local authority.

We suggest that it would be useful for the examples in the guidance to support professionals as well as commissioners. In our experience, we find that advocacy is often available but may not always be appropriately accessed by social workers and managers. There needs to be a general awareness raising of people’s rights and the role of independent advocacy, regardless of whether the outcome supports the social work staff views or not.

Regarding Appendix 2 – the relevance of this section is not clear. If it is to remain, it may need to be updated to reflect developments in the sector. An example of this is the current review of the National Care Standards currently underway. The cited solutions could be resolved by applying clear boundaries and structures around service provision from the

outset. Being transparent and maintaining communication in operational delivery should assist in this.

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?**

No.

**Are there any you would remove?**

No.

## **General Comments**

### **Background**

In section 1 it states that “there are no conflicts of interest”. It would be clearer if the statement acknowledged that if a conflict of interest does exist or arises, that this would be clearly articulated and a way forward agreed at the earliest point.

### **Introduction**

The factors listed at 1.1.6 do not, by themselves, make an individual vulnerable. It is a combination of a range of factors including social, individual, environmental, which lead to vulnerability. The statement would be clearer if this definition of vulnerable were to be acknowledged.

### **Section 3 – Importance of independent advocacy**

The wording in 3.1 is potentially contentious: “family and friends are part of the problem”. This should be rephrased to highlight that they may be too involved or unable to give a balanced viewpoint thus exacerbating the situation.

### **Section 5 – Commissioner’s statutory responsibilities**

The Care Inspectorate would query that commissioners can ensure that “everyone with a mental disorder...can access independent advocacy?” (5.3). Not everyone in such circumstances will be known to services, with those who are being offered the opportunity. However, this is up to the individual and the service to decide how this should proceed.

It is the commissioner’s role to publish and disseminate information regarding advocacy services available in local areas and to work with them to ascertain boundaries of operation.

### **Section 6 – Principles and standards**

Paragraph 6.3 implies that access to advocacy is only for “patients” with a diagnosis. Overall, the language in this section is sometimes subjective e.g. “it’s part of being a decent human being” (6.9) and “virtuous” (6.10). These would benefit from clarification.

Statement 6.12 should reflect the fact that professional workers can be aware of being critical of their employing organisation; however, this does not mean that it should not be challenged. Any organisation committed to continuous improvement would welcome comments from their staff about ways in which it can improve processes or systems. Most organisations have mechanisms for doing so.

Whilst “advocating strongly on behalf of an individual” is to be encouraged, it should be made clear, and should be cited here, that there are boundaries between this and the need for an independent advocate.

### **Section 7 – What do NHS Boards....?**

The headings in 7.2 – 7.6 may be confusing. It would be clearer to outline the three-fold role of independent advocacy:

- Supporting individuals to address an important issue.
- Contributing to campaigns to ensure services continually improve systems.
- Specific feedback to commissioners and services where trends become evident.

### **Section 8 – Planning for independent advocacy**

In using the example of LGBT communities, the document is contradictory. The paragraph indicated that people in the LGBT community may be suspicious of advocates outside this group, when previous paragraphs make clear that independent advocacy should be available for everyone.

### **Section 9 – developing the strategic advocacy plan**

It states that a strategic plan should be developed. As the document is a guide, it would be helpful if this were clarified as a recommendation or a requirement.

### **Section 11 – Supporting independent advocacy**

Paragraphs 11.5 and 11.7 are very detailed. If this document is intended as a guide, it should be about internal development within the organisation.

### **General points:**

The principles of independent advocacy need to be understood by all professionals and they need to be aware of people’s rights in this regard. Local authorities do contract advocacy but it is not always accessed by their staff. This should form part of any evaluation, and in particular, should focus on the reasons why advocacy was not proposed.

The document does not define what issues can be addressed by advocacy and it would be helpful to have some examples.

The guide does not take enough account of impending health and social care integration legislation and joint accountability with regard to adult services.

The guide is too detailed in places and makes suggestions for commissioners to advise organisations on their operational detail.

The guide does not take account of the implementation of self-directed support. The bodies referred to need to be aware of the impact this can have on their organisations and on service delivery.

It would be helpful to include a paragraph about the duty of care and codes of practice for professionals, as the guide implies that social care and health professionals do not always have the individuals' wishes at the heart of what they do.