National Institute for Health and Care Excellence

Final

Advocacy services for adults with health and social care needs

[H] Planning and commissioning services for advocacy

NICE guideline NG227

Evidence reviews underpinning recommendations 1.8.1 to 1.8.8, 1.8.11 to 1.8.13, 1.8.15 and 1.4.11 in the NICE guideline

November 2022

Final

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Key theme

- Planning and commissioning services for advocacy (including those who do not have a legal right to advocacy)

Introduction

The aim of this review is to identify ways in which planning and commissioning can be used to improve the quality of advocacy services.

Recommendations about advocacy have been made in a number of existing NICE guidelines. However, these have identified a lack of evidence relating to advocacy that would meet inclusion criteria for standard evidence reviews. Therefore, it was agreed that recommendations for this guideline would be developed by adopting and adapting advocacy-related recommendations from existing NICE guidelines, using a formal consensus process based on statements generated from a call for evidence, and documents identified by the guideline committee, and informal consensus methods to address any areas of the guideline scope that are not covered by the existing NICE guidelines or the formal consensus process.

Summary of the inclusion criteria

Please see Table 1 for a summary of the inclusion criteria applied to evidence received in response to the call for evidence and identified by the guideline committee.

Table 1: Summary of the inclusion criteria

Country	UK
Geographical level	National* *For policy or guidance documents, this means, the policies and recommendations apply nationally. For original research, this means the studies have been conducted in the national policy and practice context of our scope, i.e., the English health and social care system
Publication date	2011 onwards
Study design	Primary qualitative or quantitative studies (including unpublished research), excluding case-studies Systematic reviews of qualitative or quantitative studies, excluding case-studies Guidelines or policy documents that are based on qualitative or quantitative evidence, excluding case-studies
Topic areas	Planning and commissioning services for advocacy (including those who do not have a legal right to advocacy)

Methods and process

The process for identifying, adopting, and adapting recommendations from existing NICE guidelines, the call for evidence and formal consensus methods are described in supplementary material 1.

Declarations of interest were recorded according to NICE's 2019 conflicts of interest policy (see Register of Interests).

Effectiveness evidence

Included studies

Existing NICE guidelines

Existing recommendations relevant to planning and commissioning services for advocacy (including those who do not have a legal right to advocacy) were identified from 1 NICE guideline ([NG108] Decision-making and mental capacity). The audiences for this guideline included: people using health and social care services and their families and carers; health and social care professionals, practitioners; independent advocates (with statutory and non-statutory roles); and other staff who come into contact with people using services (for example, housing, education, employment, police and criminal justice staff).

Formal consensus

A single call for evidence was undertaken for all topics included in the scope of this guideline. Additional documents were identified by the guideline committee. See the study selection flow chart in appendix A.

Seven documents were identified for this review (Lawson 2017, Lawson 2020, Mercer 2020, Newbigging 2012, National Development Team for Inclusion [NDTi] 2014b, NDTi 2014c, Turner 2012).

Three documents focused on people living with disabilities including learning disabilities (NDTi 2014b, NDTi 2014c, Turner 2012). Two documents focused on those who have duties to commission and arrange advocacy services for safeguarding adults (Lawson 2017, Lawson 2020). One document each focused on people detained under the Mental Health Act 1983 (Newbigging 2012), or independent advocacy services (Mercer 2020).

Excluded studies

Formal consensus

Documents not included in this review are listed, and reasons for their exclusions are provided in appendix D.

Summary of included studies

Summaries of the documents included in the formal consensus process for this review are presented in Table 2.

Table 2: Summary of documents included in the formal consensus process

Document	Population	Evidence base
Lawson 2017 Report	Those who have duties to commission and arrange advocacy services for safeguarding adults	Report drawing on existing literature (including statutory guidance and core principles for safeguarding) to set out what needs to be done and what needs

Document	Population	Evidence base
England		to be addressed to make safeguarding personal
Lawson 2020 Briefing report England	Those who have duties to commission and arrange advocacy services for safeguarding adults	Briefing generated by a series of conversations with 28 advocates from 18 advocacy providers across England, covering 33 local authority areas
Mercer 2020 Scoping review England	Independent advocacy services commissioned to provide advocacy to people accessing support/service through: i) s117 aftercare (under the Mental Health Act) ii) NHS CHC (adults) iii) Children and Young People's continuing care iv) Personal Health Budgets v) Personal Wheelchair Budgets	Non-systematic scoping exercise including data from: Freedom of information requests to identify what services were commissioned, by whom and to which groups; advocacy survey for advocates to identify what advocacy providers are delivering; semi-structured telephone interviews with Independent Advocacy providers; review of legislation and guidance to identify current provision and identify gaps
Newbigging 2012 Research report England	People detained under the amended Mental Health Act 1983, who were eligible for support from IMHA services, including people with and without capacity and children under the age of 16	Multiple methods (including literature review, 11 focus groups, shadow visits with IMHAs, expert panel review) to obtain information on IMHA services to develop draft quality indicators for IMHA services. Data from 8 case studies (NHS Trust areas) to understand experiences of qualifying service users and the commissioning and delivery of IMHA services and their relationship with mental health services
NDTi 2014b Briefing note England	People living with disabilities	Survey (with 200+ responses) and fieldwork at 4 sites; also mentions 'mapping of the advocacy sector'
NDTi 2014c Executive summary England	People living with disabilities	Survey (with 200+ responses) and fieldwork at 4 sites; also mentions 'mapping of the advocacy sector'
Turner 2012 Brief report England	People with learning disabilities	2 surveys (responses from 78 local authority commissioners and 88 advocacy providers) and 3 case studies (no detailed methods reported); provides advice and suggestions on actions for commissioners and advocacy groups to provide robust evidence on the effectiveness and reach of advocacy services

IMHA: Independent Mental Health Advocate; LGA: Local Government Association, NDTi: National Development Team for Inclusion; NHS CHC: National Health Service Continuing Healthcare.

See the full evidence tables for documents included in the formal consensus process in appendix B and a summary of the quality assessment of these documents in appendix C.

Summary of the evidence

Existing NICE guidelines

One existing recommendation related to planning and commissioning services for advocacy was identified from the 1 NICE guideline. The committee agreed this recommendation should not be used in this guideline.

See Appendix F for a list of the existing recommendations, a summary of the supporting evidence behind these recommendations, and the decisions made based on the committee's discussion of these recommendations.

The quality of existing NICE guidelines was assessed using the Appraisal of Guidelines for Research & Evaluation Instrument (AGREE II). See the results of the quality assessment in appendix C.

Formal consensus round 1

One included document (Lawson, 2017) was assessed using AGREE II. One document (Mercer, 2020) was assessed using the Risk of Bias in Systematic reviews (ROBIS) checklist and 5 included documents (Lawson, 2020; Newbigging, 2012; NDTi 2014b; NDTi 2014c; Turner, 2012) were assessed using the Critical Appraisal Skills Programme (CASP) tool for qualitative research. See the results of the quality assessment in the evidence tables in appendix B and quality assessment tables in appendix C.

The committee were presented with 44 statements in round 1 of the formal consensus exercise; responses were received from 11 of 13 committee members. Thirty eight of these statements reached ≥80% agreement in round 1 and were included for the discussion with the committee. Three statements had between 60% and 80% agreement and were all redrafted for round 2. Three statements had <60% agreement; of these, 1 was redrafted for round 2, because the comments raised addressable issues and suggestions for revision, and the remaining 2 statements were discarded.

See appendix G for the statements that were rated by the committee and results of round 1, which are provided in Table 10.

Formal consensus round 2

The committee were presented with 4 statements in round 2 of the formal consensus exercise; responses were received from 12 of 13 committee members. One statement reached ≥80% agreement and was included for the discussion with the committee. Three statements had between 60% and 80% agreement and were discarded.

See appendix G for the statement that was rated by the committee and results of round 2, which are provided in Table 11.

Economic evidence

Economic consideration will be taken into account together with resource impact.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

In the methods used for this guideline (adopting and adapting existing recommendations and formal consensus) no outcomes were considered formally by the committee; therefore, the committee were not required to determine which outcomes were critical or important.

The quality of the evidence

Existing NICE guidelines

The quality of the existing NICE guidelines was assessed using AGREE II. Overall, the guideline is of a very high quality (2 or more domains scored ≥90%) and is recommended for use. In addition, the committee considered whether the recommendation could be generalised to a new context when making a decision about adopting or adapting the recommendations, which is documented in the benefits and harms section and appendix F.

Formal consensus

The quality of some of the documents identified by the committee and through the call for evidence was assessed using ROBIS and the AGREE II tool, which is explained in detail in the methods supplement for this guideline. ROBIS is intended for use in assessing the quality of systematic reviews but was also used for the purpose of this guideline to assess a number of reviews that were not intended by the authors to be systematic as it was the best available tool. The AGREE II instrument is intended for use assessing the quality of systematically developed clinical practice guidelines, including assessments of methodological rigour and transparency. Therefore, some domains of ROBIS and the AGREE II tool may be less relevant for these documents and they would not have followed reporting guidelines for systematic reviews. All supporting material published with documents was reviewed to inform quality assessment, however it was not feasible to contact the authors of each document. Therefore it is plausible that the documents may have scored lower on quality assessments than the underlying methodology would warrant had authors made their full methodology available or if more appropriate tools were available. The committee were aware of this in their discussions of the existing recommendations and statements extracted from documents identified from the call for evidence. Where shortcomings in the quality of documents impacted the committee's opinions about using the statements, this is described in the benefits and harms section below. On the whole however, where there was full committee support for a statement extracted from a lower quality document, the committee made the recommendation because their experiential knowledge corroborated the statement and strengthened the argument to use it as the basis for a recommendation.

The quality of 1 document (Lawson, 2017) was assessed using the AGREE II instrument. High quality documents were defined as those where any two domains scored ≥ 70%. The document was not deemed to be high quality. The included document scored 22% for stakeholder involvement; 4% for applicability; 8% for rigour of development and 0% for editorial independence. Overall, the document did not provide sufficient information on the stakeholder involvement in the development of the document. It was unclear whether the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the document were considered. The methods used to formulate and update the recommendations, and details on whether a systematic process had been used to gather and synthesise the evidence, were not clearly described. Declaration of any bias or competing interests from the document development group members were not reported.

The included document scored 61% for scope and purpose, and 22% for clarity of presentation. Generally, the overall aim, specific health questions and target population for the document was described, but details were limited. The document did not present recommendations in a clear and concise structure and format.

The quality of 1 document (Mercer, 2020) was assessed using the ROBIS checklist for systematic reviews. The document was judged to be at high risk of bias. Methodological limitations included a lack of clear reporting about eligibility criteria. Other concerns related to insufficient information on study selection and data collection, lack of critical appraisal of included papers, and an absence of testing the robustness of the review findings.

The quality of 5 documents (Lawson, 2020; Newbigging, 2012; NDTi 2014b; NDTi 2014c; Turner, 2012) were assessed using the CASP checklist for qualitative research. One document (Newbigging, 2012) was judged to have minor methodological limitations. The remaining 4 documents (Lawson, 2020; NDTi 2014b; NDTi 2014c; Turner, 2012) were judged to have serious methodological limitations because of insufficient detail relating to participant recruitment, data collection and data analysis. Other concerns related to the lack of adequate consideration for the relationship between researcher and participants, and lack of consideration regarding ethical issues.

Benefits and harms

The committee acknowledged that the majority of statements had been extracted from documents judged to be of lower quality. However they were in full agreement with these statements and because their own knowledge and experience chimed with the point being made they concluded it would be important to make a recommendation on that basis and that the benefits of doing so outweighed any risks of excluding these statements altogether.

Commissioning services based on assessment of local need

A number of statements focussed on the importance of planning and funding advocacy services on the basis of a clear understanding of the nature of local need. Statement 17 emphasised that commissioning of advocacy services should be based on needs assessment. Statement 1 highlighted the importance of understanding and responding to the local market and demographics to ensure commissioning and delivery of effective advocacy. Statement 30 focussed specifically on IMHA, arguing that local authorities should ensure there is a proper needs assessment in relation to IMHA provision, building on the Joint Strategic Needs Assessment. Statement 31 emphasised that local authorities should review the level of investment in advocacy services and ensure that it meets the level of potential demand. Given that these statements cover broadly the same issues, the committee agreed to reword and combine them to inform a recommendation for commissioners to build on Joint Strategic Needs Assessments and work with community groups so they have a clear understanding of local need and on that basis, commission advocacy services. The committee agreed that this recommendation would have the benefit of ensuring effective commissioning with services targeted at the people who need it and would ensure decision making is informed by accurate information about the local population. Furthermore, this would help to ensure that advocacy services are commissioned in a way to avoid the effects of structural, systemic and health inequalities, which result in unequal status, treatment and opportunities among population groups. Although this approach to commissioning is already considered best practice the committee highlighted that it is not mandated and their aim was to place a greater emphasis on this approach and standardise effective, evidence informed commissioning.

Commissioning bodies in a locality working together

Based on the committees' experience, people might be less likely to get the support they may need in the future, as there is currently a lack of evidence of long-term planning for the development of advocacy. Therefore, the committee agreed to add a recommendation that commissioning bodies in a locality should work together to agree and publish a long-term plan based on the assessment of need. Having long-term plans based on assessment of need would ensure that service commissioning had clear long-term intentions and would be based on future local need. Although the Joint Strategic Needs Assessment involves some forward planning, this does not include agreeing and publishing long-term plans, therefore some change of practice will be required. The committee wanted to ensure that all types of advocacy including statutory, non-statutory, peer advocacy, self-advocacy are included in the long-term planning. Therefore, based on their knowledge and experience the committee agreed to add that commissioners should take into account all types of advocacy.

Commissioning advocacy services so they can be used by people who do not meet the statutory criteria

Statement 3 argued that the Care Act's (2014) focus on access to social care services potentially leads to local authorities commissioning advocacy services that only meet the minimum requirement of the Act. The committee agreed that certainly in terms of local authority advocacy duties under the Care Act, which are based on people experiencing 'substantial difficulty', this leaves a lot of people falling outside the statutory requirement who still have a genuine need for advocacy. Statement 39 highlighted concerns that IMHA services are not being commissioned for children and young people. The committee agreed that both statements 3 and 39 identify how advocacy is not being commissioned for some groups that might nevertheless benefit from it. Therefore, the committee agreed to combine these statements, using them as a basis for one recommendation, aimed at commissioners, about considering advocacy even when people do not meet the statutory criteria. This would help to close the gap in the provision of advocacy, ensuring the benefits are experienced by a wider population. The committee also agreed the recommendation would benefit people by intervening earlier to provide support and prevent an escalation to situations where statutory advocacy might be required.

Addressing gaps in advocacy provision

Statement 2 described that there is a need for awareness raising among local authorities and commissioners and that further work is required to support 'market development' in relation to advocacy services. The committee agreed with the statement to some extent although they did not think the emphasis should be on 'raising awareness'. They therefore agreed to reword the statement to focus on the market development aspect and specifically, to emphasise that commissioners should work together to understand the nature of local advocacy services and population needs and to address any gaps in provision. The committee were aware that the Care Act and statutory guidance require local authorities to ensure adequate high quality care and support provision to meet needs so a recommendation based on their reworded statement would already be considered a statutory requirement. However, they wanted to emphasise the importance of commissioners talking to providers in order to establish a clear picture of whether existing services are meeting population needs. They therefore recommended that commissioners engage with providers to inform market development by identifying and addressing gaps in provision of advocacy and agreed this would be a valuable addition to Care Act requirements.

Analysing wider public policies, legislation and guidance

Statement 5 stated that existing policy and legislative frameworks requiring local investment in providing advocacy to support implementation and compliance need to be promoted and joined up. It is not within the scope of NICE guidance to recommend changes to legal frameworks. However, the committee agreed that commissioners need to be aware of policies, legislation and guidance beyond those that explicitly address statutory requirement for advocacy, as they may require changes to advocacy services in order for services to be compliant with them (e.g. the Equality Act 2010). The committee agreed that doing this would ensure that commissioning decisions are informed by all relevant policies and legislation so that advocacy services are as comprehensive as possible, compliant with all legislation, meet a diverse range of needs and promote equality.

Establishing consistent good practice in the context of safeguarding

Statement 8 highlighted the importance of commissioners understanding advocacy and safeguarding and providing support to establish consistent good practice in carrying out the advocacy role in the context of safeguarding adults. The committee agreed to reword and combine this statement with statement 25 about the need for advocacy and the importance of its value in safeguarding the rights of vulnerable service users being reflected in policy and practice. The committee agreed that the need to understand advocacy and safeguarding, which is highlighted by statement 8, is likely to be resolved by training, which is already covered by the section on training and skills for practitioners (see evidence review J), in recommendations 1.10.3 about providers and commissioners ensuring staff in agencies working with advocacy services (including Safeguarding Adult Board members) have training in the role and function of advocates. They therefore made another recommendation combining both statements which provides examples of how to establish consistent good practice in carrying out the advocacy role in the context of safeguarding. They agreed they could achieve greatest effect by focussing the recommendation on the commissioner’s role in promoting good practice in this area. The recommendation is therefore directed at commissioners, for them to help clarify the role of advocates throughout safeguarding processes and ensure it is captured in policies and commissioning arrangements. The committee agreed that this recommendation is needed, because in their experience advocacy plays an important role in safeguarding as it supports people’s involvement and decision making when there are safeguarding concerns, safeguarding enquiries or safeguarding adults’ reviews. They also agreed that advocacy acts as a safeguard in itself. Involving someone independent from services who is representing the person’s best interests and is aware of their circumstances and living conditions, may help to identify the potential for abuse or neglect. This can ensure that concerns with service quality are raised before they become a safeguarding issue. In the committee’s experience advocates are not currently consistently being involved in safeguarding processes across the country and this is corroborated by the Local Government Association (2020), which highlighted that there may be a low level of referrals for advocacy support for section 42 enquiries in some areas. In the committee’s experience this might partly be due to the lack of understanding about when advocates should be involved in the context of safeguarding and they were confident the recommendation would help to address this problem.

Operating in line with advocacy principles

Statement 9 urged commissioners to avoid placing a cap on the number of hours an advocate can support an individual. In the committee’s experience the fact that people have different needs means they require different amounts of advocacy and it is important to not have an overly restrictive contract that specifies what advocates can and cannot do, including the capping of hours. The committee highlighted that some people need considerably more advocacy hours than others and that the potential benefits of advocacy should not be compromised by insufficient hours being commissioned. On the other hand, the committee also agreed that it is important to empower people and focus on their needs and to not create situations where people become dependent on advocates. In light of these discussions the committee ultimately concluded that a generalised approach is not appropriate and that the commissioning of advocacy should be tailored to individual needs. On this basis they therefore used the statement to recommend that contracts should enable advocates to operate in line with advocacy principles and they agreed to use ‘avoiding a cap on hours’ as one way of demonstrating this.

Services should be person centred

Statements 14 and 28 both highlighted that service specifications and investment in advocacy provision should cover issues of infrastructure, competency and training for advocates, with statement 28 making specific reference to IMHA. The committee agreed that since they covered similar issues, these statements should be combined to provide the basis for one single recommendation, aimed at commissioners, to ensure that service specifications and contracts specify that services should include training and ongoing supervision. Concerned that this might focus costs and contracts solely on the provision of advocacy plus training, the committee agreed to include that commissioners should specify that services should be person centred and relationship based. Taking a person centred approach is a key tenet of advocacy and the committee agreed that adding this to the recommendation would help to ensure this would be embedded in contracts, therefore enabling advocates to carry out their role effectively. The expert witness testimony (see evidence review F) highlighted that mainstream advocacy provision has a narrow focus that fails to take account of broader issues relevant to minority communities. Therefore, the committee agreed that specifications for advocacy services being broad enough to allow people to receive advocacy support about issues that impact their health and social care needs is one example of how commissioners can ensure that services remain person-centred. They were also aware of a report from the Care Quality Commission (CQC 2020) that highlighted variation in the availability and quality of advocacy support in hospital-based services and recommended a level of personalised care that the committee agreed could be described as intensive and long-term support. Therefore, the committee agreed to include this as another example of person-centred care for people in high-risk situations, such as inpatient mental health services. These examples give some indications of steps commissioners can take to ensure services are person-centred, but the committee discussed that it is not possible to specify a particular way of developing service specifications and contracts that would ensure services meet the needs of all individuals. Therefore, in order to promote equality and avoid disadvantaging particular people, the committee agreed that reasonable adjustments should be considered when planning and providing support in order to target discrimination or inequalities that may arise from protected characteristics, as defined by the Equality Act 2010, or a person’s life circumstances and experiences. Combined with the focus on training, the committee agreed these recommendations would ensure advocates have the dedicated time and space to deliver a person-centred service and to enhance their skills on an ongoing basis, all of which is essential for maintaining quality and standards.

Involving people who use advocacy services

Statement 32 argues that local authorities should engage with ‘qualifying patients, mental health service users and carers’ to co-design IMHA services. Statement 22 similarly argued that service users should be directly involved in the commissioning process, including monitoring contracts. Statement 44 also states that to inform their own understanding of advocacy, commissioners should involve people who use or are likely to use advocacy. Acknowledging that all three statements promote service user involvement in planning and designing advocacy services the committee agreed to combine them and use them to inform a single recommendation, which also stated that people using advocacy services should be involved in contract monitoring. They agreed that this recommendation would ensure the planning and development of services would be improved by involving people with experience of advocacy, ensuring they are relevant and suited to people’s needs and preferences. In the committee’s experience this degree of involvement has been demonstrated in some areas but it is certainly not happening consistently and this is something they aim to resolve with the recommendation. The committee were aware of guidance on involving people who use services contained in the NICE guideline on community engagement [NG44] so they agreed to make this cross reference as a means of supporting implementation of the recommendation.

Sufficient advocacy services to meet statutory duties

Based on the committees’ experience, the provision of advocacy services for people who are detained or deprived of their liberty in independent hospitals is inconsistent. Although it is a legal requirement for local authority commissioners to provide advocacy to people in these circumstances, this is not happening consistently. For example, there is currently very poor commissioning for people in private mental health settings. Therefore, the committee agreed to add a recommendation for commissioners to ensure sufficient advocacy services are available to meet statutory duties for people who are detained or deprived of their liberty in independent hospitals.

Working with local organisations

Statement 35 covered local authorities considering the potential of small local organisations with particular skills, knowledge and networks to support access to IMHA for potentially disadvantaged groups. The committee discussed that a number of the recommendations made under the area of improving access aim to improve access for underserved groups specifically (see evidence review D). However, they were aware of the expert witness testimony (see evidence review F) that a lack of diversity and understanding of equality and issues relevant to minority communities can form a barrier to people accessing, or taking up, advocacy services. In the committee's experience, people are most comfortable with advocates they can relate to and have faith in, and this tends to lead to more effective advocacy. Therefore, the committee agreed that working with and drawing on the knowledge and networks of local community organisations is another way to help ensure that underserved groups (for example people with refugee status and people from traveller communities) are being provided with the advocacy support they need, and that this is important for promoting access to all types of advocacy, not just IMHA services.

Access to advocacy for people placed out of area

Statements 33 and 23 argued that local authorities should clarify arrangements for the commissioning and provision of advocacy for people placed out of area, with statement 33 focussed specifically on IMHA services. The committee agreed that arrangements to access IMHA and other statutory advocacy for people placed out of area are currently confused so they combined both statements to try to address the problem in broad terms, not simply focussing on IMHA. In the committee's experience, there is often confusion about who is responsible for advocacy provision, which can form a barrier to accessing services and cause further delays, potentially leading to ineffective advocacy. In formulating the resulting recommendation the committee noted that there is a duty on local authorities to make information available about the care and support services in their area, which should extend to advocacy services for people placed in and out of area, as covered by recommendation 1.3.5 in the section on information and signposting (see evidence review C). However judging by the statements presented to them and on the basis of their own experience, the committee agreed this information is not being provided consistently, despite the legal requirement. Therefore, the committee agreed that collaboration between local authorities and advocacy providers was required in order to remove the confusion that currently prevails and in doing so, both promote wider access to advocacy support in the context of out of area placements directly and ensure that there is clear information available that can be used to enable the recommendations mentioned above. The committee agreed that this recommendation is about improving access to advocacy and therefore placed this recommendation in the section of the guideline about improving access to advocacy (see evidence review D).

Statements that were not used in this review

There were a number of statements carried forward to committee discussions that were not used to inform recommendations. Statements 4, 7, 15, 36, and 43 were not used to inform recommendations as they did not provide enough detail on how to plan or commission services for advocacy. Statements 16, 26, and 27 were not used to inform recommendations as these were too generic, and statements 26 and 27 in particular were already addressed by the recommendations 1.8.2 and 1.2.1 about offering advocacy to people who would otherwise not be able to express their views or decisions. Statements 34, 42, 43, and 38 were not used to inform recommendations as the actions required to address the issues raised were not within the scope of NICE guidelines. Statements 10, 11 and 12 were not used to inform recommendations because the issues they covered were already addressed in the recommendation to involve people with experience of advocacy in planning and designing services and the committee agreed that the recommendation would not be improved by making reference to specific population groups.

Other statements which were not used to inform recommendations were numbers 6 and 13. This is because the issues they covered were already addressed by a number of recommendations in the section of the guideline on monitoring services and collecting data for quality improvement. Statement 29 is covered by recommendation 1.8.7 in this review about service specifications being person centred. Statement 37 was not used to inform a recommendation because the importance of training commissioners was covered in the section on training and skills for practitioners (see evidence review J) by recommendation 1.10.3 about providers and commissioners ensuring that staff in agencies working with advocacy services have training in the role and function of advocates. Statement 40 was not used to inform a recommendation because the issue of inconsistent interpretation of statutory guidance was already addressed by the committee through a recommendation about commissioners from different areas working together in the section on partnership working and relationships with families and carers, commissioners and providers (see evidence review G). Finally, statement 41 was not used to inform a recommendation because the issue highlighted was addressed by the recommendation about advocacy services from different areas working together in the section on effective advocacy.

Existing recommendations not used in this review

The committee neither adopted nor adapted the existing recommendation from the NICE guideline on decision-making and mental capacity [NG108] for the section on planning and commissioning. The reasons behind their decision making are given in appendix F.

Cost effectiveness and resource use

Currently there is variation in areas around the planning and commissioning of advocacy services. It is already a legal requirement for information to be provided about what advocacy services are available although the committee said that this was not being done in all places. For such areas there will be a short term resource impact from having to provide this information and potentially through an increased uptake in services. This recommendation will bring all areas up to statutory requirements and improve quality of life for people through allowing a greater range and more appropriate options for advocacy. Allowing people to access more appropriate services earlier, through better information around them, may save costs through avoiding the use of those services less appropriate reducing the need for repetition.

Ensuring services are commissioned so that those without a statutory right can still access it will add costs, at least in the short term, through increased uptake. This is discussed in detail in the ‘who else would benefit from advocacy’ (see evidence review B) section of the guideline.

The committee agreed that commissioners conducting an active analysis of wider public policies, legislation and guidance might require some upfront resources when trying to bring together the different policies and legislation, as these documents can be quite extensive. However, in the committee’s experience this could lead to more effective commissioning which could have preventative effects and be potentially cost saving through more efficient services, preventing commissioning of services that are not required and through better advocacy leading to a prevention of more expensive health and social care interventions such as unplanned admissions.

The committee agreed that there may be some upfront costs associated with involving people who use independent advocacy services in planning and designing advocacy services, especially as some groups may be challenging to recruit from and may require interventions to help them actively participate. However, this should lead to services being more responsive, efficient, and avoiding wastage which would lead to cost savings. It is also in line with pushes towards shared decision making in health and social care.

Ensuring that contracts support advocacy providers to maintain their independence and operate in line with the principles of advocacy, will lead to better quality service, reducing complaints and needs for judicial reviews, therefore saving costs in the long term. The committee agreed that there may be some resource impact associated with engaging with the community to base commissioning of advocacy services on local needs assessments although in the vast majority of areas this is already happening. The overall resource impact should therefore be small.

Ensuring that advocacy services are person-centred is not expected to have a resource impact. All health and social care services should already adhere to the principle that people who use a service should have care or treatment personalised specifically for them.

Recommendations supported by this evidence review

This evidence review supports recommendations the research recommendation on 1.8.1 – 1.8.6, 1.8.9 – 1.8.11, 1.8.13 and 1.4.11. Other evidence supporting these recommendations can be found in the evidence reviews on effective advocacy (see evidence review F).

References – included studies

Existing NICE guidelines

National Institute for Health and Care Excellence 2018

National Institute for Health and Care Excellence (2018). Decision-making and mental capacity (NICE Guideline 108). Available at: https://www.nice.org.uk/guidance/ng108/evidence/full-guideline-pdf-6542486605

Formal consensus

Lawson 2017

Lawson, J. (2017). Making Safeguarding Personal. What might ‘good’ look like for advocacy? Local Government Association. Available at: https://www.local.gov.uk/sites/default/files/documents/25.30%20-%20Chip_MSP%20Advocacy_WEB_2.pdf [Accessed 07/04/2021] [Accessed 07/04/2021]

Lawson 2020

Lawson, J., Petty, G. (2020). Strengthening the role of advocacy in Making Safeguarding Personal, Local Government Association. Available at: https://www.local.gov.uk/sites/default/files/documents/25.167%20Strengthening%20the%20role%20of%20advocacy%20in%20MSP_04.pdf [Accessed 07/04/2021]

Mercer 2020

Mercer, K., Petty, G. (2020). Scoping Exercise Report – An overview of advocacy delivery in relation to Personal Health Budgets and other Health Funded support. Available at: https://www.ndti.org.uk/assets/files/Advocacy-Health-Funded-Support-Report-pdf.pdf [Accessed 07/05/2021]

National Development Team for Inclusion 2014b

National Development Team for Inclusion (2014b). Office for Disabilities Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note. Unpublished

National Development Team for Inclusion 2014c:

National Development Team for Inclusion (2014c). Office for Disabilities Issues Access to Advocacy Project: Executive Summary. Unpublished

Newbigging 2012

Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L., et al. (2012). The Right to Be Heard: Review of the Quality of Independent mental Health Advocate (IMHA) Services in England, University of Central Lancashire. Available at: https://www.firah.org/upload/notices3/2012/uclan.pdf [Accessed 13/05/2021]

Turner 2012

Turner, S. (2012). Advocacy by and for adults with learning disabilities in England. Evidence into practice report no.5. Available at: https://www.ndti.org.uk/assets/files/IHAL-ev-_2012-01.pdf [Accessed 06/04/2021]

Other

Care Act 2014

Care Act 2014, c. 23. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted [Accessed 21/09/2021]

Care Quality Commission 2020

Care Quality Commission (2020). Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. Available at: cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf [Accessed 15/02/2022]

Equality Act 2010

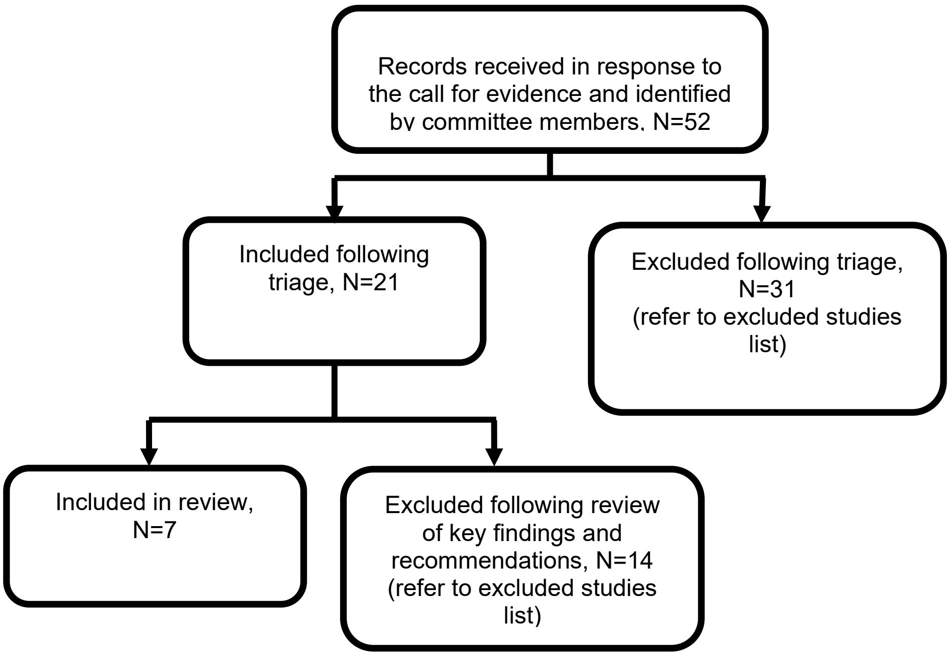
Equality Act, 2010 (c.15). Available at: https://www.legislation.gov.uk/ukpga/2010/15 [Accessed 29/04/2021]

Appendices

Appendix A Study selection for formal consensus process

Study selection for scope area: Planning and commissioning services for advocacy

Figure 1: Study selection flow chart



Appendix B Evidence tables

Evidence tables for scope area: Planning and commissioning services for advocacy

Table 3: Evidence tables

Study details	Population	Recommendations/key findings	Quality assessment
Full citation Lawson, J. (2017). Making Safeguarding Personal. What might 'good' look like for advocacy? Local Government Association. **Country/ies where the study was carried out** England **Study type** Report/review **Study dates** 2017 **Source of funding** No sources of funding reported	Those who have duties to commission and arrange advocacy services	**Recommendations** • Commissioners should avoid placing a cap on the number of hours an advocate can support an individual. To truly involve the person as envisaged under the Care Act (2014) requires more time. This is particularly so for people with substantial difficulty, complex needs or who may lack capacity in relation to safeguarding protection and decisions. • Commissioners must ensure that service specifications cover issues of competency and training for advocates including those set out above and should consider the funding implications of this. • Commissioners should specify services and monitor contracts to ensure that advocacy are working to published quality standards, core principles and the advocacy charter. This in turn connects with core principles for safeguarding	**Quality assessment using AGREE II** 1) **Scope and Purpose** 61% Overall objective and population are described. Health question is not specifically described but alluded to. 2) **Stakeholder involvement** 22% Target users are defined but not information on guideline development group and views and preferences from population has been included. 3) **Rigour of development** 8% Health benefits when describing recommendations have been considered. No information on systematic methods, criteria selection, strengths and limitations, and methods for formulating recommendations have been provided. Link between recommendations and supporting evidence not clear. No details on external reviewing or procedure for updating have been provided. 4) **Clarity of presentation** 22% Recommendations are not always specific and easily identifiable. No mentioning of different options for management. 5) **Applicability**

Study details	Population	Recommendations/key findings	Quality assessment
		and Making Safeguarding Personal.	4% Some mentioning of potential tools provided. No further information on facilitators/barriers, potential resource implications, and auditing criteria provided. **6) Editorial independence** 0.0% No funding body and competing interest have been identified. **Overall rating** 29.19%
Full citation Lawson, J., Petty, G. (2020). Strengthening the role of advocacy in Making Safeguarding Personal, Local Government Association. **Country/ies where the study was carried out** England **Study type** Qualitative (focus group discussions) **Study dates** 2020 **Source of funding** No sources of funding reported	Those who have duties to commission and arrange advocacy services	**Key findings** • Commissioners have a key role in ensuring that those in need of advocacy receive it. Commissioners need to understand both advocacy and safeguarding and provide support to establish consistent good practice in carrying out the role in the context of safeguarding adults. • Concerns were raised about potential gaps in access to advocacy in provider settings, where people are placed out of area and where there is potential for isolation and need for safeguarding may be greatest. Clarity about who commissions an advocate in these situations is crucial.	**Quality assessment using CASP qualitative studies checklist** **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – to support strengthening the role of all types of advocacy in safeguarding adults, specifically in Making Safeguarding Personal by generating multi-agency conversations based on the briefing and stimulating local action to address some of the core messages that emerge from this. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)**

Study details	Population	Recommendations/key findings	Quality assessment
			Can't tell - insufficient detail provided on recruitment strategy. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes. Semi-structured focus group discussions on teleconference calls were held with 28 advocates from 18 advocacy providers across England, covering 33 Local Authority areas. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - the authors did not discuss their own role in the formulation of the research questions, or consider the researchers influence on the respondents. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** No - ethical issues and approval for the study were not discussed. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell – no details provided. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – to some extent. Findings are discussed but researchers did not discuss credibility of their findings. **10. How valuable is the research?**

Study details	Population	Recommendations/key findings	Quality assessment
			Valuable - the authors discuss issues arising in relation to providing advocacy services in relation to safeguarding adults and provide suggestions on how to address the key issues. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious limitations.
Full citation Mercer, K., Petty, G. (2020). Scoping Exercise Report. An overview of advocacy delivery in relation to Personal Health Budgets and other health funded support **Country/ies where the study was carried out** England **Study type** Report of a scoping exercise (including freedom of information requests, advocate survey, semi-structured telephone interviews and desktop review of legislation and guidance) **Study dates** January to March 2020 **Source of funding** Commissioned by NHS England and NHS Improvement	Independent advocacy services commissioned to provide advocacy to people accessing support/service through: i) s117 aftercare (under the MHA). ii) NHS CHC (adults). iii) Children and Young People's Continuing Care. iv) PHB. v) Personal Wheelchair Budgets.	**Key findings** • Data suggested that most local authorities and CCGs did not commission specialist advocacy for people going through NHS CHC, Continuing Care, PHB or Personal Wheelchair Budgets over and above the statutory roles stated in the Care Act and Mental Health Acts. • Commissioners reported confusion over whether IMHAs or Care Act advocates were supporting people with planning (discharge or support) or receiving s117 aftercare; some areas suggested one or the other, but this was inconsistent. • The evidence suggested that there was a risk that commissioners may not fully understand their duties to commission advocacy. • There were concerns that IMHA services were not being	**Quality assessment using ROBIS** ***Phase two*** **1.1 Did the review adhere to pre-defined objectives and eligibility criteria?** Probably no - There was no evidence of eligibility criteria but pre-specification of objectives the scoping exercise are provided. **1.2 Were the eligibility criteria appropriate for the review question?** No information - Eligibility criteria were not provided. The scoping exercise included a freedom of information request, advocate survey, semi-structured telephone interviews and desktop review of legislation and guidance which appear to be conducted by the authors themselves. **1.3 Were eligibility criteria unambiguous?** No - Specific queries remain about the eligibility criteria including ambiguities about the types of study, population, interventions, comparators and outcomes. **1.4 Were all restrictions in eligibility criteria based on study characteristics appropriate?** No information - Restrictions around the studies characteristics are not provided.

Study details	Population	Recommendations/key findings	Quality assessment
		commissioned for children and young people. - There were clear differences in the provision of advocacy services across different areas, indicating discrepancies in the ways that commissioners and advocacy organisations interpret statutory guidance. **Recommendations** - Explore how co-producing updated commissioning guidance regarding advocacy for health funded support processes could address some of the current inconsistencies in commissioning arrangements. - Take into account the need for all advocacy commissioning guidance to be updated and brought together.	**1.5 Were any restrictions in eligibility criteria based on sources of information appropriate?** No information - Restrictions applied on the basis of sources of information were not clearly described. ***Concerns regarding specification of study eligibility criteria*** High concern - There were insufficient details regarding study eligibility criteria to judge whether the appropriate studies were included in the scoping exercise. **2.1 Did the search include an appropriate range of databases/ electronic sources for published and unpublished reports?** No information – No systematic searches appear to have been conducted. **2.2 Were methods additional to database searching used to identify relevant reports?** No information – Additional database searching appears not to have been conducted. **2.3 Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible?** No information. **2.4 Were restrictions based on date, publication format, or language appropriate?** No information. **2.5 Were efforts made to minimise errors in selection of studies?**

Study details	Population	Recommendations/key findings	Quality assessment
			No information. ***Concerns regarding methods used to identify and/or select studies*** High concern - There is insufficient information reported however it appears as though some eligible studies are likely to be missing from the scoping exercise. **3.1 Were efforts made to minimise error in data collection?** No information. **3.2 Were sufficient study characteristics available for both review authors and readers to be able to interpret the results?** No – study characteristics were not reported. **3.3 Were all relevant study results collected for use in the synthesis?** Probably no – Unclear whether all relevant study results were included. **3.4 Was risk of bias (or methodological quality) formally assessed using appropriate criteria?** No - Study quality was not formally assessed. **3.5 Were efforts made to minimise error in risk of bias assessment?** No. ***Concerns regarding methods used to collect data and appraise studies***

Study details	Population	Recommendations/key findings	Quality assessment
			High concern - Some bias may have been introduced through the data collection and no risk of bias assessment completed. **4.1 Did the synthesis include all studies that it should?** No information. **4.2 Were all predefined analyses followed or departures explained?** No information. **4.3 Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies?** No information. **4.4 Was between-studies variation (heterogeneity) minimal or addressed in the synthesis?** No information. **4.5 Was robustness of the finding(s) assessed e.g. through funnel plot or sensitivity analyses?** No information. **4.6 Were biases in primary studies minimal or addressed in the synthesis?** No - The studies were not explicitly evaluated for quality or risk of bias ***Concerns regarding the synthesis and findings*** Unclear concern - There is insufficient information reported to make a judgement on risk of bias.

Study details	Population	Recommendations/key findings	Quality assessment
			Phase three **A. Did the interpretation of findings address all of the concerns identified the Phase 2 assessment?** No. **B. Was the relevance of identified studies to the review's research question appropriately considered?** No. **C. Did the reviewers avoid emphasizing results on the basis of their statistical significance?** Yes. **Risk of bias** – High concern.
Full citation National Development Team for Inclusion (2014b). Office for Disabilities Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note. Unpublished **Country/ies where the study was carried out** England **Study type** Briefing Note/Survey **Study dates** 2014 **Source of funding**	Disabled people	**Recommendations** • The research highlighted the importance of understanding and responding to local demographics and the local market when commissioning and delivering effective advocacy – tailoring local delivery to fit local needs. • Further work is needed for local authorities and commissioners to raise their awareness and support the market development in relation to advocacy, which is essential to the delivery of effective advocacy.	**Quality assessment using CASP qualitative studies checklist** **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – to summarise the findings of the survey to highlight what good advocacy for disabled people should look like. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Can't tell – Survey included over 200 advocacy providers but no more information was included. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Can't tell – Insufficient information regarding the survey.

Study details	Population	Recommendations/key findings	Quality assessment
No sources of funding reported			**4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Can't tell - insufficient detail provided on recruitment strategy. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Can't tell – insufficient detail on data collection **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - the authors did not discuss their own role in the formulation of the research questions, or consider the researchers influence on the respondents. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** No - ethical issues and approval for the study were not discussed. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell – no details provided. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes – to some extent. Findings are clearly discussed but researchers do not discuss credibility of their findings. **10. How valuable is the research?**

Study details	Population	Recommendations/key findings	Quality assessment
			Valuable - the authors discuss issues in delivering advocacy for disabled people and highlight key areas to improve on as well as providing a summary as to what 'good' advocacy should look like. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious limitations.
Full citation National Development Team for Inclusion (2014c). Office for Disabilities Issues Access to Advocacy Project: Executive Summary. Unpublished **Country/ies where the study was carried out** England **Study type** See 'Office for Disability Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note' **Study dates** 2014 **Source of funding** No sources of funding reported	Disabled people	**Key findings** • Research suggested that the Care Act's focus on access to social care services could lead to local authorities commissioning advocacy services that only meet the minimum requirements of the Act, which could worsen the gap in the provision of advocacy that ensure whole-life support. • But formal arrangements to join up advocacy commissioning and provision were 'patchy' and economic evidence was lacking from which to draw conclusions as to the most cost-effective model(s) for delivering better outcomes for people living with disabilities. **Recommendations** • Existing policy and legislative frameworks requiring local	See 'Office for Disability Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note'

Study details	Population	Recommendations/key findings	Quality assessment
		investment in providing advocacy to support implementation and compliance (such as the Equality Act 2010) need to be promoted and joined up. • Support better commissioning of advocacy services, focusing on developing stronger, evidence based outcome measures and commissioning guidance on using these to ensure effective service delivery.	
Full citation Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., et al. (2012). The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England **Country/ies where the study was carried out** England **Study type** Mixed methods: literature review, qualitative research (focus groups and interviews), case studies **Study dates** 2010 to 2012	Patients detained under the amended MHA 1983, who are eligible for support from IMHA services (including people with and without capacity and children under the age of 16 years)	**Key findings** • All data sources identified the critical role that commissioning plays in the development of good quality IMHA services. • Trusts were poorly prepared for the introduction of IMHA services in 2009, but since then approaches to commissioning IMHA services had become more systematic; most Trusts had detailed service specifications, although these differed in terms of their focus (that is IMHA services only or IMHA services included as an element of a more comprehensive approach to advocacy provision).	**Quality assessment using CASP qualitative studies checklist** **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - to review the extent to which IMHA services in England are providing accessible, effective and appropriate advocacy support to people who qualify for these services under the MHA 1983. To identify the factors that affect the quality of IMHA services. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)**

Study details	Population	Recommendations/key findings	Quality assessment
Source of funding Department of Health		• There was little evidence of commissioning based on needs assessment and equality impact assessment. Particular gaps were identified in relation to people from BME communities, people with learning difficulties, older people, children, and young people. • In general, service users were not directly involved in the commissioning process or in monitoring contracts. • Commissioning arrangements for people placed out of area were confused. ○ Concerns were raised over the practice of spot purchasing which threatens the financial viability of IMHA services and compromises strategic planning. **Recommendations** • It is critical that the prominence of advocacy and its value to safeguarding the rights of vulnerable service users needs to be of continued value and importance in the planning and delivery of mental health services. This needs to be reflected in policy and practice.	Yes - how IMHA services and service users were identified is explained, in addition to identification of carers and family members, mental health staff and commissioners. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes - the methods used were explicitly described and justifications for their use were provided, although saturation of data was not discussed. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes - the authors acknowledged the potential for the quality of the data collection and analysis to be influenced by the researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes - ethical approval was received from the Cambridgeshire 3 Research Ethics Committee and the International School for Communities, Rights and Inclusion Ethics Committee at the University of Central Lancashire. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes - the authors describe the analysis process and sufficient data are presented to support the findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes.

Study details	Population	Recommendations/key findings	Quality assessment
		• Consideration should now be given to extending the opportunity to access advocacy to informal patients in hospital. • Consideration is given to extending IMHA provision to all in-patients, as recommended by NICE (2011) and introduced recently by the Welsh Government (Welsh Office, 2011a). • The investment in IMHA provision should include infrastructure costs and the costs of training and supervision for staff and associated development activities. • Local authorities to: ○ Ensure there is a proper needs assessment in relation to IMHA provision, building on the Joint Strategic Needs Assessment and engagement with community groups. ○ Review the level of investment and ensure that it is appropriate for the level of potential demand. ○ Engage with qualifying patients, mental health	**10. How valuable is the research?** Valuable - the authors highlight gaps in the evidence, how the evidence relates to previous research, and implications for practice and policy and future research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations.

Study details	Population	Recommendations/key findings	Quality assessment
		service users and carers to co-design IMHA services. ○ Clarify the arrangements for IMHA provision for people placed out of area, so that arrangements are in line with the Health and Social Care Act 2012 and ensure that IMHA services are not being commissioned by independent sector providers. ○ Clarify the interface with specialist commissioning for IMHA provision to national specialist services. Consider the potential of small local organisations that have particular skills, knowledge and networks that could support the development of access to appropriate forms of IMHA provision for potentially disadvantaged groups.	
Full citation Turner, S., National Development Team for Inclusion (NDTi) and Department of Health (2012). Advocacy by and for adults with learning disabilities in England: Evidence into practice report no.5 **Country/ies where the study was carried out**	A range of people including people living with learning disabilities	**Key findings** • Although advocacy organisations are not public bodies, they can be commissioned by public bodies and relationships between the two should take equality into consideration. For example, survey responses indicated that parents with learning disabilities and young	**Quality assessment using CASP qualitative studies checklist** **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes - to explore the nature and extent of advocacy services for people with learning disabilities in England, how funding changes affect these services, and the impact of advocacy on health and health services for people with learning disabilities.

Study details	Population	Recommendations/key findings	Quality assessment
England **Study type** Survey (open and closed ended questions) and case studies **Study dates** December 2011 and January 2012 **Source of funding** Supported by the Department of Health		people in transition may struggle to access advocacy. **Recommendations** • Understand the different types of advocacy available and commission a balance of provision, including smaller groups, which meet the differing needs of the local population, not just those eligible for services.	**2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes. **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes - how advocacy organisations and commissioners of advocacy services were identified is explained to some extent. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Can't tell – limited information on methods of data collection and no other details provided. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No - the authors did not discuss their own role in the formulation of the research questions, or consider the researchers influence on the respondents. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** No - ethical issues and approval for the study were not discussed. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Can't tell – no details provided.

Study details	Population	Recommendations/key findings	Quality assessment
			9. Is there a clear statement of findings? (Yes/Can’t tell/No) Yes – to some extent. The findings are clearly stated, but the researchers did not discuss the credibility of their findings. **10. How valuable is the research?** Valuable - the authors provide evidence on gaps in the provision of advocacy services and areas for further research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious limitations.

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument; BME: Black and minority ethnic; CASP: Critical Appraisal Skills Programme; CCG: Clinical Commissioning Group; IMHA: Independent Mental Health Advocate; MHA: Mental Health Act; NDTi: National Development Team for Inclusion; NHS CHC: National Health Service Continuing Healthcare; NICE: National Institute for Health and Care Excellence; PHB: personal health budget; ROBIS: Risk of Bias Assessment Tool for Systematic Reviews.

Appendix C Quality Assessment

Quality assessment tables for scope area: Planning and commissioning services for advocacy

Existing NICE guidelines

Table 4: AGREE II quality assessment of NICE guidelines

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
Decision-making and mental capacity (NICE Guideline 108)	2018	100 The overall objective of the guideline, the health question covered by the guideline, and the population to whom the guideline applies are specifically described.	100 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is reported in detail. The views of the target audiences were included in guideline development. The target users of the	96 Systematic methods were used to search for evidence and have been reported transparently. The criteria for selecting the evidence are clearly described in the review protocol. The risk of bias for the body of evidence has been conducted and reported clearly. There is clear and adequate	100 The recommendations are specific and unambiguous, and the different options for management of the condition or health issue are clearly presented. Key recommendations are easily identifiable and specific recommendations are grouped together in one section. The description of	96 There is a description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders were obtained. There is a clear description of how the recommendations can be put into practice and there is an implementation section in the	100 The funding body has been stated and there is an explicit statement reporting the funding body has not influenced the content of the guideline. Competing interests of guideline development group members have been recorded and addressed explicitly.	99

Domains								
			guideline are clearly defined.	information of the recommendation development process. There are supporting data and discussions of the benefits and harms of the evidence and it is clear that this has been considered when making recommendations. The guideline describes how the guideline development group linked and used the evidence to inform recommendations, and each recommendation is linked to a key evidence description. The guideline has been externally review by experts in a	recommendations are summarised as flow charts.	guideline. There are references to tools and resources to facilitate application and there are directions on how users can access these. There are details given on the potential resource implications of applying the recommendations. There are identification criteria to assess guideline implementation and monitoring or auditing criteria.		

Domains								
				consultation phase prior to its publication, and details of this process are available. A statement that the guideline will be updated is provided though the methodology for this procedure is unavailable.				

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument; NICE: National Institute for Health and Care Excellence

Formal Consensus

Table 5: AGREE II quality assessment of included guidelines

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
Lawson	2017	61	22	8	22	4	0	29

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument

Table 6: ROBIS quality assessment of included systematic reviews

Domains (Low concern/High concern/Unclear concern)						
Systematic review reference	**Year**	**Study eligibility criteria**	**Identification and selection of studies**	**Data collection and study appraisal**	**Synthesis and findings**	**Overall risk of bias**
Mercer 2020	2020	High concern	High concern	High concern	Unclear concern	High concern

ROBIS: Risk of Bias Assessment Tool for Systematic Reviews

Table 7: CASP quality assessment of included qualitative studies

Screening questions (Yes/No/Can't tell)											
Qualitative study reference	**Year**	**Clear statement of aims of research**	**Appropriate methodology**	**Research design appropriate to address aims**	**Appropriate recruitment strategy**	**Appropriate data collection methods**	**Relationship between researcher and participants adequately considered**	**Ethical issues taken into consideration**	**Data analysis sufficiently rigorous**	**Clear statement of findings**	**How valuable is the research**
Lawson 2020	2020	Yes	Yes	Yes	Can't tell	Yes	No	No	Can't tell	Yes	Valuable
Newbigging 2012	2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
NDTi 2014b	2014	Yes	Can't tell	Can't tell	Can't tell	Can't tell	No	No	Can't tell	Yes	Valuable
NDTi 2014c	2014	Yes	Can't tell	Can't tell	Can't tell	Can't tell	No	No	Can't tell	Yes	Valuable
Turner 2012	2012	Yes	Yes	Yes	Yes	Can't tell	No	No	Can't tell	Yes	Valuable

CASP: Critical Appraisal Skills Programme; NDTi: National Development Team for Inclusion

Appendix D Excluded studies

Excluded studies for scope area: Planning and commissioning services for advocacy

Formal consensus (documents identified by the call for evidence and the guideline committee)

Table 8: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Bauer, B., Wistow, G., Dixon, J., Knapp, M. (2013). Investing in Advocacy Interventions for Parents with Learning Disabilities: What is the Economic Argument? Personal Social Services Research Unit. Available at: http://eprints.lse.ac.uk/51114/1/Investing%20in%20advocay.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Chatfield, D., Lee, S., Cowley, J., Kitzinger, C., Kitzinger, J., Menon, D. (2018). Is there a broader role for independent mental capacity advocates in critical care? An exploratory study. Nursing in Critical Care, 23(2), 82-87.	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Davies, L., Townsley, R., Ward, L., Marriott A. (2009). A framework for research on costs and benefits of independent advocacy, Office for Disability Issues. Available at https://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/odiframework.pdf [Accessed 16/02/2022]	Publication has no evidence base
EY (2017). Society's return on investment (SROI) in older people's cancer advocacy services. Available at: https://opaal.org.uk/?s=Society%27s+return+on+investment+%28SROI%29+in+older+people%E2%80%99s+cancer+advocacy+services [Accessed 16/02/2022]	Publication is based on case-studies
Feeney, M., Evers, C., Agpalo, D., Cone, L., Fleisher, J., Schroeder, K. (2020). Utilizing patient advocates in Parkinson's disease: A proposed framework for patient engagement and the modern metrics that can determine its success. Health Expectations, 23, 722-730.	Non-UK based (International)
Harflett, N., Turner, S., Bown, H., National Development Team for Inclusion (2015). The impact of personalisation on the lives of the most isolated people with learning disabilities. A review of the evidence. Available at: https://www.ndti.org.uk/assets/files/Isolation_and_personalisation_evidence_review_final_02_06_15.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Healthwatch (2015). Independent Complaints Advocacy: Standards to support the commissioning, delivery and monitoring of the service. Available at:	Publication is based on case-studies

Study	Reason for Exclusion
https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/healthwatch_advocacy_standards_10022015.pdf [Accessed 16/02/2022]	
Kilinç, S. Erdem, H., Healer, R., Cole, J. (2020). Finding meaning and purpose: a framework for the self-management of neurological conditions. Disability and Rehabilitation, 44(2), 219-230.	Publication is based on case-studies
Macadam, A., Watts, R., Greig, R. (2013). The Impact of Advocacy for People who Use Social Care Services, NIHR School for Social Care Research Scoping Review. Available at: https://www.ndti.org.uk/assets/files/SSCR-scoping-review_SR007.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion (2012). Reasonably Adjusted? Mental Health Services and Support for People with Autism and People with Learning Disabilities. Available at: https://www.ndti.org.uk/assets/files/Reasonably-adjusted_2020-12-30-150637.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion (2014). The impact of advocacy for people who use social care services: a review of the evidence, NDTi Insights. Available at: https://www.ndti.org.uk/assets/files/Insights_19_Impact_of_Advocacy_FINAL.pdf [Accessed 11/02/2022]	No key findings or recommendations relevant to any scope area
National Development Team for Inclusion (2016a). Advocacy Outcomes Framework: Measuring the impact of independent advocacy. Available at: https://www.ndti.org.uk/assets/files/Advocacy_framework.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion (2016b). Advocacy Outcomes Toolkit: An accompanying guide to the advocacy outcomes framework. Available at: https://www.ndti.org.uk/assets/files/Advocacy_Outcomes_Toolkit.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion (2020). Valuing voices: Protecting rights through the pandemic and beyond. Available at: https://www.ndti.org.uk/assets/files/Valuing_voices_-_Protection_rights_through_the_pandemic_and_beyond_Oct_2020.pdf [Accessed 07/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion (2020). Valuing voices in Wales: Protecting rights through the pandemic and beyond. Available at: https://www.dewiscil.org.uk/news/valuing-voices-in-wales-report [Accessed 07/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
National Development Team for Inclusion. (2018). The Advocacy Charter (Poster).	Publication has no evidence base

Study	Reason for Exclusion
Available at: https://www.ndti.org.uk/assets/files/Advocacy-Charter-A3.pdf [Accessed 16/02/2022]	
National Development Team for Inclusion. (2018). The Easy Read Advocacy Charter (Poster). Available at: https://www.ndti.org.uk/assets/files/The-Advocacy-Charter-Easy-Read.pdf [Accessed 16/02/2022]	Publication has no evidence base
National Development Team for Inclusion. (2018). Advocacy QPM: Assessment Workbook. Available at: https://qualityadvocacy.org.uk/wp-content/uploads/2021/12/QPM-Assessment-Workbook_V4_V1.3_Dec-2021.pdf [Accessed 16/02/2022]	Publication has no evidence base
National Development Team for Inclusion, Empowerment Matters (2014). Advocacy QPM: Advocacy Code of Practice, revised edition, 2014. Available at https://qualityadvocacy.org.uk/wp-content/uploads/2018/05/Code-of-Practice-1.pdf [Accessed 25/11/2021]	Publication has no evidence base
Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L., et al. (2012). The Right to Be Heard: Review of the Quality of Independent mental Health Advocate (IMHA) Services in England, University of Central Lancashire. Available at: https://www.firah.org/upload/notices3/2012/uclan.pdf [Accessed 13/05/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Newbigging, K., Ridley, J., McKeown, M., Machin, K., Sadd, J., Machin, K., et al. (2015). Independent Mental Health Advocacy – The Right to Be Heard: Context, Values and Good Practice. Jessica Kingsley Publishers: London, UK.	Publication is a book/book-chapter.
Newbigging, K., McKeown, M., French B. (2011). Mental health advocacy and African and Caribbean men: Good practice principles and organizational models for delivery. Health Expectations, 16(1), 80-104.	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Older People's Advocacy Alliance (2014). Every Step of the Way. 13 stories illustrating the difference independent advocacy support makes to older people affected by cancer. available at: https://opaal.org.uk/app/uploads/2015/09/Advocacy-Stories.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Older People's Advocacy Alliance (2016). Facing Cancer Together. Demonstrating the power of independent advocacy. Available at: https://opaal.org.uk/app/uploads/2016/12/Facing-Cancer-Together.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Older People's Advocacy Alliance (2017). Time: Our Gift to You – why cancer advocacy volunteers support their peers. Available at:	Publication is based on case-studies

Study	Reason for Exclusion
https://opaal.org.uk/app/uploads/2017/02/Time-our-gift-to-you.pdf [Accessed 16/02/2022]	
Ridley, J., Newbigging, K., Street, C. (2018). Mental health advocacy outcomes from service user perspectives, Mental Health Review Journal, Vol. 23(4), 280-292.	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Roberts, H., Turner, S., Baines, S., Hatton, C. (2012). Advocacy by and for adults with learning disabilities in England, Improving Health and Lives: Learning Disabilities Observatory. Available at: https://www.ndti.org.uk/assets/files/IHAL_2012-03_Advocacy.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Social Care Institute for Excellence, University of Central Lancashire (2015). At a glance 68: Understanding Independent Mental Health Advocacy (IMHA) for people who use services. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-users/understanding/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence, University of Central Lancashire (2015). At a glance 68: Understanding Independent Mental Health Advocacy (IMHA) for people who use services, easy read version. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-users/understanding/easy-read/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2014). At a glance 67: Understanding Independent Mental Health Advocacy (IMHA) for mental health staff. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence and University of Central Lancashire (2015). Flowchart for Open Access IMHA. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/improving-access/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). Improving access to Independent Mental Health Advocacy for providers of mental health services. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/improving-access/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). Improving equality of access to Independent Mental Health Advocacy (IMHA): a briefing for providers. Available at:	Publication has no evidence base

Study	Reason for Exclusion
https://www.scie.org.uk/independent-mental-health-advocacy/improving-equality-of-access/briefing/ [Accessed 16/02/2022]	
Social Care Institute for Excellence and University of Central Lancashire (2015). Improving equality of access to Independent Mental Health Advocacy (IMHA): a report for providers. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/improving-equality-of-access/report/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence, University of Central Lancashire (2015). Commissioning Independent Mental Health Advocacy (IMHA) services in England: 10 top tips for commissioners. https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/10-top-tips.asp [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). What does a good IMHA service look like? (Self-assessment tool) Available at: https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/what-good-imha-service-looks-like/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). Making a difference: measuring the impact of Independent Mental Health Advocacy (IMHA). Available at: https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/impact/ [Accessed 16/02/2022]	Publication is based on case-studies
SERIO (2021). The Veterans' Advocacy People: Final Evaluation Report and Social Return on Investment Analysis, The Advocacy People. Available at: https://www.vfrhub.com/wp-content/uploads/2021/01/898ed6_d72d832632234777aa1b5b68e8c314e6.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Planning and commissioning services for advocacy
Strong, S. (2012). User-led organisation leadership of support planning and brokerage. The International Journal of Leadership in Public Services, 8(2), 83-89.	Publication is based on case-studies
Taylor & Francis Production Disability and Rehabilitation (IDRE). My Life Tool (self-management tool): www.mylifetool.co.uk	Publication has no evidence base
Teeside University (2015/2016). UTREG Online Module Specification. Advocacy - Evolution, Equality and Equity	Publication has no evidence base
Townsley, R., Marriott, A., Ward, L. (2009). Access to independent advocacy: an evidence review, Office for Disability Issues. Available at:	Not published in the last 10 years

Study	Reason for Exclusion
http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/iar-exec-summary-standard.pdf [Accessed 16/02/2022]	
Turner, S., Giraud-Saunders, A. (2014). Personal health budgets: Including people with learning disabilities, Think Local act Personal. Available at: https://www.thinklocalactpersonal.org.uk/_assets/Reports/TLAPIncludingLD.pdf [Accessed 16/02/2022]	Publication is based on case-studies
VoiceAbility (2021). STOMP and STAMP: Stopping the over medication of children, young people and adults with a learning disability, autism or both.	Publication has no evidence base
VoiceAbility (2021). Preventing over-medication: STOMP top tips for advocates: How you can help to stop the over-medication of people with a learning disability, autism or both. Available at: https://www.voiceability.org/assets/download/STOMP-2021B.pdf [Accessed 16/02/2022]	Publication has no evidence base

Excluded economic studies

No economic evidence was considered for this scope area.

Appendix E Research recommendations – full details

Research recommendations for scope area: Planning and commissioning services for advocacy

No research recommendations were made for this scope area.

Appendix F Existing NICE recommendations

Table 9: Existing NICE recommendations for scope area: Planning and commissioning services for advocacy

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
Consider expanding the commissioning of statutory Independent Mental Capacity Advocates.	**Decision-making and mental capacity [NG108] – 1.1.9** Other considerations: Recommendations 1.1.7 and 1.1.9 are based on discussions about the evidence in SDM3 and SDM4 describing ways in which people can be successfully supported to participate in decision making. On the basis of the evidence the committee noted that there are principles and tools (e.g. talking mats and signing) which could be applicable to people living with dementia or with a learning disability. The committee acknowledged that there are ways of enabling people to participate in decision making, even where they are experiencing substantial difficulty and that this would not be limited to learning disabilities and dementia. They discussed other means of support (beyond those cited in the research) and agreed, on the basis of their expertise and then supported by expert testimony (EW LS) that it is appropriate to recommend advocacy as a means of providing the kind of support which is valued by people engaged in decision making.	**Recommendation not used in this guideline** This recommendation was not used in this review as the concept of basing commissioning of advocacy services on local needs assessment is covered by recommendation 1.8.1 See the **Error! Reference source not found.** section of **Error! Reference source not found.** in this review for more information.	Not applicable

NICE: National Institute for Health and Care Excellence

Appendix G Formal consensus

Additional information related to scope area: Planning and commissioning services for advocacy

Table 10: Formal consensus round 1 statements and results for scope area: Planning and commissioning services for advocacy

Statement no.	Statement	Percentage agreement	Reference	Action taken
1	It is important to understand and respond to local demographics and the local market is important when commissioning and delivering effective advocacy in order to meet the needs of the local population.	100.00%	NDTi, 2014b; Turner, 2020	Carried forward to committee discussion
2	Further work is needed for local authorities and commissioners to raise their awareness and support the market development in relation to advocacy.	90.00%	NDTi, 2014b	Carried forward to committee discussion
3	The Care Act's focus on access to social care services could lead to local authorities commissioning advocacy services that only meet the minimum requirements of the Act, which could worsen the gap in the provision of advocacy that ensure whole-life support.	90.00%	NDTi, 2014c	Carried forward to committee discussion
4	Formal arrangements to join up advocacy commissioning and provision are 'patchy'.	80.00%	NDTi, 2014c	Carried forward to committee discussion
5	Existing policy and legislative frameworks requiring local investment in providing advocacy to support implementation and compliance (such as the Equality Act 2010) need to be promoted and joined up.	90.00%	NDTi, 2014c	Carried forward to committee discussion
6	Commissioning of advocacy services, should focus on developing stronger, evidence based outcome measures and commissioning guidance on using these to ensure effective service delivery.	100.00%	NDTi, 2014c	Carried forward to committee discussion
7	Commissioners have a key role in ensuring that those in need of advocacy receive it.	100.00%	Lawson, 2020	Carried forward to committee discussion
8	Commissioners need to understand advocacy and safeguarding and provide support to establish consistent good practice in	100.00%	Lawson, 2020	Carried forward to committee discussion

Statement no.	Statement	Percentage agreement	Reference	Action taken
	carrying out the advocacy role in the context of safeguarding adults.			
9	Commissioners should avoid placing a cap on the number of hours an advocate can support an individual.	81.82%	Turner, 2012	Carried forward to committee discussion
10	Involving people with substantial difficulty, as envisaged under the care act, requires more time.	90.91%	Turner, 2012	Carried forward to committee discussion
11	Involving people with complex needs, as envisaged under the care act, requires more time.	90.91%	Turner, 2012	Carried forward to committee discussion
12	Involving people who may lack capacity, as envisaged under the care act, requires more time.	90.91%	Turner, 2012	Carried forward to committee discussion
13	Commissioners should specify services and monitor contracts to ensure that advocacy are working to published quality standards, core principles and the advocacy charter.	100.00%	Turner, 2012	Carried forward to committee discussion
14	Commissioners must ensure that service specifications cover issues of competency and training for advocates, and should consider the funding implications of this.	100.00%	Turner, 2012	Carried forward to committee discussion
15	Commissioning plays a critical role in the development of good quality IMHA services.	100.00%	Newbigging, 2012	Carried forward to committee discussion
16	Trusts should have detailed service specifications.	81.82%	Newbigging, 2012	Carried forward to committee discussion
17	Commissioning should be based on needs assessment.	81.82%	Newbigging, 2012	Carried forward to committee discussion
18	There are gaps in commissioning for people from BME communities.	44.44%	Newbigging, 2012	Discarded
19	There are gaps in commissioning for people with learning difficulties.	66.67%	Newbigging, 2012	Redrafted for round 2
20	There are gaps in commissioning for older people.	60.00%	Newbigging, 2012	Redrafted for round 2
21	There are gaps in commissioning for children and young people.	50.00%	Newbigging, 2012	Discarded
22	Service users should be directly involved in the commissioning process, including monitoring contracts.	90.91%	Newbigging, 2012	Carried forward to committee discussion

Statement no.	Statement	Percentage agreement	Reference	Action taken
23	Commissioning arrangements for people placed out of area are confused.	100.00%	Newbigging, 2012	Carried forward to committee discussion
24	Spot purchasing threatens the financial viability of IMHA services and compromises strategic planning.	50.00%	Newbigging, 2012	Redrafted for round 2 (see section Formal Consensus Round 1 under Summary of Evidence for further explanation)
25	The prominence of advocacy and its value to safeguarding the rights of vulnerable service users is important and needs to be of continued value and needs to be reflected in policy and practice.	100.00%	Newbigging, 2012	Carried forward to committee discussion
26	Consideration should be given to extending the opportunity to access advocacy to informal patients in hospital.	90.91%	Newbigging, 2012	Carried forward to committee discussion
27	Consideration should be given to extending IMHA provision to all in-patients.	90.91%	Newbigging, 2012	Carried forward to committee discussion
28	The investment in IMHA provision should include infrastructure costs and the costs of training and supervision for staff and associated development activities.	100.00%	Newbigging, 2012	Carried forward to committee discussion
29	IMHA services have a clear person-centred focus and the centrality of relationship to advocacy work is should be recognised in service specification and contracts.	100.00%	Newbigging, 2012	Carried forward to committee discussion
30	Local authorities should ensure there is a proper needs assessment in relation to IMHA provision, building on the Joint Strategic Needs Assessment and engagement with community groups.	90.00%	Newbigging, 2012	Carried forward to committee discussion
31	Local authorities should review the level of investment and ensure that it is appropriate for the level of potential demand.	100.00%	Newbigging, 2012	Carried forward to committee discussion
32	Local authorities should engage with qualifying patients, mental health service users and carers to co-design IMHA services.	90.91%	Newbigging, 2012	Carried forward to committee discussion
33	Local authorities should clarify the arrangements for IMHA provision for people placed out of area, so that arrangements are in line with the Health and Social Care Act 2012 and ensure	80.00%	Newbigging, 2012	Carried forward to committee discussion

Statement no.	Statement	Percentage agreement	Reference	Action taken
	that IMHA services are not being commissioned by independent sector providers.			
34	Local authorities should clarify the interface with specialist commissioning for IMHA provision to national specialist services.	100.00%	Newbigging, 2012	Carried forward to committee discussion
35	Local authorities should consider the potential of small local organisations that have particular skills, knowledge and networks that could support the development of access to appropriate forms of IMHA provision for potentially disadvantaged groups.	100.00%	Newbigging, 2012	Carried forward to committee discussion
36	Local authorities and Clinical Commissioning Groups rarely did not commission specialist advocacy for people going through NHS Continuing Healthcare (CHC) (adults), Children and Young People's Continuing Care (CC), personal health budgets (PHBs) or Personal Wheelchair Budgets above statutory requirements.	100.00%	Mercer, 2020	Carried forward to committee discussion
37	There is confusion among commissioners about the roles of IMHAs and Care Act Advocates in supporting people with planning (discharge or support) or receiving s117 aftercare.	85.71%	Mercer, 2020	Carried forward to committee discussion
38	There is a risk that commissioners may not fully understand their duties to commission advocacy.	77.78%	Mercer, 2020	Redrafted for round 2
39	There are concerns that IMHA services are not being commissioned for children and young people.	83.33%	Mercer, 2020	Carried forward to committee discussion
40	There are clear differences in the provision of advocacy services across different areas, indicating discrepancies in the ways that commissioners interpret statutory guidance.	85.71%	Mercer, 2020	Carried forward to committee discussion
41	There are clear differences in the provision of advocacy services across different areas, indicating discrepancies in the ways that advocacy organisations interpret statutory guidance.	85.71%	Mercer, 2020	Carried forward to committee discussion
42	Commissioners should explore how co-producing updated commissioning guidance regarding advocacy for health funded support processes could address some of the current inconsistencies in commissioning arrangements.	100.00%	Mercer, 2020	Carried forward to committee discussion
43	All advocacy commissioning guidance should be updated and brought together.	100.00%	Mercer, 2020	Carried forward to committee discussion

Statement no.	Statement	Percentage agreement	Reference	Action taken
44	Commissioners should involve people who use or are likely to use advocacy to inform their understanding of advocacy.	100.00%	Lawson, 2017	Carried forward to committee discussion

BME: Black and minority ethnic; CC: Continuing Care; CHC: Continuing Healthcare; DoLS: Deprivation of Liberty Safeguards; IMCA: Independent Mental Capacity Advocate; IMHA: Independent Mental Health Advocate; NHS: National Health Service.

Table 11: Formal consensus round 2 statements and results for scope area: Planning and commissioning services for advocacy

Statement no.	Statement	Percentage agreement	Action taken
19	There are gaps in the provision of IMHA services for people with learning difficulties.	77.78%	Discarded
20	There are gaps in the provision of IMHA services for older people.	62.50%	Discarded
24	There is a role for spot purchasing in the commissioning of advocacy services, but it can threaten the financial viability of some IMHA services, such as smaller community based organisations, and compromise strategic planning if it is the only approach to commissioning.	66.67%	Discarded
38	Consideration should be given to refreshing commissioning guidance and providing training to increase commissioners’ understanding of their duties and support more consistent approaches to advocacy availability.	100.00%	Carried forward to committee meeting

IMHA: Independent Mental Health Advocate