National Institute for Health and Care Excellence

Final

Advocacy services for adults with health and social care needs

[J] Training and skills for practitioners who work with advocates

NICE guideline NG227

Evidence reviews underpinning recommendations 1.10.1 to 1.10.5 and 1.9.8 in the NICE guideline

November 2022

Final

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Key theme

- Training and skills for practitioners who work with advocates

Introduction

The aim of this review is to identify the training and skills needed for practitioners who work with advocates.

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 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Study design	Primary qualitative or quantitative studies (including unpublished research), excluding case-studies Systematic reviews of qualitative or quantitative studies, excluding case-studies.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	Training and skills for practitioners who work with advocates

Methods and process

The process of 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 training and skills for practitioners who work with advocates were identified from 3 NICE guidelines ([PH55] Oral health: local authorities and partners, [NG108] Decision-making and mental capacity, [NG189] Safeguarding adults in care homes). The audiences for these guidelines included: people with the condition or users of a services and their families and carers; health and social care professionals, practitioners and providers; service managers; commissioners, local authorities, health and wellbeing boards and safeguarding adults boards; and other staff who come into contact with people using services (for example, housing, education, employment, police and criminal justice staff). Only NG108 and NG189 specifically listed independent advocates (with statutory and non-statutory roles) among their target audiences.

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.

Four documents were identified for this review (Chatfield 2018, Lawson 2020, Newbigging 2012, Roberts 2012).

One document each focused on people living with learning disabilities (Roberts 2012), critical care unit clinicians, relatives of critical care patients and Independent Mental Capacity Advocates (IMCAs) (Chatfield 2017), people detained under the amended Mental Health Act 1983 (Newbigging 2012), and those who have duties to commission and arrange advocacy services (Lawson 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
Chatfield 2017 Exploratory qualitative study National	Critical care unit clinicians, relatives of critical care patients, and IMCAs.	Small-scale qualitative study assessing levels of knowledge and awareness of the MCA and understanding of the role of IMCAs in critical care to determine whether the role of IMCAs might usefully be extended.

Document	Population	Evidence base
Lawson 2020 Briefing Multiple areas	Those who have duties to commission and arrange advocacy services for safeguarding adults	Briefing including qualitative discussions with advocates from across England to determine the enablers and barriers to involvement of advocacy in safeguarding adults
Newbigging 2012 Mixed methods: literature review, qualitative research (focus groups and interviews), case studies England	Patients detained under the amended Mental Health Act 1983, who are eligible for support from IMHA services (including people with and without capacity and children under the age of 16 years)	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
Roberts 2012 Survey England	People living with learning disabilities	3 surveys (responses from 78 local authority commissioners and 88 advocacy providers) and 3 case studies; provides information on, for example, funding and also discusses gaps in advocacy provision and barriers to accessing services

IMCA: Independent Mental Capacity Advocate; IMHA: Independent Mental Health Advocate; MCA: Mental Capacity Act; NDTi: National Development Team for Inclusion; NHS: National Health Service.

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

A total of 4 existing recommendations related to training and skills for practitioners who work with advocates were identified from the 3 NICE guidelines. The committee agreed 1 recommendation should be adapted and 3 recommendations 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

All 4 included documents (Chatfield 2018, Lawson 2020, Newbigging 2012, Roberts 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 16 statements in round 1 of the formal consensus exercise; responses were received from all 12 committee members. At the time that round 1 voting for this scope area occurred, there were 12 committee members appointed. An additional committee member was appointed between the first and second round of voting; therefore, 13 committee members were eligible for voting during round 2. Ten of these statements reached ≥80% agreement in round 1 and were included for the discussion with the committee. Four statements had between 60% and 80% agreement and were re-drafted for round 2. Two statements had <60% agreement; 1 of these was re-drafted for round 2, because the comments raised addressable issues and suggestions for revision, and the other statement was discarded.

See appendix G for the statements that were rated by the committee and results of round 1, which are provided in Table 8.

Formal consensus round 2

The committee were presented with 4 statements in round 2 of the formal consensus exercise; responses were received from 10 of 13 committee members. Two statements were combined. All statements reached ≥80% agreement and were included for the discussion with the committee.

See appendix G for the statements that were rated by the committee and results of round 2, which are provided in Table 9.

Economic evidence

Economic considerations 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 guidelines are of a very high quality (2 or more domains scored ≥90%) and are recommended for use. Two guidelines scored lower in stakeholder involvement because there were fewer experts by experience included in the committee group compared to other guidelines. 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 all 4 documents were assessed using the CASP checklist for qualitative research. One document (Newbigging, 2012) was judged to have minor methodological limitations. The second document (Chatfield, 2018) was judged to have moderate methodological limitations because of the lack of adequate consideration for the relationship between researcher and participants. The last 2 documents (Lawson, 2020; Roberts, 2012) were judged to have serious methodological limitations because of insufficient detail regarding data collection, consideration between relationship of researcher and participants, ethics, data analysis, and recruitment strategy.

Benefits and harms

The committee acknowledged that most of these statements had been extracted from documents judged to be of lower quality. However they were in full agreement with the 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 the statement altogether.

Including information about advocacy in training

The committee agreed that the existing recommendation about training in applying the Mental Capacity Act 2005 and its Code of Practice (Department for Constitutional Affairs 2007) from the 2018 NICE guideline on decision-making and mental capacity [NG108] should be adapted by separating a number of points to improve readability, increase emphasis on key issues and broaden the scope of training. Further details about the committee's decisions to adopt or adapt existing NICE recommendations in the area of training practitioners are given in appendix F. The Mental Capacity Act 2005 is one piece of legislation relevant to the entitlement to advocacy support, but entitlement to advocacy support is also covered by other legislation, such as the Care Act 2014, depending on the type of advocacy support required and the individual's circumstances. It is a legal duty for an advocacy referral to be made when people are entitled to advocacy support and people who cannot self-refer to advocacy rely on referrals by others. However, in the committee's experience, the complexity around the different statutory duties and eligibility criteria for advocacy makes it difficult for practitioners to understand who is entitled to an advocate. Therefore, the committee agreed it was important that health and social care practitioners receive training to help them understand who has a statutory right to advocacy support and how to request it. The committee agreed that there are circumstances where people would benefit from advocacy support that is not covered by statute (see evidence review B). Therefore, they recommended that practitioners also received training about the additional advocacy services that are locally available. The committee agreed that there are several recommendations from this guideline highlighting actions practitioners should take in order to facilitate advocacy (see evidence review E). They therefore recommended that practitioners receive training in this to help implementation of these recommendations. Furthermore, the committee acknowledged that the advocacy role is complex and varies depending on the setting and situation, for example, practitioners may need to take different actions if advocacy is non-instructed compared to when it is instructed. Therefore, the committee agreed that it was important for practitioners to understand the role of the advocate in different settings and situations so that they can understand what training is relevant to the current situation and act accordingly. The committee also agreed that in order to overcome the problem of staff turnover and to help retain organisational and individual knowledge, this training should be part of the induction and regularly refreshed. They agreed to specify every 2 to 3 years on the basis that it achieves a balance between the need to keep knowledge current and fresh in people's minds and the time requirements and potential pressures caused by taking time out of practice for training. A number of the formal consensus statements covered training regarding different types of advocacy (statements 4 and 5), rights to advocacy (statements 4, 5, 8, 14 and 15) and how to make referrals (statements 3, 4 and 5) and were also used to inform this recommendation.

Training for staff who may be the first point of contact

Based on their knowledge and experience the committee agreed to add a recommendation about providers and commissioners ensuring that staff who may be the first point of contact understand who is entitled to advocacy and when and how to request it. In the committee's experience this is not happening consistently and it is important that people receiving health and social care services do not fall through the gaps at this early stage.

What training should cover

Statements 1 and 11 covered providing training about advocacy for health professionals and agencies working with advocacy services. The committee agreed that this was important but that more information was needed about what should be covered by training. Health and social care practitioners should receive training about advocacy as part of compulsory induction training but, in the committee's experience, this is very inconsistent. This can lead to misunderstanding about advocacy, poor practice, and negative working relationships. The committee agreed that making recommendations about the content of training, in order to clarify the role and remit of advocates, should help practitioners such as commissioners, social workers and members of Safeguarding Adults Boards, to better facilitate advocacy involvement and improve working relationships. The content of the training was agreed based on the committee's experience of common misunderstandings regarding the role of advocacy. The committee agreed, based on their knowledge and experience that it was important that training included how to challenge decisions and poor practice. The committee agreed that this is a vital part of maintaining good working relationships however, this is not happening consistently. The committee also used an existing recommendation from the NICE guideline on safeguarding adults in care homes [NG189] to inform this recommendation. The recommendation from NG189 stated that all organisations involved in safeguarding should understand the role of advocacy in relation to safeguarding, think about the person's needs and know when to refer people (see evidence review D).

What providers of training for advocacy should do

Statement 7 highlighted that people with learning disabilities should be included in leading training activities. The committee agreed that it was important that people with lived experiences of advocacy services, and not just those with learning disabilities, are involved in developing and delivering training as it provides practitioners an insight into service users' views and experiences and could help professionals to develop a better understanding of the value of advocacy to the people they will be supporting. Furthermore, people with lived experience may have different priorities about what they think is important for professionals to know and they might have a better understanding of what gaps professionals have in practice. In the committee's experience, including real life examples in training also has the potential to make the training more impactful and memorable, which may increase the likelihood that the training is then put into practice. The committee agreed, based on their experience, that people learn in different ways and that some people may find it easier to access training remotely, or in their own time, than attending fixed, in person training sessions. Therefore, they recommended that training should be delivered in various formats. Finally, statement 10, which emphasised that health and social care organisations should involve people with lived experience of advocacy in training sessions for health and social care practitioners, was also used to inform this recommendation. Stemming from these discussions, the committee agreed that it was important that training covered new staff, pre-registration and continuing development so that everyone is covered and there aren't any gaps in training which could lead to inconsistent practice and referrals. The committee agreed that making recommendations about tailoring training for different practitioners performing different roles would help to ensure that the amount of training is appropriate for the role and that everyone knows their responsibilities and, therefore, increase effectiveness in practice.

Implementing the knowledge learned

In the context of these discussions the committee agreed, based on their experience, that the knowledge gained during training is not always implemented or used effectively. Therefore, they recommended that steps are taken so that health and social care providers ensure that the knowledge is being implemented in practice. The committee were aware that supervision might be one potential mechanism for ensuring that this happens, but this is currently not well structured.

Training volunteer advocates

Statement 6 covered advocacy services ensuring that any volunteer advocates they deploy are trained. In the committee's experience, it is essential that volunteer advocates are trained, but that they also needed adequate support and supervision to help ensure consistency, and that knowledge gained during training is implemented. It is important that volunteer advocates receive the same support as paid advocates to ensure that the services provided by volunteer advocates meet the required standard. The committee agreed to move this recommendation to the section of the guideline training advocates (see evidence review I), as this recommendation is about training advocates rather than practitioners.

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. Statement 2 was not used to inform recommendations because the action required to address the issue was outside the scope of NICE guidelines. Statements 9 and 13 were not used because they did not include enough detail to inform what action should be taken. Statement 16 was not used because the committee agreed that it was too specific and only applied to a small number of people.

Existing recommendations not used in this review

There were a number of existing NICE recommendations that the committee neither adopted nor adapted for the section on training practitioners. The reasons behind their decision making are given in appendix F.

Cost effectiveness and resource use

Health and social care practitioners as well as other professionals who may come into contact with advocates or people who may require advocacy (including social workers, Safeguarding Adult Board members and commissioners of advocacy) should already be receiving training in legislation and in the role of advocates. Such training can be included in induction processes for the role using existing materials. This should minimise or eliminate any cost of providing this. However, refresher training is not routinely happening and there is variation across regions in how much training is tailored. While there may be some costs associated with providing refresher training, there are existing materials that can be used to facilitate training which if used would minimise cost. Further, tailoring training should also make sure resources are being used most efficiently, as not everyone will require the same depth of knowledge and amount of training reducing the time people are away from their core responsibilities.

The vast majority of the training is currently being delivered is done by advocacy organisations and does not routinely involve people with lived experience unless they are also advocates. For organisations that are not currently doing this, there will likely be costs associated with doing so as there is a need to provide support to enable some people to engage in the training and effectively share their experience with training attendees. However, this should improve the overall quality of training, making it more relevant and meaningful and help to improve the practitioners understanding of advocacy and people who use advocacy. This should lead to efficiencies through better understanding the needs and wishes of people using advocacy reducing inappropriate referrals, interventions and reducing the need to repeat meetings.

The delivery of training in a variety of formats may have some costs associated with it. However, costs will be minimal if training is performed through self-directed learning or if training is delivered remotely. Furthermore, people's learning experience can be improved by providing training in various formats, making it more flexible and accessible. Improved training should again lead to the efficiency savings discussed above through better understanding of advocacy.

There may be some costs associated with ensuring that knowledge gained during training is applied in practice. If this was done through supervision, existing supervision frameworks and time could be used, so that no additional time is needed. However, there might be costs associated with changing attitudes and approaches used by health and social care practitioners to enable effective supervision although these should be small and short-term. There is also the possibility that increased use of knowledge in practice could lead to an improvement in the quality of services and a reduction in complaints and adverse outcomes leading to cost savings

Currently there are inconsistencies in the level and type of training provided for volunteer advocates, so there might be additional costs and resources required to provide this. However, the amount of training required will depend on the role and responsibility of individual advocates and the needs of the population in their local area. Therefore, it is not anticipated that all volunteer advocates will need training in all of the processes and areas. Training volunteer advocates is important so that the required service standard is met. There might also be savings in the long term due higher quality services and reduction in complaints.

Improved training may help identify people who have a right to advocacy under current legislation. This will subsequently increase the total number of people accessing advocacy services leading to a greater resource impact than providing training, at least in the short term. The increased access will however be from people who have a legal right to advocacy services and resources should already be in place to meet this statutory requirement. Better access to advocacy services should lead to better outcomes and a reduction in escalation of need leading to lower downstream costs and higher quality of life. This is likely to be especially true for people with a legal right where benefits of advocacy have already been acknowledged in legislation.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.10.1 to 1.10.5, and 1.9.8, Other evidence supporting these recommendations can be found in the evidence reviews on who else would benefit (see evidence review B), enabling and supporting (see evidence review E), and improving access (see evidence review D).

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. Available at: https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

National Institute for Health and Care Excellence 2014

National Institute for Health and Care Excellence (2014). Oral Health: Local Authorities and Partners. Available at: https://www.nice.org.uk/guidance/ph55/resources/oral-health-local-authorities-and-partners-pdf-1996420085701

National Institute for Health and Care Excellence 2021

National Institute for Health and Care Excellence (2021). Safeguarding adults in care homes (NICE Guideline 189). Available at: https://www.nice.org.uk/guidance/ng189/resources/safeguarding-adults-in-care-homes-pdf-66142030079941

Formal consensus

Chatfield 2017

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.

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]

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]

Roberts 2012

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]

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]

Department for Constitutional Affairs 2007

Department for Constitutional Affairs (2007). Mental Capacity Act 2005: Code of Practice. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed 15/02/2022]

Mental Capacity Act 2005

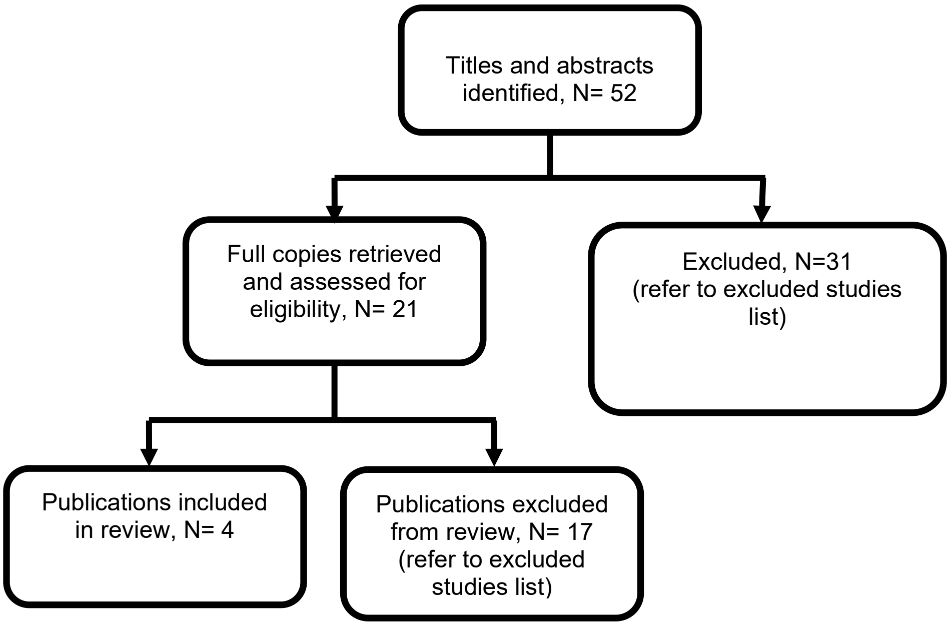
Mental Capacity Act, 2005 (c.9). Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents [Accessed 23/02/2021]

Appendices

Appendix A Study selection for formal consensus process

Study selection for scope area: Training and skills for practitioners who work with advocates

Figure 1: Study selection flow chart



Appendix B Evidence tables

Evidence tables for scope area: Training and skills for practitioners who work with advocates

Table 3: Evidence tables

Study details	Population	Recommendations/key findings	Quality assessment
Full citation 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. **Country/ies where the study was carried out** England and Wales **Study type** Mixed methods (qualitative research: interviews and survey data; open and closed ended questions) **Study dates** Not reported **Source of funding** No sources of funding reported.	n=6 critical care units; n=5 relatives of critical care patients; n=4 IMCAs	**Key findings in relation to training and skills for practitioners who work with advocates (Facilitating Advocacy)** • When asked about the Mental Capacity Act (MCA), all clinicians were familiar with it, but none could remember having been provided with formal training. For example, "The Trust provides a mountain of training of all things. Whether in that haystack there was something about Mental Capacity Act, I can't tell you." (C6, p.2) • Clinicians had obtained knowledge of the Act from internet sources, informal peer education and 'on the job' learning. **Recommendations in relation to training and skills for practitioners who work with advocates (Facilitating 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 explore existing levels of knowledge and awareness of the MCA and understanding of the role of IMCAs in critical care. **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 clinicians and IMCAs were recruited is explained (through invitation letter and relatives through critical care unit follow-up clinics across 2 NHS Trusts in England). **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes – the methods used were described, although saturation of data was not discussed.

Study details	Population	Recommendations/key findings	Quality assessment
		• Provide further and regular training on the MCA and the role of IMCAs in the critical care setting.	**6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** No – the authors did not discuss their own roles in the formulation of the research questions, or consider their influence on the participants. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes – ethical approval and site specific authorisation was obtained; participants gave consent prior to participation in the study. **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 – 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 – highlights that further training is required to ensure greater understanding of advocacy and that vulnerable patients receive services they are entitled to, and there is a need for further investigations into providing a drop in IMCA clinic. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate limitations.

Study details	Population	Recommendations/key findings	Quality assessment
Full citation 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] **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 in relation to training and skills for practitioners who work with advocates (Facilitating advocacy)** • Need to enhance knowledge about advocacy role and function across sectors including amongst social workers, SAB members, commissioners of advocacy and others • Actions that help addressing issues: ○ Offering training to for social workers so they understand what advocacy is ○ Include information about advocacy in social worker training/qualifications as well as in induction ○ Advocacy providers supporting social workers to make appropriate referrals by providing guidance and training and responding to feedback about ease of referring	**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)** 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)**

Study details	**Population**	**Recommendations/key findings**	**Quality assessment**
			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?** 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 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:	Patients detained under the amended Mental Health Act 1983, who are eligible for support from IMHA services	**Key findings in relation to training and skills for practitioners who work with advocates (facilitating advocacy)** • The findings reflected the level of training the majority of staff	**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

Study details	Population	Recommendations/key findings	Quality assessment
https://www.firah.org/upload/notices3/2012/uclan.pdf [Accessed 13/05/2021] **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 **Source of funding** Department of Health	(including people with and without capacity and children under the age of 16 years)	recalled having undertaken. Some did not recall having any training, but the majority of health professionals had received limited training, usually as part of a general overview of the Mental Health Act. • Training was often provided in-house and rarely involved the IMHA service, qualifying patients or service users. • Service users in one focus group suggested it would be helpful if doctors had training so that they had greater understanding and respect for advocates and their role. • Professionals most likely to receive training on the IMHA role were approved mental health professionals who were also more likely to receive refresher training or discuss the role at network meetings. • Improved post-qualification training is one solution, but the evidence also indicated that the issue of working with IMHAs needs to be supported through supervision and discussion in team meetings and could be facilitated by	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)** 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 Research Ethics Committee and the International School for

Study details	Population	Recommendations/key findings	Quality assessment
		location within a recovery-focused approach. **Recommendations in relation to training and skills for practitioners who work with advocates (facilitating advocacy)** • Mental health professionals working with those on CTOs should receive training about their obligation to inform qualifying patients about IMHA, and protocols for referral should be developed. • The variable relationships between MHA administrators, mental health staff and advocacy services should be noted and steps taken to optimise learning from good practice. Staff training should explicitly address issues identified as enhancing constructive working relationships between IMHAs and mental health professionals: having a mutual understanding of each other's roles and the constraints each other work under. For example, through	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. **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
		developing reflective practice using vignette case examples or role-play scenarios.	
Full citation 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] **Country/ies where the study was carried out** 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.	A range of people including people living with learning disabilities	**Key findings in relation to training and skills for practitioners who work with advocates (facilitating advocacy)** • Types of non-statutory advocacy activities identified from the survey, including providing training (cited by 5 commissioners as being provided by their local advocacy organisations): • Training programmes, staff training courses. • Training in relation to advocacy skills/inspection. • 7 organisations delivered training as part of the improvement of health services. For example, “We deliver training on disability awareness to student nurses and care staff (our members deliver the training with our support”. (p.60) • Involvement of advocacy services in the training of health professionals, “linking with University of [city] to	**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. **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.

Study details	Population	Recommendations/key findings	Quality assessment
		deliver a session on learning disability awareness to medical students". (p.62) • Training, including training volunteer advocates and people with learning disabilities leading training activities (8 organisations).	**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. 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.

CASP: Critical Appraisal Skills Programme; CTO: Community Treatment Order; IMCA: Independent Mental Capacity Advocate; IMHA: Independent Mental Health Advocate; MCA: Mental Capacity Act; MHA: Mental Health Act; n: number; NDTi: National Development Team for Inclusion; NHS: National Health Service; SAB: Safeguarding Adults Board

Appendix C Quality Assessment

Quality assessment tables for scope area: Training and skills for practitioners who work with advocates

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	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 guideline are clearly defined.	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 information of the recommendation	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	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 reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
				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 consultation phase prior to its publication, and details of this process are	recommendations are summarised as flow charts.	clear description of how the recommendations can be put into practice and there is an implementation section in the 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		

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
				available. A statement that the guideline will be updated is provided though the methodology for this procedure is unavailable.		of applying the recommendations. There are identification criteria to assess guideline implementation and monitoring or auditing criteria.		
Oral Health: Local Authorities and Partners	2014	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.	83 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is reported in detail. Very few views from the target audience were included in	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	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	92 There is description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders were	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	95

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
			guideline development. The target users of the guideline are clearly defined.	and reported clearly. There is clear and adequate 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 grouped together in one section. The description of recommendations are summarised as flow charts.	obtained. There is a clear description of how the recommendations can be put into practice and there is an implementation section in the guideline. There are references to tools and resources to facilitate application and there are directions on how users can access these. There is economic consideration, which is reported clearly. The potential resource impact of	addressed explicitly.	

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
				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.		applying the recommendations has not been reported. There are identification criteria to assess guideline implementation and monitoring or auditing criteria.		
Safeguarding adults in care homes (NICE Guideline 189)	2021	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.	89 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is reported in detail. A few views from the target audiences were included in guideline	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	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	96 There is description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders were	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	97

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
			development. The target users of the guideline are clearly defined.	and reported clearly. There is clear and adequate 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 grouped together in one section. The description of recommendations are summarised as flow charts.	obtained. There is a clear description of how the recommendations can be put into practice and there is an implementation section in the 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	addressed explicitly.	

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
				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.		are identification criteria to assess guideline implementation and monitoring or auditing criteria.		

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

Formal consensus

Table 5: 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**
Chatfield 2018	2018	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Lawson 2020	2020	Yes	Yes	Yes	Can't tell	Yes	No	No	Can't tell	Yes	Valuable

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**
Newbigging 2012	2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Roberts 2012	2012	Yes	Yes	Yes	Yes	Can't tell	No	No	Can't tell	Yes	Valuable

CASP: Critical Appraisal Skills Programme

Appendix D Excluded studies

Excluded studies for scope area: Training and skills for practitioners who work with advocates

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

Table 6: 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
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 Training and skills for practitioners who work with advocates
Healthwatch (2015). Independent Complaints Advocacy: Standards to support the commissioning, delivery and monitoring of the service. Available at: https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/healthwatch_advocacy_standards_10022015.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Kilinç, S. Erdem, H., Healer, R., Cole, J. (2020). Finding meaning and purpose: a framework for	Publication is based on case-studies

Study	Reason for Exclusion
the self-management of neurological conditions. Disability and Rehabilitation, 44(2), 219-230.	
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]	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
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 Training and skills for practitioners who work with advocates
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]	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
National Development Team for Inclusion. (2018). The Advocacy Charter (Poster). Available at: https://www.ndti.org.uk/assets/files/Advocacy-Charter-A3.pdf [Accessed 16/02/2022]	Publication has no evidence base
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 (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 Training and skills for practitioners who work with advocates
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 Training and skills for practitioners who work with advocates
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]Development Team for Inclusion programme	Publication has no evidence base
National Development Team for Inclusion, Empowerment Matters (2014). Advocacy QPM:	Publication has no evidence base

Study	Reason for Exclusion
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]	
National Development Team for Inclusion (2014b). Office for Disabilities Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note. Unpublished.	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
National Development Team for Inclusion (2014c). Office for Disabilities Issues Access to Advocacy Project: Executive Summary. Unpublished.National Development Team for Inclusion. (Unpublished). ODI Access to Advocacy Project Executive Summary	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
National Development Team for Inclusion. (2012). Reasonably Adjusted? Mental Health Services and Support for People with Autism and People with Learning Disabilities	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
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 (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 Training and skills for practitioners who work with advocates
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 Training and skills for practitioners who work with advocates
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 Training and skills for practitioners who work with advocates
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.
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 Training and skills for practitioners who work with advocates

Study	Reason for Exclusion
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: https://opaal.org.uk/app/uploads/2017/02/Time-our-gift-to-you.pdf [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 Training and skills for practitioners who work with advocates
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, 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 (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-	Publication has no evidence base

Study	Reason for Exclusion
commissioning/10-top-tips.asp [Accessed 16/02/2022]	
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: https://www.scie.org.uk/independent-mental-health-advocacy/improving-equality-of-access/briefing/ [Accessed 16/02/2022]	Publication has no evidence base
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). 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
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
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

Study	Reason for Exclusion
Teeside University (2015/2016). UTREG Online Module Specification: Advocacy - Evolution, Equality and Equity. Unpublished.	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: http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/iar-exec-summary-standard.pdf [Accessed 16/02/2022]	Not published in the last 10 years
Turner, S. & Giraud-Saunders, A. (2014). Personal health budgets: Including people with learning disabilities	Publication is based on case-studies
Turner, S. (2012). Advocacy by and for adults with learning disabilities in England: Evidence into practice report no.5, Improving Health and Lives: Learning Disabilities Observatory. Available at: https://www.ndti.org.uk/assets/files/IHAL-ev-_2012-01.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training and skills for practitioners who work with advocates
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	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: Training and skills for practitioners who work with advocates

No research recommendations were made for this scope area.

Appendix F Existing NICE recommendations

Table 7: Existing NICE recommendations for scope area: Training and skills for practitioners who work with advocates

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
Commission regular, training for frontline health and social care staff working with groups at high risk of poor oral health. This should be based on 'advice for patients' in Delivering better oral health. The aim is to ensure they can meet the needs of adults, children and young people in groups at high risk of poor oral health. The training should include: • Information on local voluntary sector organisations that may be able to offer additional advice, help or advocacy services.	**Oral Health: local authorities and partners [PH55] – 1.9.1** Impact: No new evidence was identified that would change the recommendation. Recommendation 9 currently advises on the role of high sugar diets and the link to poor oral health, which is complementary to the new sugar guidance highlighted by a topic expert. The recommendation suggests commissioning appropriate training for frontline staff and states that this should be based on the information provided in the delivering better oral health toolkit. The link will be updated to the 2017 version of Delivering better oral health: an evidence-based toolkit for prevention. The information provided is consistent with this guideline and no impact is anticipated.	**Recommendation not used in this guideline** This recommendation was not used in this guideline as the population was too specific and the concepts of this recommendation are sufficiently covered by existing recommendations in the training and skills for practitioners who work with advocates section. See the **Error! Reference source not found.** section of **Error! Reference source not found.** for more information	Not applicable
Service providers and commissioners should ensure that practitioners undergo training to help them to apply the Mental Capacity Act 2005 and its Code of Practice. Training should be tailored to the role and responsibilities of the practitioner and cover new staff, pre-registration, and continuing development and practice supervision for existing staff. Where appropriate, training should be interdisciplinary,	**Decision making and mental capacity [NG108] – 1.1.1** Evidence statement APa4: There is a good amount of evidence that practitioners lack the requisite skills and training to conduct timely and competent discussions about advance care planning. The quality of the evidence is good. • Patients in the MacPherson (2012, ++) study described poor communication by health professionals, with some of them failing to discuss the person's condition – let alone future plans – and	**Adapted** This recommendation was adapted and split into separate recommendations. This recommendation was adapted to remove the legislation and include context. See the Benefits and harms section of The committee's discussion and interpretation of the evidence for more information	Providers and commissioners should ensure that information about advocacy is included in training for all health and social care practitioners at induction, with refresher training

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
involve experts by experience and include: • the role of Independent Mental Capacity Advocates in best interests decision-making.	others attempting to initiate advance planning discussions in such a way which upset the patient and triggered a formal complaint. • Almack et al (2012, ++) identified the need for training and developing experience in advanced communication as a key barrier to conducting advance planning discussions. • In Stewart et al (2011, ++) respondents suggested that work was needed to increase staff awareness about and understanding of Priorities for Care documentation because this lack of understanding was a major barrier to advance care planning. • Some of the community matrons in the Kazmierski study (2015, ++) said they had not received any training in decision making relating to 'Do Not Attempt CPR resuscitation'. Although it had been mentioned in the practice context no training was available about how to approach those difficult discussions. • Care home staff said they felt intimidated at the prospect of initiating advance care planning discussions and others felt that they did not have a clear understanding of what was involved in advance care planning (Stone 2013, ++). Evidence statement AP11a: There was a good amount of qualitative evidence, of moderate quality, that advance planning should be completed early, to avoid the loss of capacity before advance care planning was in place. Manthorpe's UK based (2014 +), study of dementia nurses, found that nurses often only came into contact with people once they had lost capacity, making		every 2 to 3 years or as needed, so that they understand: • who is entitled to advocacy support under current legislation • what advocacy support services are available locally in addition to those required by law • when and how to request advocacy • how to facilitate advocacy • the role of the advocate in different setting and situations.

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
	assistance with advance planning difficult. Another UK qualitative study, Poppe (2013 +) found that the best time to discuss advance care planning was soon after dementia diagnosis, to maximise the persons input before they lost capacity, the study also found that a barrier to advance care planning completion was when a person was unwilling to accept their diagnosis. Sinclair (2016 +) also found that in UK based views evidence, that the best time to discuss advance care planning was when a person has come to terms with their diagnosis but still had capacity. Evidence from the UK about the importance of timing was also found in Robinson (2013 ++). This study found that delays in getting the advance care plan completed meant that they were not in place before the person lost capacity. This was particularly true of dementia. Samsi (2011 +) found that planning was difficult in the case of people with dementia who did not wish to face their diagnosis. Other considerations: Recommendation 1.1.1 is based on evidence synthesised in APa4 and AP11a and supported by expert testimony (EW LS). APa4 reported a good amount of evidence that practitioners lack the requisite skills and training to conduct timely and competent discussions about advance care planning. AP11 reported evidence from qualitative studies about the importance of the timing of advance care planning discussions. Evidence from expert testimony (EW LS) emphasised the crucial importance of communication as a means of building trust, which is essential to successfully supporting decision making. Drawing on this evidence and on their own practice experiences, the		

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
	committee had long discussions about drafting recommendations for training on various separate aspects of decision making, for instance on supported decision making or on advance care planning. They eventually agreed to draft an overall training recommendation to appear in the overarching principles of the guideline, which would cover all aspects of practice under the Mental Capacity Act. The committee discussed whether the training recommendation should focus on particular staff groups but there was some concern that the evidence to do this is not strong enough. Ultimately the committee agreed that training to apply the Mental Capacity Act and Code of Practice is in any case important for all staff so the recommendation should apply generally. Finally, committee members were aware that it is not within the scope of the guideline to mandate a particular exam, assessment, or qualification but that they should instead focus on skills and competencies required to successfully enable people to participate in decision making. They agreed that mentoring, supervision and continuing professional development are all crucial for ensuring skills are learned, reviewed and consistently applied in practice. The committee recognised and discussed the potential resource implications linked with recommendation 1.1.1 in relation to training, especially in areas where it is not currently routine practice. However given that it represents good practice and is required by law, they determined that the recommendation represents value for money. The committee also discussed the cost implications of involving experts by experience in relation to recommendation 1.1.1, and have included the		

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
	words 'where appropriate' in the recommendation to allow appropriate targeting of resources. The benefit of involving experts by experience in training outweighs the costs. Legal advice given to NICE also resulted in amendments to this recommendation following consultation to ensure legal accuracy.		
Health and social care organisations should provide toolkits to support staff to carry out and record best interests decisions. These toolkits should include: • when to instruct an Independent Mental Capacity Advocate	**Decision making and mental capacity [NG108] – 1.5.14** Evidence statement BIA5: There is some evidence that practitioners are unclear about how to determine the best interests of a person who lacks capacity to make a particular decision. The quality of the evidence is low. Ramasubramanian et al. (2011 ++) found in their audit of practice in a specialist learning disabilities unit that before the introduction of a checklist practitioners had not always checked whether the person had an advance statement, lasting power of attorney, court-appointed deputy, etc; had not always involved families, carers and other relevant parties in the decision-making process; and had not always considered involving an independent mental capacity advocate in cases where this would have been appropriate. Sorinmade et al. (2011 ++) found that while the majority of mental health practitioners did consult with family and friends when making a best interests decision, this was not always the case. Enquiries regarding the existence of a court appointed deputy or the involvement of an independent mental capacity advocate were only recoded in a small minority of cases.	**Recommendation not used in this guideline** This recommendation was not used in this guideline as it is about toolkits to support best interest decisions. Information on when to instruct and IMCA (or any other type of advocate) is covered by recommendation 1.10.1 about training staff to apply the legislation. See the **Error! Reference source not found.** section of **Error! Reference source not found.** for more information	Not applicable

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
	Other considerations: Recommendation 1.5.14 is based on evidence in BIA5 which suggests that practitioners are unclear about how to determine someone's best interests. In discussing the evidence the committee highlighted that the findings may to some extent be explained by the research having been conducted several years ago, since when practitioners are likely to have become more proficient in determining best interests. Rather than developing a training recommendation on this issue they therefore felt it would be a better reflection of current practice to recommend that organisations provide toolkits for best interests decision making in order to support practitioners in this process. The committee agreed that guidance on recording best interests decision making processes is as vital as guidance on how to conduct the process and this was confirmed in expert witness testimony. Legal advice given to NICE also resulted in amendments to this recommendation following consultation to ensure legal accuracy.		
All organisations involved with safeguarding adults in care homes should: • understand the role of advocacy in relation to safeguarding, and that the advocate is the only person who acts solely according to instructions from the resident • think about the resident's needs and know when to refer people for advocacy	**Safeguarding adults in care homes [NG189] – 1.8.11** Why the committee made the recommendations: The committee used qualitative themes from research evidence on responding to and managing safeguarding concerns in care homes, and support and information needs for everyone involved in safeguarding concerns in care homes. The evidence showed that residents benefit when they are involved and kept informed throughout the safeguarding process. The evidence also emphasised the value that residents place on support from family, friends or advocates in helping them achieve their	**Recommendation not used in this guideline** This recommendation was not used in this guideline as the concept of understanding the role of advocacy in relation to safeguarding is covered by recommendation 1.10.3. The other concepts of this recommendation are covered by recommendation 1.1.1 in who has a legal right to advocacy.	Not applicable

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
- involve an independent advocate for the resident, when this is required by the Care Act 2014 and Care Act 2014 statutory guidance or the Mental Capacity Act 2005 - ensure that anyone supporting the resident as an informal or independent advocate has been identified in line with the resident's statutory rights to advocacy under the Care Act and the Mental Capacity Act.	desired outcomes. However, the committee had some concerns about the quality of the data, which had some methodological limitations as well as questionable relevance (it was not always clear whether findings related specifically to care home settings). The committee therefore also used the Making Safeguarding Personal framework and the Care Act 2014. These sources highlight the importance of involving people fully as possible in decisions and giving them the information and support they need to participate. The evidence matched the committee's experience of practice. They agreed that involving people in decision making will help them achieve the outcomes they want, and make it more likely that they will receive safe and effective care after the enquiry ends. Although the committee were able to draw on their own knowledge and experience, they felt that the gap in the evidence indicated that a research recommendation was needed about the views of care home residents in relation to their experiences of safeguarding enquiries. Getting the views of residents will ensure that their needs are understood and that subsequent care can be person-centred and outcomes-focused. The committee recognised that there should be a clear difference and understanding of the roles of the practitioners and independent advocate involved in safeguarding. Although the practitioner might be acting in the best interest of the person, they may be operating within the constraints of their role. It is only the independent advocate who acts according to instruction from the person.	See the **Error! Reference source not found.** section of **Error! Reference source not found.** for more information	

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
	Residents will often need emotional and practical support while an enquiry is taking place. In addition, they may need this support to continue afterwards, and their needs should be reassessed after the enquiry.		

CPR: cardiopulmonary resuscitation; IMCA: Independent Mental Capacity Advocate; NICE: National Institute for Health and Care Excellence; SACN: Scientific Advisory Committee on Nutrition

Appendix G Formal consensus

Additional information related to scope area: Training and skills for practitioners who work with advocates

Table 8: Formal consensus round 1 statements and results for scope area: Training and skills for practitioners who work with advocates

Statement no.	Statement	Percentage agreement	Reference	Action taken
1	Provide training to all agencies working with advocacy services (including social workers, SAB members, commissioners of advocacy) to enhance knowledge about advocacy role and function.	100.00%	Lawson, 2020	Carried forward to committee discussion
2	Include information about advocacy in social worker training/qualifications as well as in induction training.	100.00%	Lawson, 2020	Carried forward to committee discussion
3	Advocacy providers supporting social workers should provide guidance and training to enable them to make appropriate referrals.	90.00%	Lawson, 2020	Carried forward to committee discussion
4	Advocacy organisations should deliver training on disability awareness to medical students, student nurses and care staff.	50.00%	Roberts, 2012	Redrafted for round 2 (see section Formal Consensus Round 1 under Summary of Evidence for further explanation)
5	Advocacy services should be involved in the training of health professionals.	75.00%	Roberts, 2012	Redrafted for round 2
6	Training should include training volunteer advocates.	75.00%	Roberts, 2012	Redrafted for round 2
7	Training should include people with learning disabilities leading training activities.	91.67%	Roberts, 2012	Carried forward to committee discussion
8	Health and social care organisations should provide health professionals with training on the Mental Health Act.	66.67%	Newbigging, 2012	Redrafted for round 2

Statement no.	Statement	Percentage agreement	Reference	Action taken
9	Health and social care organisations should provide training sessions to health professionals that involve professionals from IMHA services.	81.82%	Newbigging, 2012	Carried forward to committee discussion
10	Health and social care organisations should provide training sessions to health professionals that involve qualifying patients or people who use services.	75.00%	Newbigging, 2012	Redrafted for round 2
11	Health and social care organisations should provide training to health professionals' to enhance their understanding and respect for advocacy.	100.00%	Newbigging, 2012	Carried forward to committee discussion
12	Health professionals working with IMHAs should be provided with supervision.	50.00%	Newbigging, 2012	Discarded
13	Health professionals should discuss working with IMHAs in team meetings.	90.00%	Newbigging, 2012	Carried forward to committee discussion
14	Clinicians should be provided with formal training on the Mental Capacity Act.	91.67%	Chatfield, 2017	Carried forward to committee discussion
15	Provide further and regular training on the MCA to clinicians.	83.33%	Chatfield, 2017	Carried forward to committee discussion
16	Provide further and regular training to clinicians on the role of IMCAs in the critical care setting.	83.33%	Chatfield, 2017	Carried forward to committee discussion

IMCA: Independent Mental Capacity Advocate; IMHA: Independent Mental Health Advocate; MCA: Mental Capacity Act; SAB: Safeguarding Adult Board.

Table 9: Formal consensus round 2 statements and results for scope area: Training and skills for practitioners who work with advocates

Statement no.	Statement	Percentage agreement	Action taken
4 & 5	Advocacy providers should be commissioned to provide training to health professionals (including health professional students) about advocacy, including: the different advocacy roles, rights to advocacy, and their duties to refer people for advocacy support.	100.00%	Carried forward to committee discussion
6	Advocacy services should ensure any volunteer advocates they deploy are trained.	100.00%	Carried forward to committee discussion
8	Health and social care organisations should ensure health and social care professionals are provided with training on entitlement to advocacy as covered by legislation (e.g., the Mental Health Act, Mental Capacity Act and Care Act).	90.00%	Carried forward to committee discussion
10	Health and social care organisations should involve people with lived experience of using an advocate when providing training sessions about advocacy services to health and social care professionals.	100.00%	Carried forward to committee discussion