

## **Action for Advocacy's response to Modernising Commissioning**

### **Introduction**

This is the response of Action for Advocacy to the Cabinet Office consultation paper, *Modernising Commissioning*.

### **About Action for Advocacy (A4A)**

Action for Advocacy (A4A) is the central point of information on independent advocacy and a resource and support agency for independent advocacy schemes. We aim to:

- To 'advocate for advocacy' at a strategic level
- To support the development of independent advocacy schemes
- To facilitate effective networking between advocates and advocacy schemes
- To promote good practice and information sharing across the advocacy sector

Established in 2001, we work in England and Wales. We have built a reputation as the leading authority on the development of effective advocacy services for vulnerable and disempowered people.

A4A has a diverse range of 550 members; organisations of widely varying sizes that provide advocacy services for vulnerable and disempowered people (e.g. people with mental health problems, older people, people with learning and/or physical and sensory disabilities, carers, and refugees and asylum seekers). Membership of A4A is free.

The consultation period allowed insufficient time for consultation with member organisations regarding this response. We have based our response on our knowledge and understanding of the commissioning environment for advocacy organisations. Our response is not necessarily reflective of the views and experience of all member organisations.

The short consultation deadline also means that this response is restricted to key questions and issues we feel need to be taken into account rather than detailed suggestions.

### **Our comments**

Unfortunately, we have numerous examples of poor commissioning processes in relation to advocacy services. The Green Paper cites the example of Cambridge House's experience of Independent Mental Capacity Advocacy services in London (p.13). However, A4A are aware of multiple and repeated instances of poor commissioning practice, even for services such as Independent Mental Health Advocacy which commissioners have a legal duty to make available.

Appended to this response is a summary of a survey that A4A conducted last year regarding Independent Mental Health Advocacy commissioning. This study paints a picture of commissioning that is all too often blighted by poor demand/need analysis, unclear funding/contract value, restricted tendering, insufficient funding to permit full cost recovery and unreasonably tight timescales and contract lead-in times.

Our survey highlights some of the barriers to SME organisations in the commissioning process.

Some key points arise from our experience:

- Do not over-complicate commissioning processes and requirements. Bidding, reporting and monitoring arrangements should be proportionate and relevant to the service.
- Value highly local knowledge, community links and long-term local commitment as part of all stages of process, including assessment of bids. This is where local community and user led organisations bring great value and reach to the table which is often not reflected in tendering process.
- Encourage organisations to work collaboratively in consortia and recognise that building such delivery partnerships takes time and resources but ultimately adds diversity and, again, reach to the service.
- Resolve key contractual issues such as value, VAT and TUPE at an early stage.
- Ensure that the value of the contract permits full cost recovery. To not do this risks weakening the very bodies from whom more is expected. Cutting costs may not deliver the transformative change desired.
- Ensure realistic timescales for each stage or the commissioning process.
- Commission services to deliver services over longer time periods. Three years is often not enough time to deliver real transformations. Five years is more realistic.

In our response to another current Cabinet Office consultation paper “Supporting a Stronger Civil Society”, we noted the barrier that commissioning practice often presents for civil society:

‘...an increasingly competitive environment means that larger civil society organisations do not look upon smaller organisations as enterprises to support, but more frequently as potential competitors to squeeze out of the market or take over. The Government must therefore ensure that the funding and commissioning environment does not favour larger organisations over small and must also make it advantageous to larger organisations to share their resources with smaller ones. The Government should encourage commissioners to put a value on local knowledge. This would support localism and boost the chances of smaller groups getting contracts.’

We therefore welcome the Government's acknowledgement of the need to modernise commissioning in order to achieve the desired 'power shift'. However, we remain concerned about the emphasis on 'opening up markets'. This can often prove very negative for local communities and civil society organisations if repeated in short-term cycles. The value of organisations that have a long-term commitment to a locality is often not recognised, particular in tender processes when larger bidders that can compete on costs will often win the tender round, and then struggle to establish a service because they don't have the local contacts and network that are required to provide effective advocacy (and it's not worth while them investing in developing this, certainly not over the long-term).

Communities are about cooperation and collaboration over the long term and not competition in the short term. The Government and commissioners need to find ways of encouraging and supporting that long-term collaboration in the ways that they commission services, particular in terms of contract specification. This should involve a mix of grants and contracts, perhaps by framing bits of contracts to support providers collaborate with other local organisations and networks (for example, investing in local 'collaborative' infrastructure such as advocacy networks).

We would commend the findings of the study *A Bridge Between Two Worlds*, completed by Reshenia for NAVCA, which thoroughly describes how commissioning should be done intelligently and how support organisations like A4A could be involved.

Our particular concern is that small and medium sized advocacy organisations are excluded by poor commissioning practice and it is commissioners, communities and individuals who lose out. They are often not involved in needs assessment and prioritisation, planning and design stages and monitoring and review stages, let alone procurement. This can result in public services that are not responsive to real community needs and fail to reach disadvantaged and vulnerable groups.

Quantifying full value can be difficult and costly for advocacy organisations where an on-going relationship with a service user to track longer-term outcomes and impact may not be possible or desirable. However, we totally agree that 'Commissioners need to be enabled to think strategically and take a holistic approach to understanding needs and identifying appropriate outcomes and results' (p.18). In respect of independent advocacy, we suggest that commissioners should be reminded that the core function of advocacy services is about addressing inequalities, something which the equalities impact assessment of the Health White Paper states, "will lead to greater efficiencies in the healthcare system as well as promoting and supporting a fairer society". Our publication "Lost in Translation"<sup>1</sup> may help commissioners to understand the issues particular to outcomes recording for advocacy services. We at A4A will continue working to support organisations to better demonstrate their impact.

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<sup>1</sup> Lost in Translation, Action for Advocacy (2009) [http://www.aqv59.dsl.pipex.com/Lost\\_in\\_translation.pdf](http://www.aqv59.dsl.pipex.com/Lost_in_translation.pdf)

We also suggest that the knowledge of advocacy organisations is currently under-utilised in the design and commissioning of other services. Advocacy services help people say what they want, secure their rights, represent their interests and obtain services they need. They offer a unique means to access the voices of people who feel let down by the system and by public services. They can help commissioners to identify needs, design better service specifications and monitor and review services that are put in place, enabling **citizen and community involvement**.

While many advocacy organisations will not wish to bid for contracts to deliver public services, other than advocacy, that fall outside their remit or conflict with their independent role, they still have a key role to play in the commissioning or related health, social care, housing and other welfare services. With adequate funding, they could add great value to commissioning processes – bringing their expert knowledge to the needs assessment, design and monitoring stages and helping to assess bids. We too often find that commissioners exclude local organisations from all stages of the process, based on the mistaken belief that to do so would contravene procurement law. This myth must be challenged by the Government.

Civil society organisations may be able to make a large impact through the new Health Watch structures and we would hope that independent advocacy services will be able to do this as well. An increased ability to be able to report back on issues which advocacy service users have had would be an important step in this regard. Simultaneously, Health Watch must be clear on the nature, role and accepted good practice required in the provision of independent advocacy. HealthWatch bodies must also be confident in their ability to effectively commission this aspect of their brief. Action for Advocacy's resources and quality framework (QPM<sup>2</sup>) will be useful to HealthWatch in this regard.

In terms of the ability of civil society groups to contribute to the uptake of personal budgets, we would suggest that the independent advocacy sector has consistently worked for the opportunities afforded by personal budgets for decades. The ability to materially affect the care and opportunities one has could provide real change for many in our society. However this change is unlikely to happen if individuals are unaware of their rights and choices or are not supported to pursue courses of action that may be outside the standard service delivery model. Those with more profound disabilities and those facing greater discrimination are also significantly less likely to be able to realise the benefits that personal budgets may bring. Independent advocacy needs to be available to help address these inequalities. In fact, the Equalities and Human Rights Commission stated in its report "From Safety net to Springboard" that,

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<sup>2</sup> QPM 2<sup>nd</sup> Edition, Action for Advocacy (2010)

[http://static.actionforadvocacy.org.uk/opendocs/a4a\\_QPM\\_Workbook\\_2nd\\_Edition.pdf](http://static.actionforadvocacy.org.uk/opendocs/a4a_QPM_Workbook_2nd_Edition.pdf)

“Local authorities should make provision, including working in partnership with other agencies or via a budget-holding lead professional to ensure that independent advocacy is made available to those who require it, in particular people with learning disabilities, mental health conditions, dementia or who are on the autistic spectrum.”

We would urge that guidance is provided to commissioners to ensure that funding is available to make independent advocacy available to these groups, outside the personal budgets system.

**Martin Coyle**

Deputy Chief Executive  
Action for Advocacy

## **Appendix: Action for Advocacy's IMHA Commissioning Survey**

The Independent Mental Health Advocacy (IMHA) service came into force in England in April 2009 and has been operating in Wales since November 2008. Another example of the right to advocacy being enshrined in legislation, IMHA is there to provide a safeguard and a voice for those subject to compulsory powers under the mental health act. Given the importance of the service, its backing in legislation and a long established mental health advocacy sector, everything seemed to be in place to make sure that the new service could be commissioned smoothly and appropriately.

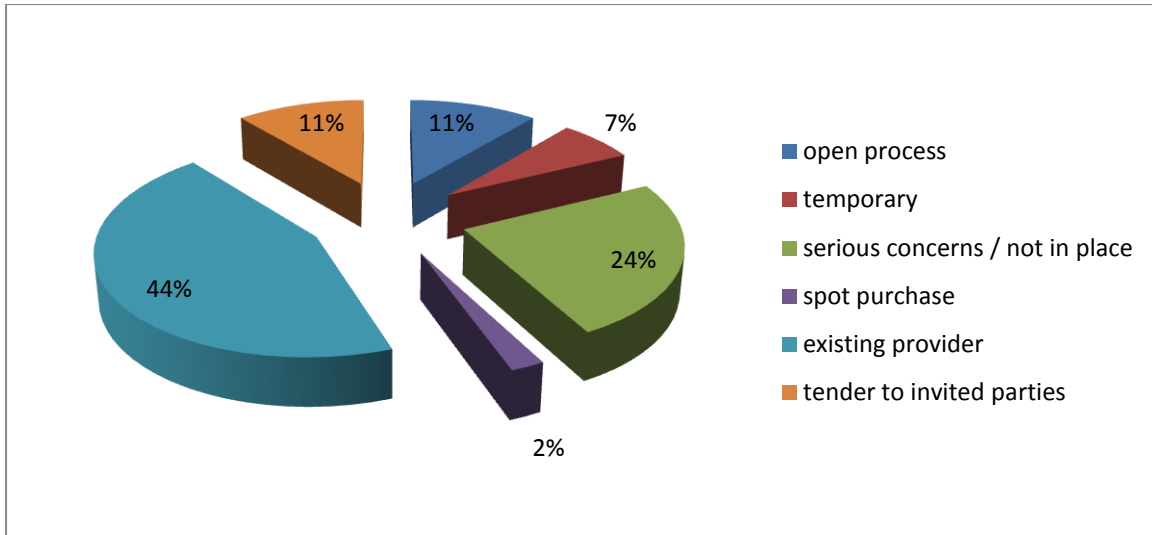
At Action for Advocacy, we started hearing groups expressing concerns about how the process was going in England. In some places people were unsure how the commissioning process was going to operate and couldn't find out the level of funding available. Guidance for commissioners didn't come out until December 2008 and timescales started looking quite tight. Commissioning was to take place at a local level and soon wide differences became apparent across the country. Some commissioners were proactive in negotiating IMHA service specifications, others waited until guidance came out. There were with differences in how clearly commissioners were able to name the amount of money available. In late March and early April we were told of services that were still not in place, where funding had yet to be agreed or where IMHA had been tacked on to existing funding agreements without clear thought about the impact or cost of providing the new service.

In May we launched an online survey in asking advocacy services how IMHA commissioning had gone. We were careful to keep the questions neutral and made it clear that we were looking for both good experiences and bad. 54 respondents told us about the process used, timescales, estimates of demand, impact on other services etc. The respondents included services that provide IMHA (roughly half), those that were unsuccessful bidders and those who chose not to bid.

The results of the survey are striking. One of the questions asked how the contract was awarded. 31% of respondents indicated either that there was no contract in place, the contract was awarded on a temporary basis or that there were serious concerns about the way the process was handled. An example of this latter category was one group that were asked to submit a tender for the contract less than one week before the service was due to go live.

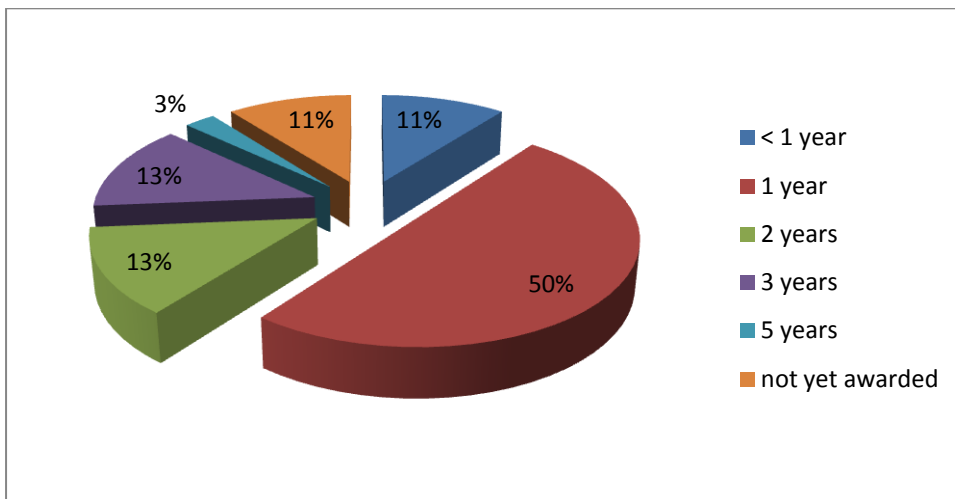
8 respondents indicated that the IMHA service was not operational in their area on the 1<sup>st</sup> of April. In these areas it appears that people have been denied their legal right of access to advocacy. A further 3 respondents said that although the IMHA service was operational there was no contract or funding in place to enable this. In these areas it appears that commissioners have expected advocacy providers to perform a statutory duty on goodwill.

The process used to decide the IMHA provider was variable across the country. Only 11% of respondents described an open tendering process. Nearly half described the contract being awarded automatically to the existing mental health advocacy provider, another 11% described a restricted tender to invited organisations.



**Figure 1 How the IMHA contract was awarded**

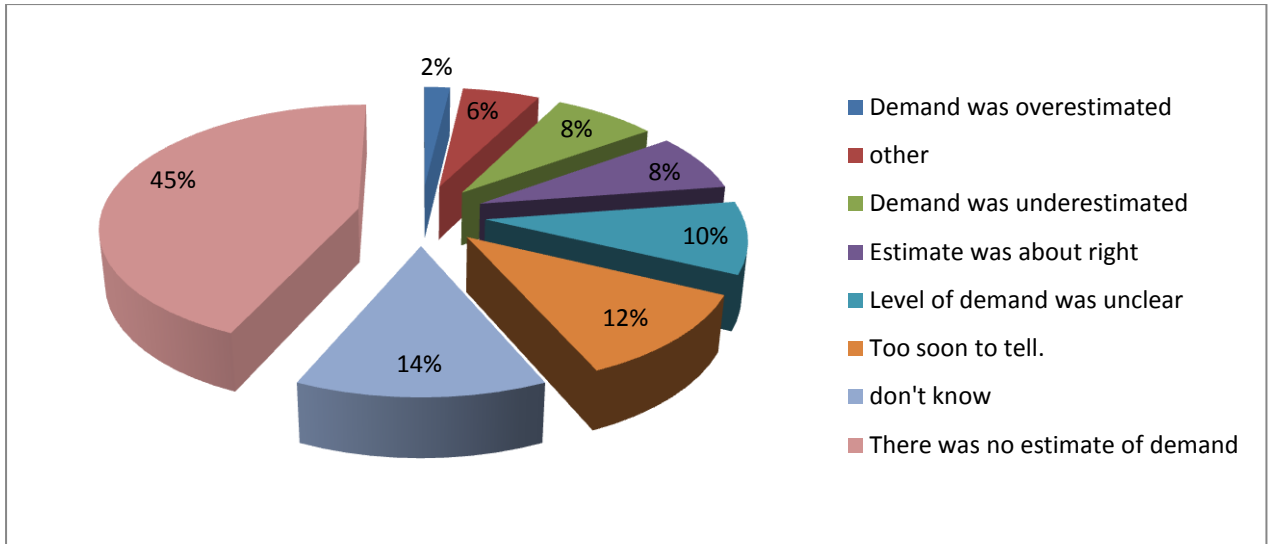
The number of cases in which the IMHA contract was awarded to existing providers may reflect a determination to support existing services or a lack of planning. Looking at the length of contract awarded may throw further light onto this issue.



**Figure 2 Length of IMHA contracts**

Of those respondents who knew the length of the contract, 50% told us that the contract would run for 1 year. In fact, there were more instances of contracts being awarded for less than one year or not at all than there were of contracts of 3 years or more. This does not sound like a huge shout of support for the existing IMHA providers, nor does it appear entirely to reflect expectations from Compact.

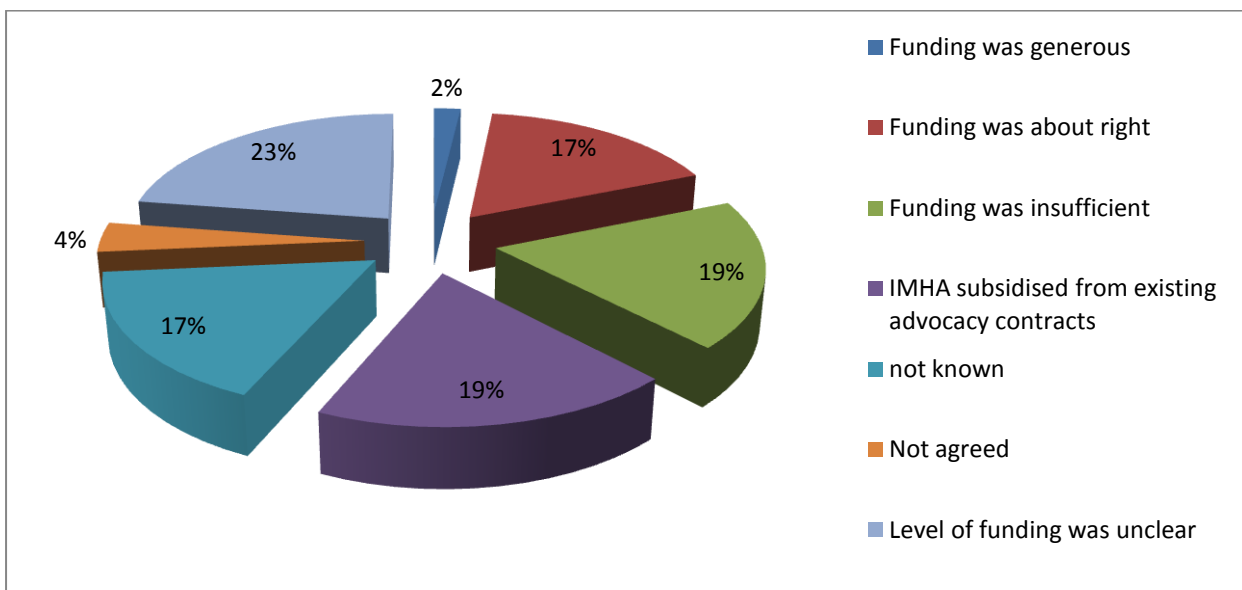
The way in which the level of demand for IMHA was estimated supports the suggestion that commissioning of the IMHA service may not have been exactly “world class”. Given the function of the IMHA service you would expect to see some estimate of demand based on previous use of compulsory powers of the Mental Health Act. Obviously you would not expect a 100% take up rate, but it is clear that publicly available information could be used to shape service specification and funding.



**Figure 3 - Was there a realistic estimate of demand?**

However, 45% of respondents said that there was no estimate of demand and a further 10% said the estimate was unclear. The fact that only 8% of respondents said that the estimate of demand was about right points to a widespread problem in the commissioning process.

It is unsurprising to find that advocacy services were not happy with the level of funding for IMHA. However, it is worrying to see that the level of funding was unclear in nearly one quarter of cases and deeply concerning to see that nearly 1 in 5 respondents have said that they will have to subsidise the IMHA contract from existing provision. Without a clear estimate of demand it is difficult to see how funding levels could have been set appropriately. Without clear levels of funding stated, it is unclear how advocacy services could decide whether or not to bid, or how they can plan recruitment and training budgets.





#### Figure 4. Perceptions of level of funding

It is not all bad news. Some examples of proactive and positive commissioning were found. 19% of respondents reported some positive impact on other mental health advocacy services, whether through recognition or rounding out of coverage. However we can clearly see that something is not right.

A picture emerges of a commissioning process happening late in the day, often with unclear estimates of demand, sometimes with unclear levels of funding and rarely leading to long term contracts. The outcome is that many services are likely to go through another commissioning round this year. Something needs to be different this time if we are to avoid a situation where only 2% of respondents describe themselves as completely satisfied with the process, and 42% are completely unsatisfied.

For the legal rights of those detained under the Mental Health Act to be upheld, IMHA services **must** be commissioned in a way that allows them to plan for the future, ensure capacity to meet demand and facilitate appropriate levels of recruitment, training and supervision. Further, the advance in the right of access to advocacy for some should not come at the expense of those whose access to advocacy may currently reduce the likelihood of becoming subject to compulsory powers.

Action for Advocacy undertook the IMHA commissioning survey to discover if there were any lessons to be learned - positive or negative. It appears that we need to learn quickly. The next round of IMHA commissioning must be clearer about the processes it uses, the timescales from tender to delivery, levels of expected demand and funding available. It needs to be realistic about what infrastructure and training are required to deliver high quality services, the costs of these and the means of monitoring effectiveness. If these lessons are not learned we risk undermining advocacy services, losing control of public money and compromising the rights that the IMHA service is meant to safeguard.