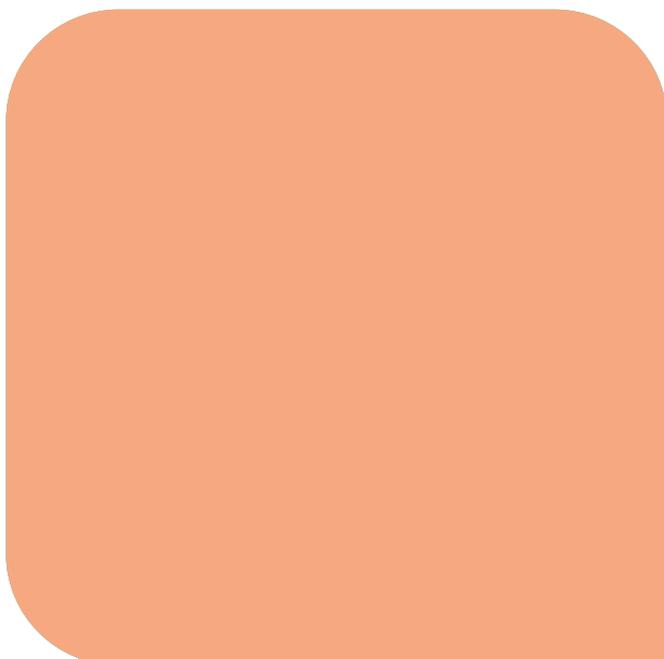




social care
institute for excellence

Care Act 2014: Commissioning independent advocacy (Version 1)



The guide is intended to help commissioning officers in local authorities think through their new duties and understand what they are required to do to comply with the new requirements of the Care Act 2014.

The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

First published in Great Britain in October 2014
by the Social Care Institute for Excellence

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Acknowledgements

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Foreword



The Care Act 2014 has created a single piece of legislation that makes it clear what kind of care and support people should expect.

The Act requires local authorities to change their approach from primarily providing services to promoting people's individual wellbeing. This means thinking about people in the context of their lives and relationships, understanding their views, wishes and feelings and involving them in every decision made about them. In other words, 'Nothing about us, without us'.

In order for this change happen, the Act strengthens the voice of people and their carers throughout the system – from assessment, support planning and review processes, through to safeguarding enquiries or appeals.

At certain times, however, some people may struggle to be fully involved in important decisions about their lives and will need support. It is essential that they have access to independent advocates to assist in this. The Act, for the first time, places a duty on local authorities to make sure that independent advocacy is available for those who need such support and don't have anyone appropriate to provide it.

Access to independent advocacy lies at the very heart of the Care Act. I welcome the Social Care Institute for Excellence's guide as an important contribution to the government's commitment to helping local authorities make sure these duties become a reality.

Good commissioning is about more than ticking a box. It is about complying with duties and targets with the genuine engagement of people who need care and support, as well as providers and voluntary, community and user-led organisations. It also requires a commitment to quality and flexibility in uncertain times. This guide provides clear guidance to new and experienced commissioners alike.

A handwritten signature in black ink, appearing to read 'Michael Bichard', written in a cursive style.

Lord Michael Bichard, Chair of the Board, SCIE

Key messages

- It is important that you clearly understand your legal duties under the Care Act 2014 and prepare for the increased demand this will create for independent advocacy in your area.
- Keep in mind the driving principles of the Care Act: the promotion of wellbeing and the prevention, delay and reduction of the need for care and support.
- You will need to clearly identify and analyse how your local authority meets its existing statutory advocacy duties and ensure maximum cooperation between all commissioned advocacy services to meet the range of duties required.
- Commissioning independent advocacy to meet duties under the Care Act should be informed by good practice in order to secure best value and outcomes.
- Co-production of all commissioning activity – starting from the point of view of people who use services and their carers – will maximise the effectiveness of independent advocacy commissioning.
- When commissioning, you should work in partnership with providers and other stakeholders and encourage collaboration to secure the best use of local capacity and best value for money.
- An ‘equality and diversity’ thread should run through your commissioning activities, ensuring compliance with human rights and equality law.
- Always work closely with other services (health, housing, benefits) and consider joint commissioning arrangements to minimise advocacy ‘silos’.
- Because demand and funding are bound to fluctuate, you need to be flexible about procurement and contractual arrangements. However, it remains essential to set clear expectations for providers and practitioners as part of the process of promoting the independent advocacy duties set out in the Care Act. Remember that trained and capable independent advocates need to be available from 1 April 2015.

Introduction

This guide was commissioned by the joint Programme Management Office (PMO) established by the Care and Support Reform Programme Board to work in partnership to support local areas with the implementation of the Care Act 2014.

The Programme Management Office enables the Board to have appropriate ownership and oversight of the programme as well as supporting implementation by local authorities. The Office includes representation from the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA).

The guide is aimed at commissioners charged with meeting the new duties to provide advocacy under the Care Act 2014. It was developed using a 'scope and search' exercise to identify relevant existing literature in the field of advocacy and commissioning, co-production with potential users of the Care Act and consultation with key stakeholders. It was tested by commissioning teams in the London boroughs of Newham and Islington.

The guide is intended to help commissioning officers in local authorities think through their new duties and understand what they are required to do to comply with the new requirements of the Act. It will be regularly updated as implementation practice emerges.

This is version 1. Send us your comments and examples of how you are developing commissioning arrangements by 21 November 2014 so that we can continue to update and improve this guide.

Please help to make this resource as useful as possible for you by answering the following questions:

- **What format would you like to see the information in?**
- **Does the guide provide useful background, including the duties of the Act?**
- **Are there commissioning activities that have been missed out?**
- **Do you have any examples of interesting practice from your area you'd like to share?**

Please send final comments to info@scie.org.uk by Friday 21 November 2014.

Background

'An advocate is truly independent. They're impartial, they're available, they're reliable, they're person-centred and they're knowledgeable about the sector.'

Co-production workshop participant

This section aims to give you some background about the place of the new advocacy duties in the Care Act 2014.

The Care Act is the most significant reform of social care in more than 60 years, replacing a legal 'patchwork' from successive pieces of legislation dating from the beginning of the welfare state. The Act aims to clarify the duties of local authorities and other bodies and ensure people are aware of what care and support they are entitled to.

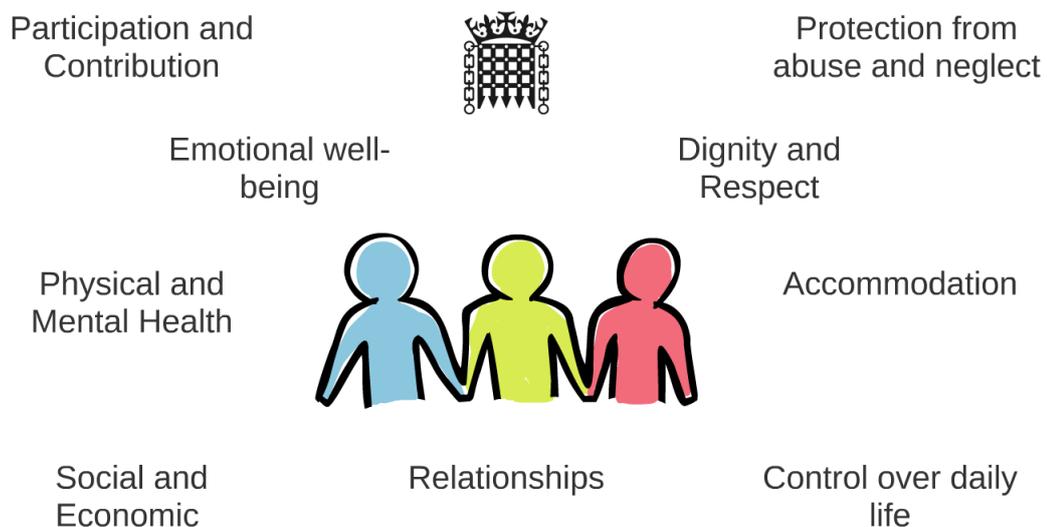
The Act puts a limit on the amount people have to pay toward their care and will place a duty on local authorities to provide deferred payment schemes to prevent individuals being forced to sell their home to pay for care home fees.

The Act sets a national minimum eligibility criteria for access to support, rather than allowing local authorities to decide this for themselves. For the first time, carers will be given rights in law to have their needs assessed and met by local authorities.

Local authorities must offer information and advice to everyone in their area to help them understand their rights, responsibilities and entitlements.

At the heart of the Act are the concepts of **wellbeing** and **prevention**. All actions taken by local authorities under the Act will be driven by their duty to consider the impact of care needs on people's wellbeing, as well as a duty to prevent needs arising and consequently having an increasing effect on that wellbeing.

How does the Care Act Define 'Well-being'?



This means that local authorities will need to refocus their activities from providing 'one-size-fits-all' services to promoting wellbeing by paying attention to people's strengths, personalities and connections with the places they live.

'Choice is important. Choice should be included 'cause people have different opinions and different views, so choice should be included in this.'

Co-production workshop participant

In order for this change in approach to happen, the Act strengthens the voice of people and their carers going through assessment, care and/or support planning and care review processes, as well as those people who are part of a safeguarding enquiry or safeguarding adult review (SAR). From April 2016 (subject to further consultation) the duty to provide advocacy will also apply if an individual makes an appeal against a local authority decision.

Involvement and the Care Act

The Local Authority *must*

Listen to people's views,
wishes, feelings and
beliefs

Assume people are
the best judge of their
own well-being



Ensure the individual can participate as fully as possible in decisions about their care

NOT make unjustified
assumptions based on
their age, appearance, or
behaviour

Local authorities must involve people in decisions made about them and their care and support. **Involvement** requires a local authority to help people understand how they can be involved, how they can contribute and take part and, in some cases, how they can lead or direct the process. People should be active partners in the key care and support processes of assessment, care and support planning, and review (or safeguarding). The **duty to involve** applies in all settings, including in the community and in care homes or prisons (apart from safeguarding enquiries and reviews).

However, some people can have **substantial difficulty** in being involved in the process and do not have an **appropriate individual** to support them in this. If a person meets both these criteria then the local authority must arrange for an **independent advocate** to assist them and their involvement.

Local authorities are preparing for the implementation of the Care Act. Many are expecting an increase in demand for assessments, as more people will want to access the system at an early stage to ensure their costs are capped.

This guide will help you to understand your duties under the Care Act and it is hoped will act as a prompt to activity that will assist you in establishing appropriate services in your local area.

Advocacy duties

This section will explain advocacy duties under the Care Act 2014, other advocacy duties local authorities have, and how they might interact. It is not intended as a replacement for detailed, local, legal analysis of the Act, but to help you get to grips with what commissioners will need to do.

Independent advocacy under the Care Act

Advocacy and the duty to involve

Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

When does the advocacy duty apply?

The advocacy duty will apply from the point of first contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding adult review. If it appears to the authority that a person has care and support needs, then a judgement must be made as to whether that person has **substantial difficulty** in being involved. If they do, is there an **appropriate individual** to support them? An **independent advocate** must be appointed to support and represent the person for the purpose of assisting their involvement if these two conditions are met and if the individual is required to take part in one or more of the following processes described in the Care Act:

- a needs assessment
- a carer's assessment
- the preparation of a care and support or support plan
- a review of a care and support or support plan
- a child's needs assessment
- a child's carer's assessment
- a young carer's assessment
- a safeguarding enquiry
- a safeguarding adult review
- an appeal against a local authority decision under Part 1 of the Care Act (subject to further consultation).

Judging 'substantial difficulty'

Local authorities must consider, for each person, whether they are likely have substantial difficulty in engaging with the care and support process. The Care Act defines four areas in any one of which substantial difficulty might be found. These are:

- understanding relevant Information

- retaining information
- using or weighing information
- communicating views, wishes and feelings.

Who is an ‘appropriate individual’ to assist a person’s involvement?

‘If the person being supported doesn’t want that person to support them, that’s not an appropriate adult. You can’t force an advocate on someone.’

Co-production workshop participant

Local authorities must consider whether there is an appropriate individual who can facilitate a person’s involvement in the assessment, planning or review process, and this includes four specific considerations. The appropriate individual cannot be:

- already providing care or treatment to the person in a professional capacity or on a paid basis
- someone the person does not want to support them
- someone who is unlikely to be able to, or available to, adequately support the person’s involvement
- someone implicated in an enquiry into abuse or neglect or who has been judged by a safeguarding adult review to have failed to prevent abuse or neglect.

The role of an ‘appropriate individual’ under the Care Act is potentially fuller and more demanding than that of an individual with whom it is ‘appropriate to consult’ under the Mental Capacity Act (MCA). Under the Care Act the appropriate individual’s role is to **facilitate** the person’s involvement, not merely to be consulted about it.

Sometimes the local authority will not know at the point of first contact or at an early stage of the assessment whether there is someone appropriate to assist the person in engaging. As a result, an advocate may be appointed only for it to be discovered later that there is an appropriate person available. The appointed advocate can at that stage ‘hand over’ to the appropriate individual. Alternatively, the local authority may agree with the person, the appropriate individual and the advocate that it would be beneficial for the advocate to continue their role, although this is not a specific requirement under the Care Act. Equally, it is possible that the local authority will consider someone appropriate who may then turn out to have difficulties in supporting the person to be involved in the process. At that point arrangements for an independent advocate must be made.

Information and advice

The Care Act places a duty on local authorities to ensure that all adults in their area have access to information and advice on care and support, and keeping safe from abuse and neglect. Prior to making contact with the local authority, there may be some people who require independent advocacy to access information and advice. This need should be built into any analysis of demand that you make.

Continuing health care

The advocacy duty in the Care Act applies equally to those people whose needs are being jointly accessed by the NHS and the local authority, or where a package of support is planned, commissioned or funded by both a local authority and a clinical commissioning group (CCG), known as a 'joint package' of care. Historically this arrangement has often been difficult for people who use services, their carers and friends to understand and be involved in. Local authorities and clinical commissioning groups will therefore want to consider the benefits of providing access to independent advice or independent advocacy for those who do **not** have substantial difficulty and/or those who have an appropriate person to support their involvement. Effective joint commissioning arrangements would involve:

- dealing with the person holistically, providing a seamless service and avoiding duplication
- reducing communication breakdown
- the involvement of the person, their family and carers
- effective partnership working between health and social care, addressing needs together
- improved communication and continued care to achieve joint outcomes.

Independence

The independence of the service is an important consideration for all commissioners. For services to be meaningful and acceptable to those they are designed to support they must have the confidence of individuals, carers and the public. Anything compromising that independence could easily undermine confidence.

The Care Act regulations for independent advocacy are clear: providers of advocacy must be independent of the local authority, with their own constitution, code of practice and complaints procedure. Advocates under the Care Act will be managed by, and primarily accountable to, the advocacy organisation that recruits and employs them, thereby maintaining their independence from the local authority.

Exceptions

There are times when an independent advocate should be provided for a person who has substantial difficulty even though they have an appropriate individual (family member, carer or friend) to support them. These are:

- where a placement is being considered in NHS-funded provision in either a hospital (for a period exceeding four weeks) or in a care home (for a period of eight weeks or more), and the local authority believes that it would be in the best interests of the individual to arrange an advocate
- where there is a disagreement between the local authority and the appropriate person whose role it would be to facilitate the individual's involvement, and the local authority and the appropriate person agree that the involvement of an independent advocate would be beneficial to the individual

Prisoners

From April 2015 local authorities will also be responsible for assessing and meeting the social care needs of adult prisoners (not just on discharge from prison but also while in custody). All prisoners will be treated as if they are resident in that area for the purposes of the Care Act and for as long as they reside in that prison. Prisoners will be entitled to the support of an independent advocate in the same circumstances as people in the community. You should therefore work with custodial managers to ensure there is a sufficient supply of advocates for this environment. Local authority areas containing prisons should build this into their plans for meeting the requirements of the Act.

Training

Once appointed, all independent advocates under the Act should work towards the National Qualification in Independent Advocacy (City & Guilds, level 3) within a year of being appointed, and achieve it in a reasonable amount of time thereafter. The qualification is competency-based. To successfully complete the four core units (301–304) candidates are required to provide evidence of real work practice.

In addition, given the role of the advocate under the Care Act and the close relationship with the Mental Capacity Act and independent mental capacity advocacy (IMCA), you may wish to encourage advocates to complete unit 305 (providing independent mental capacity advocacy) and unit 310 (Deprivation of Liberty Safeguards).

In addition to completing the Independent Advocacy qualification, providers should be expected to ensure that all independent advocates have access to further relevant training. This may cover:

- good practice in safeguarding adults
- non-instructed advocacy
- care and support planning (or person-centred planning)
- good practice in challenging decisions or the decision-making process effectively
- supported decision-making (how to effectively support an individual who is experiencing difficulty with decision-making).

For more detailed guidance, please see the [Care and Support Statutory Guidance](#)

Other statutory advocacy duties

Local authorities have a number of other statutory duties to ensure access to advocacy which are described below. You should work closely with colleagues in assessment and care management as well as accessing legal advice to gain a full understanding of these duties and how they interact.

The Mental Capacity Act 2005

‘Both the Care Act and the Mental Capacity Act recognise the same areas of difficulty, and both require a person with these difficulties to be supported and represented, either by family or

friends, or by an advocate in order to communicate their views, wishes and feelings.'

Care and Support Statutory Guidance

The right to an independent mental capacity advocate was introduced by the Mental Capacity Act 2005. The Act gives some people who lack capacity a right to receive support from an independent mental capacity advocate.

Local authorities have commissioned independent mental capacity advocacy services in England. Responsible bodies, the NHS and local authorities all have a duty to make sure that independent mental capacity advocates are available to represent people who lack capacity to make specific decisions, and so any staff affected will need to know when an independent mental capacity advocate needs to be involved.

For further information see: <https://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf>.

The Mental Health Act 2007

Independent mental health advocacy services were introduced to safeguard the rights of people detained under the Mental Health Act 2007 and those on community treatment orders (CTOs). Independent mental health advocates (IMHAs) aim to enable qualifying users to participate in decisions about their care and treatment.

An independent mental health advocate is a statutory advocate, granted specific roles and responsibilities under the Mental Health Act. Their is to assist qualifying patients understand the legal provisions to which they are subject under the Mental Health Act 1983 and the rights and safeguards to which they are entitled. They also assist qualifying users to exercise their rights by supporting participation in decision-making.

People are eligible to use independent mental health advocacy services in England if they are:

- detained under the Mental Health Act 1983 (excluding people detained under certain short-term sections)
- conditionally discharged restricted patients
- subject to guardianship
- subject to CTOs.

People who are being considered for treatment requiring consent and/or a second opinion may also qualify for independent mental health advocate assistance.

The Health and Social Care Act 2012

The NHS Complaints Advocacy Service (NHS CA) was set up in April 2013, replacing the Independent Complaints Advocacy Service (ICAS), which provided support to people wishing to make a complaint about the NHS. This service was centrally commissioned by the Department of Health on a regional basis, but the new service is now commissioned by local authorities individually or in cooperation with others.

The service aims to provide support to people who want to make a complaint about the NHS, and need some support to do this. Support may range from receiving a self-help pack, information and options, to support from an advocate, depending on needs.

How do these duties interact?

Independent advocacy under the duty imposed by the Care Act 2014 is similar in many respects to independent advocacy under the Mental Capacity Act. Regulations have been designed to enable independent advocates to carry out both roles. However, the duty to provide independent advocacy under the Care Act is broader and applies in a wider set of circumstances, providing support to:

- people who have capacity but have substantial difficulty in being involved in the care and support process
- people in relation to their assessment and/or care and support planning regardless of whether a change of accommodation is being considered for the person
- people in relation to the review of a care and/or support plan
- people in relation to safeguarding processes (though independent mental capacity advocates may be involved if the authority has exercised its discretionary power under the Mental Capacity Act)
- carers who have substantial difficulty in engaging, whether or not they have capacity
- people have someone who is appropriate to consult for the purpose of best interests decisions under the Mental Capacity Act, but where that person is not able or willing to assist with advocacy in any other capacity.

There are likely to be people who qualify for advocacy under the Care Act but not for an independent mental capacity advocate. However, most people who qualify for independent advocacy under the Mental Capacity Act will also qualify for independent advocacy under the Care Act. To enable a person to receive seamless advocacy and not to have to repeat their story to different advocates, the same person can provide support in both roles, provided they are trained and qualified to do so.

If someone has previously had access to an IMHA and is being jointly assessed by the NHS and local authority (often under what is called a Care Programme Approach), they should be considered for an advocate under the Care Act, if they have substantial difficulty in being involved and if there is no appropriate person to support their involvement.

Local authorities do not have to commission one organisation to provide the different types of advocacy but, over time, there may be advantages to this.

The Care Act extends the range of situations and people to whom there is a duty to make advocacy available. Nothing in the Act prevents advocacy being provided in other circumstances.

Advocacy: inclusion, empowerment and human rights

I think advocacy is something about rights. I think it's about people knowing what their rights are and having access to that information and the advocate feeling that they have a role in which they're being heard and have some strength in the wider discussion. People have a right to have their voices heard to the end of their lives.'

Co-production workshop participant

This section is informed by SCIE research and the input of people who use services and carers. We've also identified some principles of good practice that can enable commissioners to better understand and specify relevant services. It is also intended to give less experienced commissioners a short introduction to advocacy.

Principles

Advocates are independent of services and represent people's interests as if they were their own. Independent advocacy should be available to everyone who needs it, regardless of his or her age, gender, disability, sexuality or ethnicity.

Advocacy promotes equality, social justice, social inclusion and human rights. It aims to make things happen in the most direct and empowering ways possible. It recognises that self-advocacy – whereby people, perhaps with encouragement and support, speak out and act on their own behalf – is the most empowering form of advocacy. This is the goal which underpins all forms of high quality advocacy, as emphasised in the **'Advocacy Code of Practice'**.

Types of advocacy

'It seems that local authorities have advocacy services for people with learning difficulties, people in the mental health system and so on, and one of the things that I think is really worrying is that people are not just experiencing an individual impairment or illness, they've often got two or three things that are very important and it's understanding that holistic approach to what they might need and how they might need supporting.'

Co-production workshop participant

There are many different types of advocacy, including:

- self-advocacy
- group advocacy
- peer advocacy
- citizen advocacy
- professional advocacy

- non-instructed advocacy.

Self-advocacy

'I have seen in my many years working in self-advocacy that when people with learning difficulties move into self-advocacy they can move away from the family because they start to have more of a voice.'

Co-production workshop participant

Self-advocacy refers to an individual's ability to effectively communicate his or her own interests, desires, needs and rights. It recognises that people are experts by experience and involves them in speaking out for themselves about the things that are important to them. It means that people are able to ask for what they want and need and to tell others about their thoughts and feelings.

The goal of self-advocacy is for people to decide what they want and to carry out plans to help them get it. Self-advocacy differs from other forms of advocacy in that the individual self-assesses a situation or problem and then speaks for his or her own needs. The ultimate aim of all forms of advocacy should be to support people to self-advocate as far as they are able to.

Group advocacy

Group advocacy involves people with shared experiences, positions or values coming together in groups to talk and listen to each other and speak up collectively about issues that are important to them. These groups aim to influence public opinion, policy and service provision. They vary considerably in size, influence and motive. Representatives of local groups are often included on planning committees and involved in the commissioning and monitoring of health and social care services.

Peer advocacy

Peer advocacy refers to one-to-one support provided by advocates with a similar disability or experience to a person using services. Trained and supported volunteers often provide peer advocacy as part of a coordinated project. Peer advocacy schemes argue that they are particularly well placed to empathise with the needs of people, to approach them as their equals and to feel strongly about, and fight hard for, their needs.

Citizen advocacy

Citizen advocacy aims to involve people in their local community by enabling them to have a voice and to make decisions about the things that affect their lives. Citizen advocacy partnerships are long term, not time-limited, and last for as long as the citizen advocate and the individual want them to. Citizen advocates are ordinary members of the local community. They are unpaid and usually operate with support from a coordinated scheme.

Professional advocacy

Paid independent advocates support and enable people to speak up and represent their views, usually during times of major change or crisis. Such advocacy is issue-based and the advocate may only need to work with the person for a short time.

Non-instructed advocacy

Non-instructed advocacy supports people who have found themselves unable to articulate to an advocate what it is that they want the advocate to do. Non-instructed advocacy is often provided to people who appear to need support to have their rights respected and live a fuller life without any professional referral.

There are four recognised approaches to non-instructed advocacy and providers should endeavour to integrate them all when providing support:

- rights-based approach – we all have certain fundamental human rights that can be defined and measured
- person-centred approach – based on the development of long term, trusting and mutually respectful relationships between advocates and people
- watching brief approach – placing the person at the centre of thinking about the best way to support them
- witness/observer approach – in which the advocate observes or witnesses the way in which a person leads his or her life.

It is important to remember that an individual's capacity to be involved in decision-making or to instruct an advocate may fluctuate. This provides a further argument in favour of a whole-systems approach to advocacy, which maximises the chances of continuity of support.

Advocacy principles and standards

Co-production

Co-production means that what you have to say as a service user is just as important as what other people have to say about the service you receive.

Co-production workshop participant

Guidance on market-shaping and the commissioning of care and support in relation to the Care Act 2014 states that local authorities should take a co-production approach to market-shaping and commissioning.

Quality advocacy services are person-centred and developed using a co-production approach that aims to maximise the participation of people who use services and their carers. Co-production means delivering services based on an equal and reciprocal relationship between users, carers and professionals, and results in the provision of support that meets individual needs.

Equality and diversity

Advocacy projects should be able to meet the needs of diverse local populations.

Publically funded advocacy providers must comply with the public sector equality duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people who share a 'protected characteristic'.

The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation.

For further information on complying with the public sector equality duty please see the Equality and Human Rights Commission (EHRC) [guidance](#).

The eight quality areas

The advocacy **Quality Performance Mark (QPM)** is a robust, quality assessment and assurance system for providers of independent advocacy. It is a tool used to benchmark independent advocacy services against a framework. The eight key quality areas that form the Mark are as follows.

Independence

The Quality Performance Mark framework is designed for use by providers of independent advocacy. It is the independence of advocacy that allows services to be led by and responsible to the client. Research shows that independence is one of the key attributes that people coming to advocacy services are looking for.

Clarity of purpose

It is essential that everyone knows what they can expect from an advocacy service. Providing clarity helps in the following ways:

- users can evaluate the support they receive
- advocates are clear about their role and its boundaries
- it is easier for appropriate referrals to be made, and to ensure that funding intended for independent advocacy is used in precisely that way.

Confidentiality

Confidentiality is a cornerstone of independent advocacy. It establishes a relationship of trust that enables people to tell their stories and explore the options available to them. However, confidentiality should not be a barrier to the supervision and support of advocates.

It is essential that services have a clear confidentiality policy which is regularly reviewed. It is equally important that people who come to the advocacy service are given clear information about what confidentiality means and the circumstances under which it will not be possible to maintain confidentiality.

Safeguarding

An additional set of indicators relating to safeguarding has been added to the latest edition of the Quality Performance Mark. This was necessary following the abuse and neglect at the Winterbourne View and Mid-Staffordshire hospitals, to ensure that advocacy providers and advocates are suitably knowledgeable and experienced in identifying safeguarding issues.

Empowerment and putting people first

Advocacy services need to be focused on the person they are working with. One way of achieving this is to ensure that people who do, or may, use the advocacy service have meaningful influence over the direction of that service.

As advocacy is about increasing the amount of control that people have over their own lives, advocacy services need to ensure they are working in a way that fosters independence. It is important to create a culture that promotes individual empowerment and to develop methods to determine outcomes with clients and measure the effectiveness of the advocacy relationship.

Equality, accessibility and diversity

As well as complying with equality legislation (Equality Act 2010 in particular), it is expected that advocacy services take proactive steps to ensure equitable and easy access to them. Having equal opportunities policies is only part of the process. Proactive efforts must be made to implement such policies, remove barriers and deliver accessible and equitable services.

Accountability and complaints

Advocacy services must be held accountable for the work they do and the way they use the funding they receive. Different stakeholders can hold advocacy services to account in different ways. Funders should be able to see that money is being spent wisely by assessing the effectiveness of the advocacy service. The service should be accountable for meeting the needs of its local community, its legal responsibilities and adhering to agreed advocacy principles. Just as importantly, individuals should be able to expect a high quality service and should have a clear and accessible route for complaints if they are unhappy with the service provided. This must include independent support for complainants.

Supporting advocates

Policies, procedures and organisational structure count for nothing if the people delivering advocacy are not adequately trained or supported. Providing training for advocates and ensuring adequate and appropriate supervision is essential if services are to retain skilled advocates and ensure high quality advocacy for people who need it.

Getting started

To meet their duty under the Care Act, local authorities will need to have a service in place that provides for 'qualifying people' in their area to access independent advocacy.

Begin by linking preparations for new advocacy duties with those for the Care Act overall:

- make advocacy a central part of your preparations, and ensure your authority is not underestimating the impact this may have and that appropriate funding will be available
- ensure preparation of the workforce includes awareness of new advocacy eligibility (including provider staff)
- be clear about pathway for referral and ensure the new duties are embedded into assessment, care planning, review and safeguarding processes, IT systems and forms

Then review existing provision:

- this should include any existing contractual arrangements for independent mental capacity advocacy, independent mental health advocacy, NHS complaints advocacy and any non-statutory advocacy – where this is practicable this process should encompass health, housing and benefits
- discuss the performance of existing providers with lead commissioners and contract managers
- consider (with contract and procurement colleagues) how existing arrangements might be modified to include activity under the new duty
- If you are planning a procurement exercise, make sure it is proportionate and flexible, enabling enough time for the successful bidders to recruit and train staff

And plan for analysing demand for Care Act advocacy:

- in line with demand analysis for assessments, estimate the potential increase in demand for advocacy under the Care Act (see 'Commissioning tasks' in this guide for more information)
- test your assumptions by closely monitoring demand for advocacy throughout the system from April 2015 and begin the analysis stage of the commissioning cycle for a longer-term solution to meet demand
- prepare for the steady growth in demand for the service, as well as a potential 'spike' in demand for advocacy from April 2016, when the funding reforms come into force

Commissioning: good practice

'I think sometimes we can get too stuck on, "Okay, we've commissioned a contract for this through IMCA, commissioned a contract for IMHA, got one for NHS complaints advocacy and now we've got one for Care Act advocacy." We want to encourage people to think creatively about the different duties.'

Co-production workshop participant

This section aims to provide an overview of good practice in commissioning. It draws on work from:

- the Institute for Public Care, Oxford Brookes University
- the Institute of Local Government Studies, University of Birmingham
- the Care Act and Care and Support Statutory Guidance

What is commissioning?

'When we say commissioning, we don't always mean buying a new service, but what it might be is looking at a number of different options to fill the demand that might come along with these new duties.'

Co-production workshop participant

'Commissioning' is a broad concept with competing definitions. For our purposes, it represents a systematic approach to planning and resourcing public services. The aim of all social care commissioning activity by local authorities is to achieve the best possible outcomes for the community as a whole and for individuals who require care and support.

This includes people who may need care and support at some time in the future. Commissioning should ensure that there are personalised approaches to meeting people's needs, in all services and settings. It must also achieve best value and comply with legislation.

A useful definition is provided in the coalition government's **'Modernising commissioning'** Green Paper:

'The cycle of assessing the needs of people in an area, designing and then achieving appropriate outcomes. The service may be delivered by the public, private or civil society sectors.'

‘Commissioning for better outcomes’ defines commissioning as:

‘A dynamic process to design, specify and procure services to deliver personalised outcomes that build on personal, social and community assets, and enhance capability, independence and promote equality, co-produced with social care users and their carers in a strategic partnership with health and housing organisations and in collaboration with providers.’

The Care Act presents local authorities with a number of challenges in relation to commissioning advocacy services, not least ensuring there is enough provision to meet current and future demand, along with making sure that advocacy services can be aligned and developed with other ongoing developments in assessment and review.

While there are many models of commissioning and purchasing available, they all fundamentally break down into four key areas (illustrated below):

- **analyse** – understand the values and purpose of the agencies involved, the needs they must address and the environment in which they operate
- **plan** – identify the gaps between what is needed and what is available, and decide how these gaps will be addressed
- **do** – secure services and ensure they are delivered as planned
- **review** – monitor the impact of services and ensure any future commissioning activities take the findings of this review into account.

Importantly, commissioning and procurement are closely linked and the commissioning activities highlighted in the outer circle below must inform the ongoing development of procurement activities (as illustrated in the inner circle).



Each set of activities are grouped against the four elements of the commissioning cycle and are equally important, and these must be equitable and transparent – offering opportunities for all stakeholders to influence the types of service provided.

The Care Act: market shaping and commissioning

The Care Act itself does not specifically mention commissioning, but it is included in the vocabulary of the statutory guidance ‘Market shaping and commissioning’ and is seen as a core part of implementing the changes proposed by the Act.

The Care Act promotes the following commissioning principles:

- focusing on outcomes and wellbeing
- promoting quality services, including via workforce development and remuneration and ensuring appropriately resourced care and support
- supporting sustainability
- ensuring choice
- co-production with partners.

For some commissioners, Care Act advocacy services will be commissioned separately from other types of advocacy. Others may want to use the Care Act as an opportunity to

review all advocacy services within their area, and to develop a wider strategy around how best to meet the needs of their local population.

Standards for good commissioning

Here we reproduce the key principles of good commissioning identified by the Commissioning for Better Outcomes' programme at the University of Birmingham in partnership with Think Local Act Personal.

Good commissioning:

Is person-centred and outcomes-focused:

- promotes health and wellbeing for all
- delivers social value.

Is inclusive:

- is co-produced with people and their communities
- promotes positive engagement with providers
- promotes equality.

Is well-led by local authorities:

- demonstrates a whole-system approach
- uses evidence about what works.

Promotes a diverse and sustainable market:

- ensures diversity, sustainability and quality of the market
- provides value for money.

Commissioning tasks

This section seeks to enable local authorities to think through the commissioning tasks that will help them to ensure that good quality advocacy will be available for all adults who are entitled to it under the provisions of the Care Act.

It can be used in conjunction with the **commissioning self-assessment tool** to help commissioners think through where they are now and what they need to do.

Analyse

Collect and analyse information to understand current and future demand for advocacy under the Care Act.

Work closely with colleagues (researchers, public health, project leads, etc.) to gather information about the likely demand for independent advocacy under the new duties.

This could include data on population projections such as your local joint strategic needs assessment or national databases such as **POPPI** and **PANSI**.

The duties of an advocate under the Care Act are also more robust than other kinds of specific engagement. They focus more on enabling involvement, and this in turn may require more time and hence resources.

Analysis should also consider any proposed changes in the assessment and care management pathway for people with social care needs (including children in transition to adulthood), and **carers**, along any increased engagement with **self-funders**, and the likely impact this may have on the uptake of advocacy services.

The analysis should take into account the increase in demand on the system that will accompany the implementation of funding reforms, as well as the likely increase in demand as people become more aware of their rights under the Act. A good starting point is the government's **impact assessment** of the reforms.

You should review current advocacy provision and uptake, considering:

- who currently uses advocacy services
- what local people understand about advocacy services and the potential benefits
- the barriers people currently experience in accessing care, which may best be addressed through improved access to advocacy
- the types of advocacy services people want and need
- how people currently access services
- how they might choose to access services in the future
- what people consider to be a good local advocacy service which meets their needs.

You should analyse potential demand for Care Act advocacy in conjunction with preparations for the potential increase in demand for needs and carers assessments in line with the new duties under the Act.

The Local Government Association provides some useful tools for understanding the costs of the reforms overall. See: http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/6403229/ARTICLE.

In addition, the impact assessment for the Care Act sets out the anticipated national costs associated with access to independent advocacy under the Act:

Year	15/16	16/17	17/18	18/19
Total recurring costs	14.5m	34.6m	49.5m	67.1m

These costings were based on the expected numbers of needs assessments, carers assessments and reviews and applied specific assumptions to the expected numbers having a right to and take-up of advocacy, based on the experience of existing advocacy provision. For more information see:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317817/ConsultationIA.pdf.

The overall national costings and the model used in the impact assessment when applied to local figures may assist you in getting a sense of the scale of potential demand. You may want to test this locally by undertaking a review of recent assessments/reviews and applying the Care Act provisions to them.

Modelling should be based on your understanding of how these variables will affect each area. You might consider auditing a small sample of assessments, making a judgement about their need for advocacy in light of the changes, then extrapolating these findings. A judgement could then be made about what proportion of assessments post April 2015 and 2016 will require advocacy.

This modelling exercise should include analysis in conjunction with any proposed redesign of the assessment and care management regime in response to the duties under the Care Act.

Seek out and reflect on research and best practice evidence to understand the quality of services and decide what mix of services will meet local needs.

Seek out best practice in the form of quality standards including:

- ‘Quality standards for independent advocacy’
<http://www.qualityadvocacy.org.uk/>
- The ‘Advocacy Charter’
http://www.ndti.org.uk/uploads/files/Advocacy_Charter.pdf
- The ‘Advocacy Code of Practice’
<http://www.aqv59.dsl.pipex.com/Code%20of%20Practice%20booklet.pdf>

Refer to the SCIE [resources on advocacy](#). This type of reflection on good practice in advocacy should assist you in specifying the type of service most appropriate to meet post-Act demand in your area. It may also help you identify good practice that is already taking place.

Understand the resources available to meet your advocacy duties under the Care Act and project future financial commitments based on likely demand.

As a commissioner of independent advocacy under the Act you should ensure all plans are linked with overall departmental and corporate aims in relation to preparations for Care Act implementation. Implementation plans should begin with an analysis of demand (as described above) and commit appropriate resources to ensure compliance with the Act.

Benchmark the costs of commissioning plans and discuss this with commissioners from comparable councils.

Communicate with comparable local authorities to benchmark demand analysis and resource allocations. Consider seeking support from representatives of different councils through the Local Government Association and the Association of Directors of Adult Social Services in order to identify potential partner authorities.

Develop systematic processes of co-producing commissioning.

Refer to SCIE's [guide to co-production](#).

Commissioning, purchasing and monitoring activity should be developed alongside users and potential users of services to ensure that the supply of advocates meets local need effectively.

Seek to understand current levels of supply including what currently works well, and where there is over- and under-supply of services.

Review what happens locally and seek to understand what works well now and how this could be expanded if required.

Map current provision and uptake of services against the current level of demand and the service user pathway to understand fluctuations and barriers to accessing advocacy services.

Analyse and explore the impact of any changes to advocacy services on users, and seek to understand the implications of any changes in line with the Equalities Act 2010.

Analyse the performance and demand of existing advocacy provision in your local authority area.

Consider the performance of existing advocacy services in your area (statutory and non-statutory). In light of this analysis, you may decide to review the provision of all services and consolidate them into one contractual arrangement

Plan

Develop a clear, written strategy and agree outcomes for the provision of advocacy to meet Care Act duties that signal your future commissioning intentions for the local area.

Integrate the collection and analysis of demand information, good practice, financial resources, benchmarked costs, co-production and involvement plans as well as a wider analysis of advocacy in the local area to develop a clear commissioning strategy and/or plan.

Agree, through a process of engagement with existing and potential providers, as well as local people who use services, a clear strategy setting out legal duties and intentions for the future of independent advocacy provision under the Act. Consider situating the service as part of the wider provision of advocacy in your area.

Be clear about the risks of not complying with the Care Act or underestimating the possible increase in demand for advocacy services. Review contracting options and consider the use of outcomes-based service specifications which enable more flexible purchasing arrangements with providers. You may want to consider:

- arrangements in which an expected minimum level of support to individuals and core services (including awareness-raising), and commensurate level of funding, is specified together with additional funding as demand increases
- arrangements for flexibility between different elements of advocacy provision, where these are combined, to allow for peaks and troughs
- arrangements whereby awareness-raising and service delivery are balanced: in the early stages time can be spent on the former to enable your local authority to meet its duties
- joint commissioning arrangements with NHS colleagues, and with children's services.

Facilitate dialogue with key stakeholders and potential providers in order to build consensus on the implications of the commissioning plans for your area.

Develop mechanisms for ongoing dialogue with local partners (including the NHS and related local authority services) and existing and potential providers. These mechanisms might include forums, individual discussions, 'meet the buyer' events and feedback through email or online chatrooms.

It is important to involve potential providers at an early stage of the process. They will provide insight and constructive challenges to your plans.

Develop business cases for the commissioning of advocacy in line with the Care Act duties.

Using your needs analysis, model a range of options which will offer a good mix of advocacy services for your area (including maintaining the status quo). Review existing contracts to see how well they align with these models. Seek to understand the financial implications of each model.

Work with decision-makers to ensure they understand the significance of the changes in the Care Act. Be clear about possible business risks and costs of non-compliance. Develop evidenced cases to present to senior staff and politicians.

Ensure that advocacy forms a key part of the business case and financial planning for overall Care Act implementation.

Develop a person-centred approach to commissioning advocacy services, which enables local people to contribute to the design of services and maximises control over services once they are established.

Ensure your plans and strategies prioritise the ability of people to choose appropriate and proportionate support at each stage of their care pathway. Establish a clear link with your strategy for implementing Care Act duties to provide information and advice under the Care Act.

Ensure that any potential implications of new services have been analysed in line with the requirements of the Equality Act 2010.

Develop strategies for communicating commissioning issues with a range of stakeholders.

Ensure new advocacy entitlements are clearly linked with corporate and departmental communication plans for Care Act implementation. Be clear and consistent about messages to citizens, providers and staff about the process and timescales for commissioning the new service.

Do

Develop a clear picture of the range of potential providers in your area: their strengths, weaknesses and future plans.

Consider developing an understanding of potential providers through:

- market testing/'meet the buyer' events
- involving users of existing advocacy services
- site visits
- provider questionnaires.

Influence the local market for advocacy to develop services in line with your population needs, rather than the historical awarding of contracts.

Engage in regular and productive dialogue with providers which encourages consensus and partnership-orientated relationships

Using the above mechanisms, work with providers to ensure diversity of available services and encourage collaboration where possible to develop the market. Work with service users, potential service users and providers to design services which meet the needs identified in the earlier analysis.

Build any plans for commissioning advocacy services into market position statements and work with providers to understand the market and the potential challenges your commissioning plans present.

Consider encouraging the development of partnerships between larger organisations and smaller, local ones. This could be developed through peer-to-peer evaluation and support or more formal consortium arrangements.

Develop service specifications and contracts that are flexible, evidenced-based, specific about what is required from the provider (or providers) and outcome-focused.

Be clear about the legal requirements for providers (see the sections 'Background' and 'Advocacy duties' in this guide). Consider and specify the requirements for organisations or consortiums to enable them to deliver this service and ensure compliance with your legal duties.

Consider the level of training and expertise individual advocates must have in relation to the wide range of processes through which they will need to support people. You should ensure that contracts allow for sufficient time and adequate arrangements for staff training and support, along with continuing professional development

Specify the funding model for the service, considering the expected growth in demand over the life of the contract and your analysis of demand and available resources. Ensure flexibility and funding stability for providers. Carefully specify the expected outcomes, developed locally with key stakeholders, including potential users of services. Specify a mechanism for ensuring the independence of the service – it is good practice to identify the means of safeguarding independence in funding agreements and contracts. This would include, for example:

- Having a clear system for resolving disputes which could be included in an engagement protocol. For example, this could allow the service to raise issues in relation to independent advocacy referral at a senior level within the local authority.
- The commissioning authority not being involved in any matters of staff deployment or discipline. This would include not trying to determine whether a particular advocate does or does not support and represent a specific individual.

Be clear about the pathway for referral/instruction in the new service and about how this fits with any redesign of the assessment and care management processes of your local authority (link).

Specify the need for clear feedback mechanisms for users of, and referrers to, the new service, to both provider and commissioner. Specify a clear requirement to collect and provide information about protected groups, in line with human rights legislation

Specify requirements for any provider to promote and market their service, both alongside the council in its duty to provide information and advice, and independently, particularly within 'seldom heard' groups. Ensure contracts enable access and influence for commissioners in relation to the effective operation of the service and consider the results of feedback from referrers and users of the advocacy service.

Treat all providers equally.

Be open and transparent about any communication with potential providers. Ensure you offer the same opportunities for communication to all, and be clear about the requirements of any procurement process you seek to pursue.

Ensure procurement and contract monitoring activities are proportionate to risk and promote the delivery of outcomes.

Procurement should be led by the strategic analysis of need over the life of the contract and in terms of the relationship with other services. Consider joint commissioning with other agencies including other local authorities, health services and children's services.

Work with providers to understand how you can build flexibility into the delivery of services and the ability to respond quickly to changes in demand.

Maintain good and consistent dialogue with providers and the users of services so that issues of delivery can be picked up quickly and easily, before they become a contractual issue.

Have effective strategies and plans in place to ensure staff, users and their carers are aware of and understand the advocacy offer.

Develop plans for training and development of staff so that they are aware of the changes to advocacy arrangements under the Care Act, and how this might impact their roles and responsibilities.

Review the pathways for people using services and ensure that assessment processes are effective in picking up a potential need for advocacy services every step of the way.

Work with users and their carers to test approaches and develop information and support materials to enable people to access services quickly and easily if they are required.

Review information and guidance support to ensure this aligns with the Care Act advocacy duty.

Review

Bring together relevant data on activity, finance and outcomes for services, to judge whether they give value for money.

- review the service against specified deliverables
- ensure reviews are evidence- and outcome-driven
- Consider the development of service user involvement in contract monitoring.

Use measures which enable you to assess uptake and demand for services in real time and to work flexibly with providers to help them respond.

Develop contract monitoring processes that focus on developing relationships with providers. Work in positive partnership with them to improve performance.

Ensure that procurement and contract monitoring activities are proportionate to risk and promote the delivery of outcomes.

Work with providers to understand where performance may be falling short and how they might address any issues.

If necessary, decommission services where they fail to meet outcomes and provide value for money, and where efforts to work in partnership have failed to improve performance.

Decommissioning should be evidence-based with any proposed plans for recommissioning new or different services based on a detailed knowledge of supply and demand and the needs of users.

Seek to continuously improve your commissioning arrangements, reviewing learning to inform all your commissioning activities.

Keep clear and consistent records of the commissioning activities described above. Work with commissioners in other local authorities and national improvement agencies (e.g. SCIE) to benchmark your own performance and keep up with good practice. Discuss and reflect on your commissioning of independent advocacy under the Act with colleagues.

Compliance with the Equality Act 2010: public sector equality duty

Local authorities must pay due regard to the public sector equality duty when commissioning advocacy services.

To 'pay due regard' means that when making decisions a local authority:

'must consciously consider the need to do the things set out in the general equality duty: eliminate discrimination, advance equality of opportunity and foster good relations'.

PSED technical guidance p 19

Due regard:

'is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under consideration as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind'.

PSED technical guidance p 20

The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation.

Paying due regard

- As a commissioner, you should identify the advocacy needs of people who share protected characteristics in the local authority.
- You should undertake analysis of access to, experiences of and outcomes from current advocacy provision and use this analysis to inform your commissioning of future advocacy provision.
- You should ensure contracts with providers are designed in such a way as to meet the advocacy needs of people who share protected characteristics.

- You should include in contracts requirements on providers to monitor access to, experience of and outcomes from service provision for people who share protected characteristics.
- You should engage with users of advocacy services who share protected characteristics and with organisations representing people who share protected characteristics to identify issues regarding access to, experience of and outcomes from commissioned advocacy services for these groups.

Scenarios

These scenarios are intended to help you, as a commissioner, think about different models for the provision of advocacy in your area. As the Care Act is implemented, SCIE will seek to update this section with real-time examples of commissioning for the new statutory duties.

Lancashire County Council

When Lancashire County Council became the responsible body for commissioning independent mental health advocacy services, it decided to do this for better outcomes, in partnership with people who use services and in a more forward-thinking way. The service has changed from a multitude of disparate user-group-specific services, which duplicated functions across the NHS and social care in Lancashire and Blackburn with Darwen, to a joined up, clear and simple single point of access. The demonstrable outcomes are:

- a whole-systems approach to advocacy agreed with six clinical commissioning groups and Blackburn with Darwen
- single point of access with no postcode lottery in the Lancashire and Blackburn with Darwen areas, serving over 1.3 million people
- no gaps in advocacy provision for adults receiving health and social care services
- increase in people who are seldom heard getting help in health and social care processes and systems
- increase in children and young people who are supported with their health complaints
- joined up children's and adult health and social care advocacy support
- doubling of people who are eligible under the Mental Health Act benefiting from their statutory right to independent mental health advocates.

Background

As a result of the Health and Social Care Act 2012, additional advocacy commissioning responsibilities transferred to councils. The main changes were the addition of three areas:

- independent mental health advocacy for anyone detained under the Mental Health Act
- non-statutory mental health advocacy services offering support to voluntary patients at individual meetings or when liaising with health professionals
- health complaints advocacy offering support for people to make a complaint about NHS funded treatment or care (to include children's services).

Councils were already commissioning statutory independent mental capacity advocacy

to assist vulnerable people facing important decisions (change of accommodation or medical treatment) made by the NHS and local authorities. Lancashire County Council also joint commissioned non-statutory generic advocacy with primary care trusts.

The council therefore worked with Blackburn with Darwen and NHS commissioners to adopt a strategy to run from 2013 to 2016. This has closed gaps in provision and ensured that statutory responsibilities continue to be met and the consistency of advocacy service quality is not lost.

The Pan Lancashire Clinical Commissioning Group Network agreed that there were inconsistencies in NHS funding and that all clinical commissioning group areas should contribute more fairly to overall existing advocacy health costs. Seven business cases for each group were produced, citing equality impact considerations which related to the Equalities Act, the Human Rights Act and human rights principles of freedom, respect, equity, autonomy and dignity, as laid out in the NHS constitution.

Co-production and involvement

A provider day introduced the procurement process. People using services were involved in the commissioning process through discrete engagement days. Invitations were sent to partnership boards, user forums, carers and Black and Minority Ethnic organisations. Almost 20 seldom-heard adults attended on the day and a discrete Children and Young People's event was also organised. People participated in shaping the future of advocacy services by being asked their opinions on a series of questions. Feedback was used within the procurement service specification and to set further questions and scenarios in the tender questionnaire. People were asked to express an interest in becoming a member of the tender panel and assist with shortlisting the applications.

Once the tender had closed, separate panels were held involving the seldom-heard adult and children and young peoples representatives and they were fully engaged in shortlisting the application forms from advocacy providers, in scoring the applications and in recommending contract awards as follows:

- generic adult social care and health advocacy, to include health complaints
- independent mental capacity advocates and relevant person's representatives, single point of access
- non-statutory mental health advocacy and independent mental health advocacy.

Efficiencies and new investment

Using some of the economies of scale and over £100,000 of efficiencies generated by commissioning together, more money was subsequently invested in a new non-statutory advocacy service which closed all gaps in adult advocacy provision. This is the Non-instructed Advocacy (NIA) and Citizen Advocacy (CA) Service which is now available for all adults with complex needs.

The service provides specialist independent help for people who lack mental capacity to instruct an advocate with regard to specific health or social care decisions when independent mental capacity advocacy does not apply. Alongside this, the Citizen

Advocacy Service recruits and supports one-to-one volunteer advocates for people with long-term conditions at risk of social exclusion.

The service is available to anyone aged 18 or over, whose capacity is impaired by a condition such as dementia, learning disability, acquired brain injury, physical or medical need, a mental health problem or substance misuse.

Performance

The uptake of all advocacy services is measured on a quarterly basis and at twice-yearly 'advocacy monitoring days'. Peer monitoring is being introduced with a focus on a questionnaire which measures outcomes after the advocacy partnership has been completed. Regular reporting takes place to Blackburn with Darwen, each clinical commissioning group and strategic advocacy commissioners. This information is used to develop advocacy strategy and planning in the future through twice-yearly strategic advocacy meetings which involve NHS and local government commissioners, providers and user representatives. Information is also shared with Local Healthwatch.

Conclusion

The advocacy landscape has been simplified for both staff and the public by creating a single point of access across all areas. The advent of the Care Act will further embed the role of statutory advocacy in social care assessment and care management processes. Many people with disabilities have a heavy dependence on health and social care services, and dealing with large organisations can be a daunting task. Advocacy staff and volunteers know how NHS and social care systems work and who to talk to. Advocates help people to speak up for themselves, making sure they get their views across. Our organisations must welcome and invest in this customer feedback to ensure we can learn from people's experiences and improve services as a direct result, learning the lessons from failings such as Mid Staffordshire and Winterbourne View.

Total Voice Suffolk: a countywide advocacy partnership

Following a substantial period of working with local stakeholders in Suffolk to develop a 'fit for purpose' model of advocacy for the future – and recognising the expertise of valued local advocacy providers – Suffolk County Council decided to commission an integrated advocacy service that would honour that expertise. In doing so, the council also wanted to respond to feedback from people using local services about difficulties of access and knowing which provider performed which type of advocacy in which area of the county. There was also recognition that occasionally, and through lack of coordination, people were falling through the gaps between different services or teams.

VoiceAbility, working closely with a range of local providers, developed a partnership model to respond to this ambitious vision and operated it initially for a one-year pilot during which the approach could be tested carefully. The model then moved to formal contract status following a tender exercise.

This model of integrated advocacy is:

- delivered by Total Voice Suffolk (TVS), a partnership of five Suffolk providers led by VoiceAbility
- accessed through a single point of contact

- provided as a fully integrated model, responding to evidenced need, and with flexibility to respond to variations in demand
- recorded on a single database, achieving consistency of data
- reaching a more diverse range of people
- significantly improving response times, with no waiting lists.

Background

Suffolk County Council has a long history of grassroots advocacy provision to a wide range of people across the county. Some services specialised in formal advocacy, including both statutory and non-statutory advocacy, delivered by paid and professionally trained advocates. Others focused on informal types of advocacy, delivered by both professional advocates and volunteers. Suffolk County Council supported this via contract arrangements and grant-aided funding.

Suffolk Advocacy Forum (SAF) brought those with an interest in advocacy together on a regular basis, to facilitate ongoing development and training during this period. Working with the Forum and wider stakeholders including those who referred into advocacy services, and those who used those services, the council reviewed its advocacy services and requirements, resulting, in 2011, in a report outlining a number of recommendations for the future. The report recognised that in order to achieve better coordination, consistency, quality, access and measurable activity and outcome, the council needed to secure a different model that would increase equity of access for people across the county. In doing so, it wanted to enable a wider range of people to exert choice and control and have real autonomy over services they needed, but also to highlight poor practice and abuse.

While some authorities had opted to tender large unified contracts bringing together all statutory services (and any additional non-statutory services they chose to prioritise), Suffolk decided on a different approach.

Partners in commissioning, partners in delivery

Working closely with the Suffolk Advocacy Forum and its voluntary sector members, the local authority discussed changing the way services might be commissioned and delivered. A series of meetings and discussions brought together the views of people who used advocacy services, family carers, advocacy providers and local authority specialists to focus on achieving a model that would deliver consistently high quality and affordable advocacy in an increasingly constrained financial environment.

In summer 2012, Suffolk County Council invited proposals to deliver a range of specified professional advocacy services (both statutory and non-statutory) on a partnership model, initially for a one-year pilot. This coincided with the implementation of the new NHS complaints advocacy duties and the transfer of responsibility for independent mental health advocacy from primary care trusts to the local authority. Provision was also made for the development of more informal types of advocacy during this pilot year.

The pilot provision by Total Voice Suffolk, led by VoiceAbility and working in partnership with the Alzheimer’s Society, Age UK Suffolk, Impact, ACE and Suffolk Family Carers started on 1 April 2013. Following the pilot year, Total Voice Suffolk won the current contract from 1 April 2014.

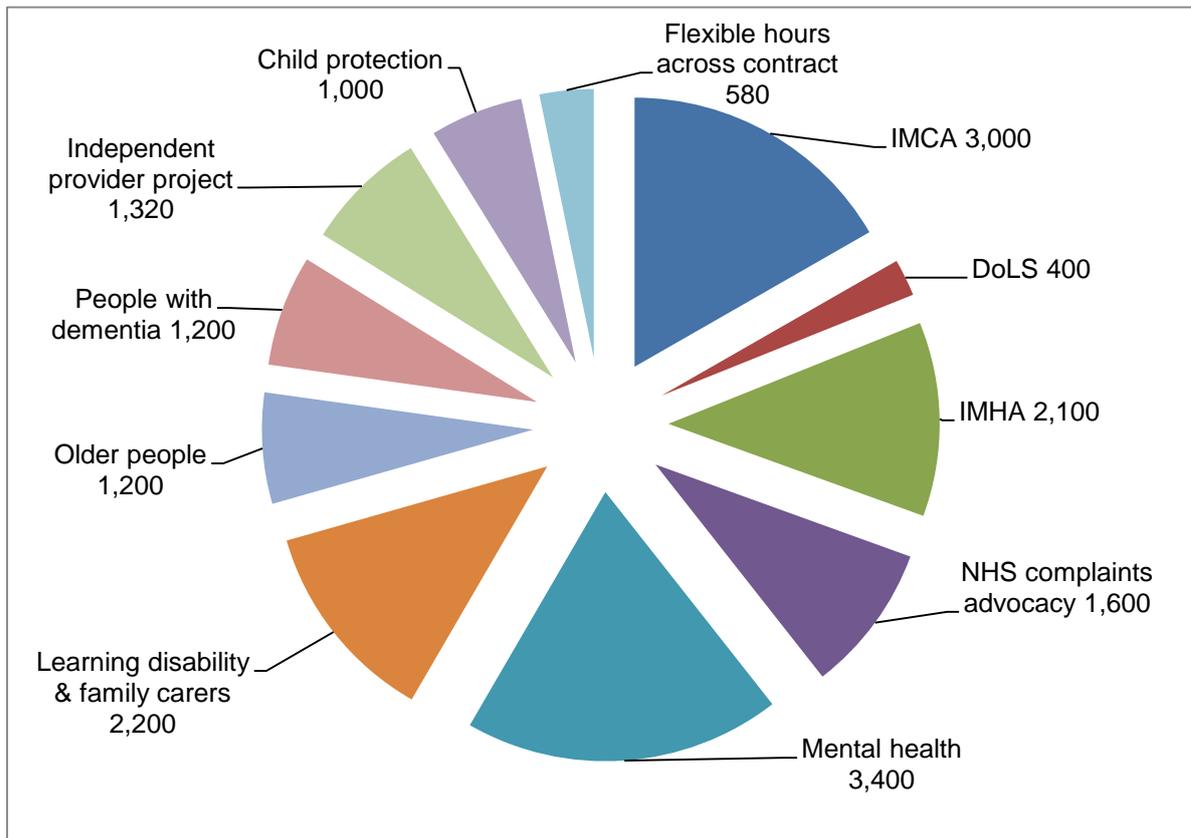


Figure 1 - Breakdown of advocacy hours per annum and types of advocacy

The service now delivers over 18,000 hours of advocacy per annum covering a broad range of advocacy interventions and approaches (as indicated in the pie chart). Each strand of work is delivered collaboratively by different configurations of providers and as a result is able to work responsively with a very diverse range of vulnerable adults. The service brings together into one team an invaluable knowledge base including a plethora of relationships with key statutory and voluntary sector teams across the county. Considerable expertise is required to hold this complex matrix together and each partner plays a strong role in ensuring everything is done to make this as straightforward as possible.

The contract does not include advocacy for children and young people with additional needs or those who are looked-after.

To develop greater provision of more informal types of advocacy a new pilot, Suffolk Community Advocacy (SCA), has replaced and will build upon the work of the Suffolk Advocacy Forum by actively supporting community organisations, enabling them to provide informal advocacy within their communities. Funding for Total Voice Suffolk also allows formal advocacy partnerships to actively support Suffolk Community Advocacy

and ensure that boundaries with formal advocacy are respected for the benefit of individuals.

New investment and efficiencies

Over the past few years there has been a significant investment in advocacy provision within Suffolk, both in additional funding and in active and ongoing development support from Suffolk County Council. This investment has increased access to all types of advocacy and will enable a speedy response to new requirements, such as the Care Act 2014. Resources have also enabled a substantial training programme for advocates across providers.

The new contract, born from the 2012 pilot, has introduced significant benefits and efficiencies:

- recording, reporting and contract management is quicker, more effective and more informative
- a single point of contact has made advocacy more accessible and has facilitated easier allocation of case work
- the database for recording has benefited consistency of practice and improved intelligence about advocacy issues and awareness of unmet need; it has also contributed to the ability of advocates to support each other during times of absence
- a larger team, comprising advocates from different organisations, has made it easier for the service to reach people across the county in a timely way, reducing the proportion of time spent travelling
- there is a common training and best practice development programme for all partners and advocates with information, updates and briefings shared easily across the partnership
- all partners contribute to sharing skills and expertise, and collaborate to develop aspects of the contract provision and mutual support.

Benefits for users

The key benefits are:

- ease of access – one number and one website saves people trying to contact the service both time and effort
- speed of response – most people get a same-day response with a clear indication of how their advocacy support will be progressed
- ability to signpost quickly to advocates with specialist skills – helpful if the individual needs someone skilled in a particular area
- ‘My story, once’ – a common database minimises the number of times people need to repeat their story

- more consistent approach to advocacy – a clearer outcome-focused issue-based model of advocacy
- earlier resolution – we're able to work with people more quickly, more appropriately and more effectively
- clearer accountability – it's easier to praise the service when things go well, and to complain when they don't.

A model of effective commissioning

Suffolk's commissioning model has worked very well, and for a number of reasons:

- it was informed by research and by extensive discussion with people who used local advocacy services and with local providers
- it looked beyond a model that delivered statutory advocacy alone and recognised that non-statutory advocacy has a vital role in prevention, critical to the success of the transformation of adult social care
- it was clear about the value of advocacy in promoting the rights of the individual
- the council was determined that advocacy should be provided by a range of providers and ensured that funding was available to manage and support a partnership model.

Suffolk County Council has taken an open and collaborative approach to developing and delivering the contract, with an emphasis on ongoing development and responding to wider requirements such as the Care Act 2014. As a result, better advocacy is being delivered by more highly-trained advocates to a greater number of people from more diverse groups across the county. Work and outcomes are evidenced by comprehensive data, which in turn can inform longer-term strategic planning and commissioning. Problems can be identified more easily and addressed earlier, and the collaborative spirit on which the partnership is based has enabled frank and honest relationships between organisations which have come as a bonus. As one partner explained:

'The partnership has raised standards – we measure our work against each other and this has definitely raised our game. You can't help but learn. We are more professional and there is a good mix of people. It has taken the competition out of things. No one is thinking "You might pinch my bit of work!"'

And as one of the people using these services pointed out recently:

'I don't know how I would've coped on my own. I'm just thankful for your service.'

Supporting implementation of the Care Act 2014



SCIE's Care Act work is part of a suite of resources commissioned by the Department of Health in partnership with the Local Government Association, Association of Directors of Adult Social Services and the Care Providers Alliance to support those commissioning and providing care and support in implementing the Care Act 2014.

Find out more, visit www.local.gov.uk/care-support-reform.

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