social care
institute for excellence

Commissioning independent advocacy under the Care Act

About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

Published in Great Britain October 2014 and last updated October 2022 by the Social Care Institute for Excellence

Social Care Institute for Excellence

Isosceles Head Office

One High Street, Egham TW20 9HJ

https://www.scie.org.uk

Contents

1. Introduction

This resource is aimed at commissioners charged with meeting the duties to provide advocacy under the Care Act 2014. It will help commissioning officers in local authorities think through their duties and understand what they are required to do to comply with the requirements of the Act. It also sets out the relationship to advocacy requirements under other legislation and summarises good practice in advocacy.

2. Key messages

- Local authorities must involve people in decisions about their care and support, and provide an independent advocate where the person has substantial difficulty being involved and has no appropriate individual to support them. It is important that you clearly understand the local authority’s advocacy duties under the Care Act 2014 and how they interact with other advocacy duties.
- Commissioning integrated advocacy may offer benefits including easier access to multi-skilled advocates, improved working relationships, and better communication.
- Co-production maximises the effectiveness of independent advocacy commissioning and offers an opportunity to explore the challenges in your area.
- An ‘**equality and diversity**’ thread should run through your commissioning activities, ensuring compliance with human rights and equality law.
- 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 – as well as standards for good commissioning and measuring the quality of advocacy services to ensure best value and outcomes.
- Analyse and review a range of information to help you understand current and future demand for advocacy, as well as how your local authority meets its existing statutory advocacy duties in practice.
- Work in partnership with providers and other stakeholders and services and encourage collaboration to secure the best use of local capacity and best value for money.
- Ensure the advocacy offer is widely known and understood.
- Set clear expectations for providers and practitioners in line with advocacy duties set out in the Care Act. These should be reflected in specific, outcome-focused specifications and contracts.
- Because demand and funding will fluctuate, you should be flexible about procurement and contractual arrangements.

3. Advocacy duties

This section explains 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 need to do.

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 applies 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 there is an absence of 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.

The advocacy role may also involve assisting a person to challenge a decision or process made by the local authority; and where a person cannot challenge the decision even with assistance, then to challenge it on their behalf. This **guidance** from Voiceability includes routes to challenge under the Care Act.

Judging ‘substantial difficulty’

Local authorities must consider, for each person, whether they are likely to have substantial difficulty in engaging with the care and support process. The Care Act defines four areas where people may experience substantial difficulty. 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 consult them and make decisions on their behalf.

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.

Exceptions

There are times when an independent advocate must 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, and both agree that an independent advocate would be beneficial to the individual.

Ordinary residence

Local authorities are required to make sure there is sufficient provision of independent advocacy for all who qualify, and this could include adults placed into their area. As understanding of local communities may be important, the advocate should be from the area where the person is resident when the assessment, planning or review takes place. It is therefore important to have policies in place that address appointing advocates:

- from advocacy services out of the area, if there is no direct commissioning relationship already in place
- for people temporarily placed out of the area
- for people moving area when an advocate is already involved. The same advocate should continue if at all possible.

Prisoners

Local authorities are also 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 are treated as if they are resident in that area for the purposes of the Care Act, for as long as they reside in that prison. Prisoners are 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.

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 information and advice to keep them 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 duty to provide advocacy in the Care Act applies equally to those people whose needs are being jointly assessed by the NHS together with the local authority, or where a ‘joint package’ of support is planned, commissioned or funded.

However, a **report from NDTi** has found that people are often left without advocacy support when accessing NHS Continuing Heathcare and other health funded support and that legislation and guidance does not sufficiently provide for this. Commissioners should therefore consider carefully how they will ensure that people receive any advocacy support needed in relation to these processes.

Historically, continuing health care arrangements have often been difficult for people who use services, their carers and friends to understand and be involved in. Local authorities and health partners will therefore want to consider the benefits of providing access to independent advice or independent advocacy beyond the requirements of the Care Act, by including those people who do not have substantial difficulty and/or those who do have an appropriate person to support their involvement. Effective joint commissioning arrangements would include:

- supporting 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, and extending beyond the statutory requirements
- improved communication and continued care to achieve joint outcomes.

Independence

The independence of the advocacy 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.

Training

Once appointed, all independent advocates under the Act should work towards the National Qualification in Independent Advocacy (3614), or IAP City & Guilds level 4 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 three core units (401–403) candidates are required to provide evidence of real work practice.

The Certificate comprises three mandatory units and one optional unit. Mandatory units (these must be taken first) are:

- Principles and practice of independent advocacy (401)
- The legislative framework which impacts upon the independent advocacy role (402)
- Entitlements to independent advocacy (403).

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 404 (independent mental capacity advocacy) and unit 406 (independent advocacy within adult social care).

After completing the Independent Advocacy qualification, providers should be expected to ensure that all independent advocates have access to further relevant training.

This may cover:

- understanding safeguarding and the responsibilities of the advocate
- 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, section 7**.

Other statutory advocacy duties (not related to the Care Act 2014)

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 (IMCA).

Local authorities commission 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; staff will therefore need to know when an independent mental capacity advocate needs to be involved.

For further information see **The Mental Capacity Act 2005: Code of practice**.

The Mental Health Act 2007

Independent mental health advocacy services were introduced in 2007 to safeguard the rights of people detained under the Mental Health Act 1983 (amended) and those on community treatment orders (CTOs). Independent mental health advocates (IMHAs) aim to enable people 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 role is to assist people to 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 people 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 aims to provide support to people who want to make a complaint about services provided or funded by 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.

Since April 2013, the service has been commissioned by local authorities individually or in cooperation with other local authorities.

Interactions between statutory advocacy duties

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. It provides 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 who 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 people who qualify for advocacy under the Care Act but not for an independent mental capacity advocate. Many 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.

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. Commissioners should consider how they will extend access to advocacy beyond the minimum legal requirements, in order to better meet the needs of the local population.

Joined-up advocacy commissioning

Local authorities are not required to commission one organisation to provide different types of advocacy, but there are advantages to doing so. Integrated advocacy can be of benefit because many people will require advocacy support under more than one statutory duty, whether it be under the Care Act, Mental Health Act, Mental Capacity Act or any non-statutory advocacy that may also be provided by the local authority. The advantages of packaging the commissioning of different advocacy together include:

- clearer and easier access to support for people requiring advocacy through single points of contact, and easier and joined-up referral pathways
- facilitating the provision of multi-skilled advocates, so that people can have a single advocate working on their behalf and not have to tell their story repeatedly
- allowing advocates and their clients build a meaningful working relationship, based on trust
- improving outcomes in non-instructed advocacy by giving the advocate more time to get to know the person properly and more fully understand their views, wishes and feelings as well as their family and other relationships (especially people who need additional support to communicate)
- better and more consistent communication with health and social care professionals, greater coordination and reduced fragmentation of services, and understanding of advocacy referral pathways
- better community engagement and embedding of services in the local authority, with less confusion about advocacy providers and routes to access support.

‘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

4. Commissioning advocacy: inclusion, empowerment and human rights

This section outlines the different types of advocacy and includes some principles of good practice and some challenges to consider to support commissioners to better understand and specify relevant services. It is informed by input from people who use services and carers.

> ‘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

Principles and types of advocacy

The **Advocacy Code of Practice** states that advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.

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. In self-advocacy the individual self-assesses a situation or problem and then speaks for his or her own needs. A principal aim for all forms of advocacy is 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 to 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.

Non-statutory advocacy

Individual advocacy provided by skilled professionals can be essential to ensuring that people who find it difficult to have their voices heard and rights respected receive the support that they need, when they do not fit the specific statutory eligibility criteria.

This is often referred to as “non-statutory advocacy” but may be described under many different names, including “community advocacy”, “generic advocacy” and “professional advocacy”. Non-statutory advocacy plays a vital role in ensuring that that people get their voice heard, are involved and have their rights respected, including when facing major decisions, and at times of crisis.

Non-instructed advocacy

Non-instructed advocacy is needed when, despite the provision of assistance and support, a person is still unable to give their views and make their own decisions. If this is the case, the independent advocate needs to gather information and insights from a range of sources and use this to represent the person. The aim of non-instructed advocacy is to secure the person’s rights, promote their wellbeing and ensure their wishes are fully considered.

Non-instructed advocacy is often required to provide advocacy under the Care Act as well as that required under other legislation.

There are four recognised approaches to non-instructed advocacy. Providers should endeavour to integrate all these when providing support:

1. A rights-based approach – we all have certain fundamental human rights that can be defined and measured.
2. A person-centred approach – based on the development of long-term, trusting and mutually respectful relationships between advocates and people.
3. A watching brief approach – placing the person at the centre of thinking about the best way to support them.
4. A 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 commissioning advocacy under different legislation together, because this maximises the chances of continuity of support.

Peer advocacy

Peer advocacy refers to one-to-one support provided by advocates with a similar disability or experience or facing similar barriers to a person using services. Trained and supported paid staff and 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.

It is helpful for commissioners to consider the value of these different types of advocacy and how they may benefit people with different needs and from different communities. Some advocacy services were concerned that the introduction of the Care Act could result in the range of advocacy support decreasing, as resources became targeted only at advocacy that was required by law.

Co-production

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. Advocacy under the Care Act should be commissioned in meaningful partnership with people who use services and carers.

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 people who use services, carers and professionals, and results in the provision of support that meets individual goals as well as needs. For co-production to flourish, both within advocacy providers and in local authority commissioning, organisational structures, processes and culture, staff values and attitudes may need to change.

SCIE has a collection of **co-production resources** providing more information and practical guidance.

> ‘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

Challenges to the provision of independent advocacy

Co-production enables honest conversations between those who use, provide and commission advocacy to help develop and improve the service. People who use and provide advocacy have supported the update of this guide and have identified the following challenges to the provision of independent advocacy under the Care Act. Consider whether any of them may be a challenge in your area:

- ensuring the individual is placed at the heart of advocacy provision
- providing information and advice about advocacy and the benefits it offers in a range of ways and places, particularly now information and services are more often provided online
- making sure social care staff understand the value of advocacy, and are fully aware of how and when to refer individuals for this support
- ensuring advocacy is made available to those who need it despite the time and budget pressures social care staff face

- being clear about how people can challenge a decision not to provide advocacy
- ensuring the views of those who have accessed advocacy services and those who have been advised they did not meet the criteria are captured and understood, and recognising that some need advocacy support to do this
- recognising the complexity of needs people using advocacy services may have, and the difficulty of supporting them to address these needs within a limited timescale
- providing good-quality post-qualifying training for advocates
- supporting self-advocacy, which may require more time than other types of advocacy, but which should be the ultimate aim
- encouraging and supporting the market of advocacy providers, ensuring specialist services are available to meet local needs where required.

Equality, diversity and compliance with the Equality Act 2010

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

Publicly 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**.

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 ...have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.’

PSED essential guidance

And in order to have due regard:

> ‘Those who exercise its functions must be aware of the general equality duty’s requirements. Compliance with the general equality duty involves a conscious approach and state of mind. General regard to the issue of equality is not enough to comply.’

PSED essential guidance

As a commissioner, you should:

- identify the advocacy needs of people who share protected characteristics in the local authority
- 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
- ensure contracts with providers are designed in such a way as to meet the advocacy needs of people who share protected characteristics
- include in contracts requirements on providers to monitor access to, experience of and outcomes from, service provision for people who share protected characteristics
- 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.

Standards and quality

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 QPM 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:

- people 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

Additional indicators relating to safeguarding were added to the updated 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 to measure the effectiveness of the advocacy relationship.

Equality, accessibility and diversity

As well as complying with equality legislation (The 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, to understand the barriers that different people and communities face and to 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, are essential if services are to retain skilled advocates and ensure high-quality advocacy for people who need it.

Learning from COVID-19

Advocates and advocacy organisations demonstrated flexibility and imagination in ensuring continuity of provision during the pandemic. Remote methods of working were rapidly introduced, and in many instances, steps were taken to ensure that people who draw on support services were met with safely in-person.

Together advocacy organisations established a set of principles underpinning how to deliver advocacy effectively during and beyond the pandemic. These highlight and confirm the vital importance of advocates meeting with people face-to-face whenever required. Without this it can be hard to gain a full understanding of the person’s communication, views and situation. This can include identifying potential safeguarding concerns.

Contracts for advocacy should encourage continued access to advocacy online and by telephone, where this is genuinely the way in which the person drawing on advocacy support prefers to communicate, while ensuring that advocacy is always available in-person when wanted or needed.

It was at times difficult for advocates and other professionals to meet with people who lived in care homes or who were patients in hospital. In the event of future restrictions, commissioners will want to bear in mind ADASS guidance to

> ‘[U]se the commissioning or contracting role and relationships to encourage and support NHS, independent sector and local authority service providers to promote people’s ability to access to advocacy. This needs to be available both face-to-face in Covid-safe ways and by facilitating video and telephone meetings.’

5. Overview of commissioning independent advocacy

This section aims to provide an overview of good practice in commissioning independent advocacy. 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.

> ‘I think sometimes we can get too stuck on, 'Okay, we’ve commissioned a contract for this through IMCA, commissioned a contract for [an] 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

What is commissioning?

‘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. So it’s about promoting better lives.

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 the best value and comply with legislation.

> ‘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 for better outcomes (TLAP) provides a clear definition of commissioning and **Social care commissioning beyond COVID-19** (SCIE) provides guidance for commissioners that may help them develop good approaches during the COVID-19 pandemic and into the future.

A commitment to commission in asset-based ways presents opportunities for more holistic approaches to meet statutory duties as well as collaborate to deliver them.

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

- Analyse: understand the needs that must be addressed, the values and purpose of the agencies involved, 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 approaches and ensure any future commissioning activities take the findings of this review into account.

Importantly, commissioning and procurement are closely linked, as shown in the illustration below (Figure 1). However, commissioning doesn't have to involve procurement – there are lots of ways of responding to needs and gaps.

Figure 1: Commissioning and procurement cycle

IPC Commissioning Framework / Model

Highlighted in the outer circle are commissioning activities. They must inform the ongoing development of procurement activities (if procurement is the most appropriate commissioning route) which are 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.

Market shaping and commissioning for advocacy

The Care Act itself does not specifically mention commissioning, but it is included in the vocabulary of the chapter of the statutory guidance '**Market shaping and commissioning'** and is seen as a core part of implementing the requirements of 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.

Commissioners may wish to consider how they will further develop advocacy under the Care Act, as a part of their strategies to shape future advocacy support to meet the overall needs of their local population. Research undertaken following the implementation of the Care Act found that good practice in commissioning advocacy includes:

- working with advocacy providers to develop solutions and overcome barriers
- working with people who use services, carers and the local community to understand what is important to them
- incentivising providers to work together and with local communities recognising that partnerships take time and investment
- realising the potential of market shaping and its role in building the capacity of user-led and community organisations to deliver advocacy under the Care Act
- sustaining provision by agreeing three-year contracts as a minimum and including flexibility to respond to changes in demand.

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. These set out 12 commissioning standards across four domains.

1. Person-centred and outcome-focused:

- person-centred and focuses on outcomes
- promotes health and wellbeing for all
- delivers social value.

2. Inclusive:
   - is co-produced with local people, their carers and communities
   - promotes positive engagement with providers
   - promotes equality.
3. Well-led by local authorities:
   - well-led
   - demonstrates a whole-system approach
   - uses evidence about what works.
4. Promotes a sustainable and diverse market place:
   - a diverse and sustainable market
   - provides value for money
   - develops the workforce.

NDTi have developed a **framework** that highlights the outcomes advocacy services have the potential to deliver. This may be helpful when considering the commissioning of these services.

6. Commissioning tasks

This section seeks to enable local authorities to think through the commissioning tasks to ensure that good quality advocacy is available for all adults who are entitled to it under the provisions of the Care Act. It can be used in conjunction with **SCIE's commissioning self-assessment tool**, which is designed to help commissioners think through where they are now and what they need to do.

Analyse

Collect information to understand current and future demand for advocacy

Work closely with local colleagues and stakeholders including researchers, public health, project leads, integrated care boards (ICBs), voluntary, community and social enterprises (VCSE), etc.) to gather information and data about the likely demand for independent advocacy under the 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, therefore, resources. Co-production with local residents and community groups will help you understand current access to advocacy, any delays or barriers to getting the right advocacy.

Analyse information to understand current and future demand for advocacy

Consider demand since Care Act implementation in your analysis as well as where there might be unmet need or low referral rates. Include any proposed changes or improvements in the assessment and care management pathway for people with social care needs (including children in transition to adulthood), and **carers**, together with the likely impact this has had or may have on the uptake of advocacy services.

Consider carefully engagement with **self-funders**. This includes the potential impact of the planned introduction of the cap on care costs, how this may affect the number of people undergoing assessment and care planning, and who will come in scope for advocacy under the Care Act.

Take into account the increase in demand on the system that will accompany the implementation of future funding reforms,

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
- the experience of practitioners in referring to advocacy services including wait times and responsiveness
- quality monitoring of existing contracts
- what people consider to be a good local advocacy service which meets their needs.

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

Consider whether any particular challenges within either the Local Authority or amongst providers are impacting the provision of advocacy in your area.

Complete a modelling exercise to confirm practice use

Even though the Care Act should be well embedded in local practice by now, modelling and ongoing assessment against the Care Act duties should be based on your understanding of how these variables affect each area.

This could be done in conjunction with the principal social worker by auditing a small sample of assessments, making a judgement about their need for advocacy and what action has resulted. This can be used to keep improving practice and also to extrapolate in terms of demand and provision if advocacy has not been put in place or been available at the right time.

Seeking evidence and thinking afresh about the likely referral levels may be especially important, given that widespread variation in use of advocacy under the Care Act could suggest potential non-compliance with the legislation. There could also be micro-variations within a local authority area that commissioners should seek to understand. It is important that commissioners do not assume that historical referral levels alone provide sufficient indication of future needs, but instead consider carefully and draw in evidence to model and understand what full legal compliance would require.

Seek out and reflect on research, and good practice evidence

Seek out good practice in the form of quality standards to understand the quality of local services and decide, in co-production, what mix of services will meet and continue to meet local needs. These include:

- **Quality standards for independent advocacy**
- **The 'Advocacy Charter'**
- **The 'Advocacy Code of Practice'.**

Refer to the **SCIE resources on advocacy**, including the e-learning resource. This type of reflection on good practice in advocacy should assist you in specifying the types of services most appropriate to meet demand in your area. It may also help you identify good practice that is already taking place.

Understand the resources available

Ensure any review or evolving plans are linked with overall departmental and corporate aims in relation to Care Act compliance to meet your advocacy duties under the Care Act; project future financial commitments based on likely demand. These are your responsibilities as a commissioner of independent advocacy.

Plans should have begun with an analysis of demand (as described above) and commit appropriate resources to ensure compliance with the Act on an ongoing basis.

Benchmark the costs of commissioning plans

Communicate with comparable local authorities to benchmark demand analysis and resource allocations around any areas of commissioning. If you need to identify potential partner authorities or critical friends to enable ongoing quality improvement, seek out support from representatives of different councils through the Local Government Association and the Association of Directors of Adult Social Services.

Develop systematic processes of co-producing commissioning

Refer to **SCIE's guide to co-production**.

Develop commissioning, purchasing and monitoring activity alongside people who use services and potential users of services to ensure that the supply of advocates meets local need effectively.

Seek to understand current levels of supply and uptake

Review what happens locally and seek to understand what works well now and how this could be expanded if required. This includes what currently works well, and where there is over- and under-supply of services.

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. Check this against your equalities data, to understand if any cohorts are missing out or to understand discrepancies.

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 Equality Act 2010.

Analyse the local performance and demand of existing advocacy provision

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 advocacy services and consolidate them into one contractual arrangement. There may, of course, also be benefits to having a number of advocacy providers either accessed via a lead provider arrangement or through a number of contracts. Key to effective commissioning is recognising that 'one size does not fit all' and the local context (population, geography, local views and provider capacity) should play a role in determining the appropriate model.

Plan

Develop a clear, written strategy

Agree outcomes for the provision of advocacy to meet Care Act duties that signal your future commissioning intentions for the local area.

Integrate the ongoing 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 amend and review a clear commissioning strategy and/or plan.

Have a process of engagement with existing and potential providers, as well as co-production with local people who use services, around a clear strategy setting out legal duties and intentions of independent advocacy provision under the Act. Positive working relationships between commissioners and providers will enable services to continue to develop.

Remain vigilant about the risks of not complying with the Care Act or underestimating the possible increases in demand for advocacy services. Needs may have changed or increased through the pandemic too. Review contracting options and consider the use of outcomes-based service specifications that 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 a commensurate level of funding, are 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: 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

Develop mechanisms for ongoing dialogue with local partners (including the NHS and related local authority services) and existing and potential providers in order to build consensus on the implications of the commissioning plans for your area. 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. Ensure this includes smaller community advocacy services that may have the trust of particular communities.

Develop business cases for the commissioning (or re-commissioning) of advocacy in line with the Care Act duties

Using your needs analysis, continuous assessment and monitoring, you should always model a range of options that 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 Care Act requirements. 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 of financial planning for ongoing Care Act implementation.

Develop a person-centred approach to commissioning advocacy services

Use co-production to assess and understand how advocacy is working in your area. This enables local people to contribute to the design of services and the standards expected, and maximises control over services once they are established. Please see information on **co-production** and other sections on co-production in this **commissioning guide**.

You should ensure that any current provision or future 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 delivering Care Act duties to provide information and advice.

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

Do

Review so that you have a clear picture of local providers and their strengths, weaknesses and future plans

Develop an understanding of providers through:

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

Continue to influence the local market for advocacy

Engage in regular and productive dialogue with providers that encourages consensus and partnership-orientated relationships to develop services in line with your population needs, rather than the historical awarding of contracts. Continue to review, reassess and, where necessary, re-commission to meet your population needs.

Using the above mechanisms:

- work with providers to ensure diversity of available services and encourage collaboration where possible to develop the market
- work with people who use services, potential service users and providers to design services that meet the needs identified in the earlier or ongoing 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. Consider whether it might be appropriate to “reserve” contracts for local or small VCSE organisations.

Develop service specifications and contracts that are flexible, evidenced-based, specific and outcome-focused

Be clear about the legal requirements for providers (see the section ‘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, and use the intelligence from the last few years, considering the 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.
- The commissioning authority avoiding stepping into how cases are managed.

Be clear about the pathway for referral/instruction in any services, and about how this fits with any proposed redesign of the assessment and care management processes of your local authority.

Specify the need for co-production of quality assurance and clear feedback mechanisms for users of, and referrers to, the new service, to both provider and commissioner for ongoing monitoring and quality improvement.

Specify a clear requirement to collect and provide information about protected groups, in line with equalities and 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.

Consider using the **Advocacy Outcomes Framework** developed by NDTi as a basis for the approach you want the advocacy provider to take. An outcomes-based approach may be more beneficial for clients to help ensure the quality and focus of advocacy provision and it allows very clear measures by which you can evidence the quality of service within commissioning.

In determining the length of contract to offer, it may be helpful to consider the potential advantages of long-term flexible contracts that:

- avoid regular disruption to advocacy support to your population
- ensure consistency of services and relationships between advocates and their clients
- more effectively embed advocacy and advocates with in the wider professional and community groups they engage with across your population
- leverage expertise and knowledge within advocacy providers, to ensure continual improvement throughout the contract term.

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

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.

Ensure staff, people who use services and their carers are aware of, and understand, the advocacy offer.

As the commissioner of the advocacy service you play a vital role in conjunction with both your colleagues in the local authority and the advocacy service, to facilitate effective advocacy provision and ensure that the duty to refer to advocacy is complied with.

This includes:

- ensuring that information about advocacy is provided
- encouraging training of front-line local authority staff
- ensuring local authority systems and processes remind and encourage professionals involved in assessment, planning, review and safeguarding to make a referral whenever legally required and, if in doubt, to make appropriate enquiries, including seeking clarity from the advocacy service provider.

You also play an important role in developing a culture which embraces challenge from advocacy. ADASS reminds senior managers and commissioners to “embrace and promote receiving challenges from advocates as an essential way of safeguarding people's human rights and voice and role model this behaviour.”

Training and development for staff should be embedded as standard so that they are aware of the advocacy duties under the Care Act, and how this impacts upon their roles and responsibilities. Everyone involved in social care locally needs to have a clear understanding of advocacy, including:

- why it needs to be independent
- its various forms
- the legal context
- its role in implementing the Care Act wellbeing principle
- its duties in relation to prevention as well as supporting peoples' involvement in their care.

To develop an understanding of advocacy and roles in promoting and supporting access and uptake, those involved should look at capacity building and support for commissioners and frontline staff, including the development of co-produced training.

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 and case management systems prompt referrals.

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

Ensure information and guidance support continues to align 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 that enable you to assess uptake and demand for services in real time and to work flexibly with providers to help them respond
- use continuous feedback from people and professionals to adapt and make changes as and when required
- create mechanisms or forums for shared learning, if you haven't already.

Develop contract monitoring processes that focus on developing relationships with providers

Ensure that procurement and contract monitoring activities are proportionate to risk and promote the delivery of outcomes. Building the evidence for impact with user and community-defined outcomes, rather than outputs, is central to sustainability. This should be supported by a simple and agreed system for data collection that supports meaningful and proportionate monitoring. Data might include:

- access rates
- demographic detail
- outcome measures
- descriptive accounts of trends in use of advocacy services, partnership working and co-production
- case studies.

Dialogue between commissioners and providers is key. Work in positive partnership with providers, to understand where performance may be falling short and how they might address any issues.

Decommission services where they fail to meet outcomes

Consider decommissioning when services fail to meet outcomes or do not provide value for money, and where efforts to work in partnership have failed to improve performance. This 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 and knowledge of people who use services.

In any situation where there are concerns about service failure or viability, commissioners need to be ready to put contingency arrangements in place so legal duties to provide advocacy can continue to be met. Mitigation might include making arrangements with advocacy services in neighbouring boroughs, to manage or supply advocates until longer-term arrangements can be implemented.

Seek to continuously improve your commissioning arrangements

Keep clear and consistent records of the commissioning activities described above. Work with commissioners in other local authorities and national improvement agencies (such as SCIE and NDTi) 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.

When reflecting on commissioning arrangements, consider the tendering process and how you can ensure all providers are given sufficient opportunity to engage with the process. Ways this can be done include: market engagement activities; offering opportunities to clarify any queries or concerns; and well published and thought-through timelines, which will allow providers to develop well-considered and appropriate responses to a tender, and for panels to have sufficient time to assess bids.

When establishing timetables for the tendering and implementation of advocacy, ensure a period of at least three to six months for implementation of a new contract, or handing over of a service to a new provider. Work with the outgoing and incoming providers to support a smooth transition of any staff, advocacy clients, and to make sure professionals who need to know about service changes are informed in good time. The implementation period of when contract is officially awarded and the start date of a new contract should not be shorter than three months.

Self-assessment tool

Complete the **self-assessment tool** with the checklists above.

How to use:

- score yourself green, amber or red under each commissioning area.
- for each area you score green, record your key strengths in this area in the box provided.
- for each area you score amber or red, identify areas for development.
- once you have completed it, identify actions to address areas for development and how and who will be taking them forward; prioritise areas you have scored red.
- if you identify an area in which you think your authority is particularly strong, please share it with SCIE.

As well as with the frontline workforce, this assessment may be worth completing with providers, people who use the services and carers.

Case studies

These case studies are intended to help you, as a commissioner, think about different models for the provision of advocacy in your area.

Advocacy in Manchester: Case study

Manchester City Council, taking a lead from the strong steer within statutory Care Act guidance, has established an integrated, independent advocacy service which embraces the Care Act, Mental Capacity Act, Mental Health Act and NHS complaints statutory advocacy requirements. The service is known as Gaddum Advocacy, run by Manchester-based charity, Gaddum.

This followed a public consultation and competitive procurement process. The integrated approach received strong support from stakeholders. Advocacy services within Manchester were poorly developed; investment was spread across a number of small contracts which inhibited sustainable investment in management, training and data collection. They had no means by which we could measure need and outcomes.

The specification embraced the SCIE recommendation to retain some flexibility to respond to levels of demand which were likely to grow, but at a rate that may have been difficult to predict. It has taken time for Care Act requirements to be fully absorbed into practice with the consequent peaks and troughs, whilst the Cheshire West MCA judgement has created a sustained increase in demand for Independent Mental Capacity Advocacy (IMCA) services.

Manchester's specification is broken down into two components. A block contract covers the core infrastructure of Gaddum Advocacy including a set number of hours of independent advocacy per year. In addition, a spot contract provides an hourly price at which additional hours may be purchased as demand requires. All Gaddum Advocates are trained to provide a range of Advocacy services to support the individual.

The central function of Gaddum Advocacy is to deliver statutory independent advocacy services as and when required without delay to core assessment and safeguarding processes. Gaddum Advocacy uses integrated webforms to triage and allocate priority referrals. In addition, the specification requires Gaddum Advocacy to bear down on demand and dependency by developing tools to:

- support self-advocacy
- support relatives and friends who come forward to act as informal advocates
- support the valuable role played by the wider charity, voluntary and peer-support sector.

Advocacy in Essex: Case study

Background

In 2013, Essex County Council carried out a comprehensive review of advocacy provision, a number of factors lead to this. Essex was taking on the responsibility for NHS complaints advocacy and Independent Mental Health Advocacy (IMHA), and its social care and mental health advocacy contracts were coming to an end.

The review included benchmarking against other local authorities, researching best practice and a consultation with users and providers of advocacy services, Essex County Council operational staff and other referrers to advocacy services.

It was a very mixed picture, Essex spent around the same as other comparator authorities and people said advocacy support was very important to them but there was no way of measuring the impact of advocacy, there were long waiting lists, a lot of duplication between paid support and advocacy and that most of the spend was on formal 1:1 advocacy. Essex was also facing significant financial challenges and needed to be able to build a case for recommissioning advocacy that would both improve outcomes and be cost-effective going forward.

Re-commissioning formal advocacy

The current provider had developed a 'prioritisation matrix' to help determine how waiting lists should be prioritised. Essex built on this approach and developed a process for determining 'eligibility' for formal advocacy support. It ensured those that were the most vulnerable had access to support, but also reduced the duplication in the system.

Essex carried out formal public consultation and found the following areas were key in determining if someone requires a formal advocate:

- complexity of the advocacy issue
- impact of the issue
- support network(s) and ability to access community-based resources
- individuals capacity to make decisions and ensure their voice is heard.

The formal 1:1 advocacy and IMHA services went out as a full procurement with one contract that consisted of two lots (one for each service). Essex involved people who use services as part of the bid evaluation panels. The eventual winning organisation for the formal 1:1 service was a lead provider working in partnership with seven Essex-based providers, employing local people to deliver local services. This service has now been running since July 2014, delivering advocacy to 960 people in the first six months.

The IMHA service went to a large provider that Essex had worked with in the past on other advocacy-based services. The formal advocacy 1:1 service was commissioned on a 'block' contract for a number of cases per year (based on previous usage) with an ability to pay for additional cases should they be required. This means that if someone has the 'need' for formal advocacy (including NHS complaints advocacy), they can always access it.

The provider further refined the prioritisation process to ensure that the right people got access to formal advocacy at the right time. Essex believed they were the right people to make sure that they were able to support vulnerable people to make informed choices and have their voice heard.

When the Care Act guidance was issued, Essex looked at its plans for formal advocacy and found that the new service that it was commissioning would meet the new requirements. This ensured that those that don't have support or the ability to speak up for themselves during social care assessments, support planning, review or safeguarding had access to a formal advocate. Modelling around the new demand was undertaken and the contract varied to meet this demand. Essex also ensured that social workers were aware of the requirements.

Citizen advocacy

Essex County Council has had a citizen advocacy service for a number of years, but it has had patchy coverage. The review highlighted the importance of this approach to advocacy, building long-term partnerships to support people to make choices and have their voices heard. When the Care Act guidance was issued, Essex agreed that it needed to formalise the arrangements for citizen advocacy to provide long-term advocacy partnerships for people that were likely to have a repeat need for an advocate.

Essex subsequently tendered for a county-wide citizen advocacy service to support 150 citizen advocates across Essex.

Further service developments

Ahead of the expiring advocacy contracts (four adults' and one children's) in 2018, there was still a significant proportion of advocacy responding to the statutory duties. Essex noted the delivery model lacked the incentive for providers to use and support the development of self, peer and citizen advocacy. In order to further develop citizen advocacy, Essex commissioned an 'All Age' advocacy hub with a single provider to support all statutory advocacy duties in addition to developing volunteer and peer advocates.

The aim was to have a range of on-going citizen support that bridged the gap between statutory and non-statutory support, as well as to provide ongoing support for young people transitioning from children's to adults' services.

The types of citizen advocacy includes supporting:

- family, friends or someone else in the support network to speak on behalf of an individual or support them to speak for themselves
- long-term advocacy partnerships with peers or volunteers (peer or citizen advocacy)
- the development of 'speaking up skills' in a facilitated group situation (self-advocacy).

A service review carried out in October 2019 explored some of the successes and challenges of developing citizen advocacy. Essex has learnt some of the referrals that could be supported via citizen or peer support would require the volunteer or peer advocate to have, in some instance, detailed knowledge or experience on a particular type of support. They have had a combination of lived experienced or experience gained in professional roles. Recruiting volunteers has been slow and progressive, as many are only able to dedicate a few hours a week, so it's been important to ensure the cases allocated to volunteers fit their work—life balance.

There has also been work to develop a number of peer groups, and the Essex advocacy hub has helped to form:

- Outhouse in Colchester – supporting members of the LGBTQ+ community
- Older people walk and talk in Southminster
- Motivating minds speaking up group in Basildon
- A group for single mums with postnatal depression in Harwich.

The main aim for these groups is to become self-sufficient after 12 months. Their objectives are to:

- improve mental health and wellbeing for members
- increase empowerment and resilience of members
- deliver the ‘Speak Up’ toolkit (developed by Rethink Mental Illness) to learn self-advocacy
- develop the skills to stand up and speak out about issues that matter
- increase skills, i.e. communication, social, listening and increased empathic understanding
- improve understanding and raised awareness of important issues within the community
- reduce feelings of loneliness and isolation for members of the community by having indoor and outdoor activities.

The recent COVID-19 pandemic also unearthed a vast number of volunteers with a range of skills, experience and willingness to support the community through the Essex Wellbeing service. Going forward, Essex would to like to encourage the development of citizen and peer advocacy support from these volunteers who now also have the lived experience of supporting the vulnerable members in their community.

Advocacy in Suffolk: Case study

VoiceAbility, working closely with commissioners and a range of local providers, developed a partnership model to respond to an ambitious new vision for advocacy in Suffolk. They tested the approach carefully in an initial one-year pilot. 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 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
- significantly improving response times, with no waiting lists for statutory services.

Background

Suffolk County Council had a long history of grassroots advocacy provision to a wide range of people across the county. Some local services specialised in formal 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 a blend of contract arrangements and grant-aided funding. All of these providers attended the informal Suffolk Advocacy Forum (SAF) to facilitate ongoing development and training.

In 2011, the council reviewed its advocacy services and requirements with SAF and wider stakeholders, including referrers and advocacy clients. The result was a report outlining recommendations for the future. The report found that a new commissioning model was needed in order to achieve:

- strong coordination and leadership of the service
- greater equity of access for people across the county
- better consistency of support and outcomes for clients.

The Council also wanted to better highlight poor practice and abuse, and enable a wider range of people to have choice and control over services they needed.

Working closely with SAF, the local authority discussed how to achieve consistently high-quality and affordable advocacy in an increasingly constrained financial environment. They worked with people who used advocacy services, family carers, advocacy providers and local authority specialists to deliver a co-designed, integrated model of services.

Partners in commissioning, partners in delivery

In summer 2012, Suffolk County Council invited proposals from partnerships of organisations, who between them could deliver a range of specified statutory and non-statutory services, initially for a one-year pilot.

In response, the partnership ‘Total Voice Suffolk’ was formed, and took on the pilot opportunity on 1 April 2013. The partnership was led by VoiceAbility, and along with the other partners:

- Alzheimer’s Society
- Age UK Suffolk
- Impact
- ACE
- Suffolk Family Carers.

Following the pilot year, Total Voice Suffolk won the current contract from 1 April 2014.

Service evolution

The open, collaborative approach taken by commissioners and VoiceAbility (as lead provider) has enabled Total Voice Suffolk to evolve in line with the changing needs of local people and the Council.

This has resulted in many changes to provision over the life of the contract. Originally, Total Voice Suffolk delivered over 18,000 hours of advocacy provision to adults across 850 referrals, including specific non-statutory services for different user groups.

The increase in demand for statutory advocacy, particularly with respect to the Care Act, Mental Capacity Act and Deprivation of Liberty Safeguards has required a re-focusing of resource. In 2019/20, Total Voice Suffolk delivered 26,000 hours of advocacy provision across more than 2,250 referrals.

Figure 1: Breakdown of advocacy hours per annum and types of advocacy (2014/15)

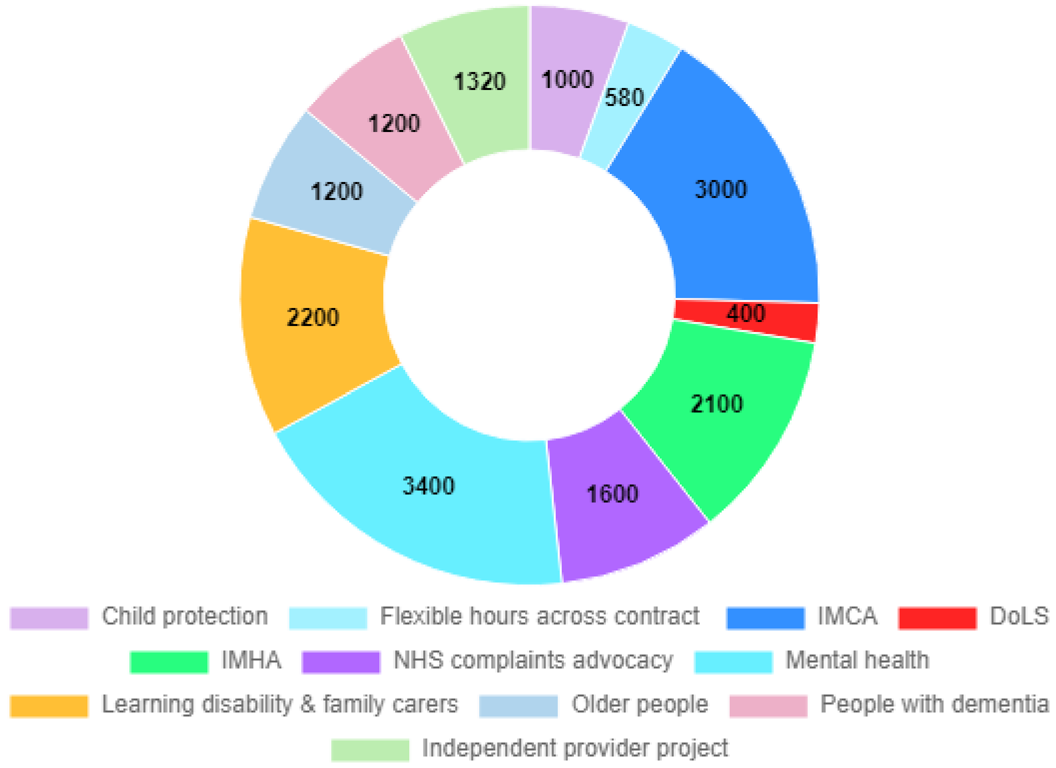
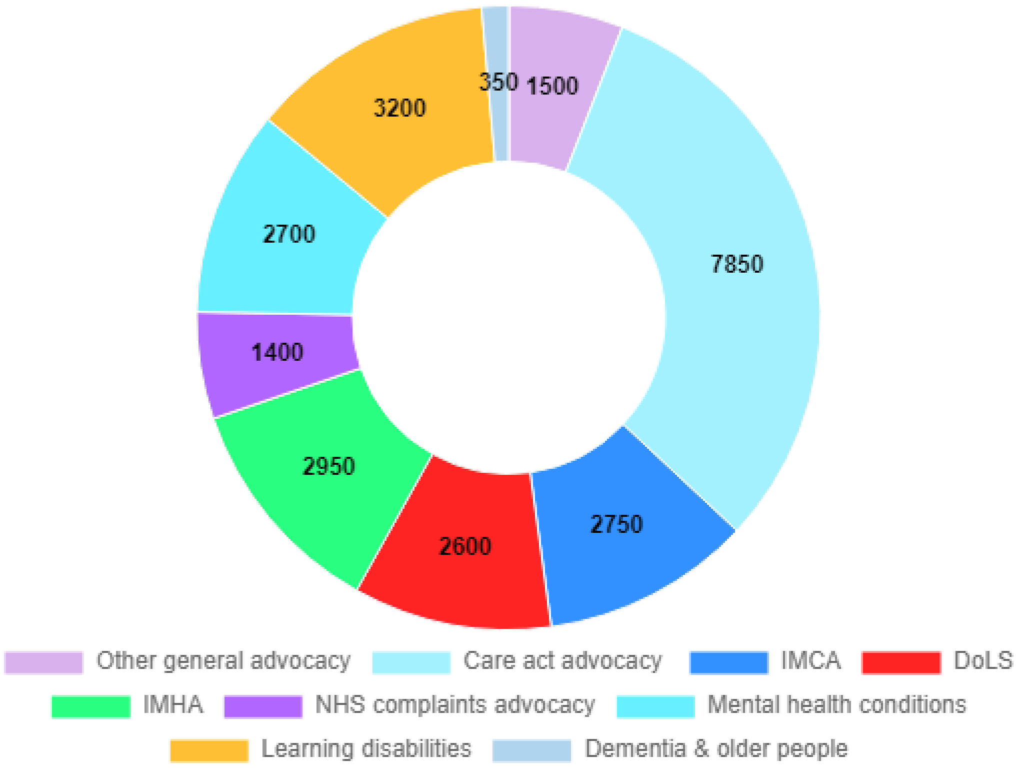


Figure 2: Breakdown of advocacy hours per annum and types of advocacy (2019/20)



Total Voice Suffolk has also been instrumental in supporting local authority and Clinical Commissioning Group (CCG) priorities. Since 2018, multi-skilled VoiceAbility advocates have been co-located with discharge social work teams at West Suffolk and Ipswich hospitals, identifying cases where rapid access to advocacy can expedite appropriate, sustained discharge. This has reduced delayed transfers of care and readmissions.

> The advocacy requests are responded to much quicker now, in fact the whole process of involving an advocate is much easier. Having one person advocating for customers in hospital means we have one person to talk to so we can simply ask for advice and information.
>
> **Discharge social workers**

Originally, advocacy for children and young people was not part of the Total Voice Suffolk provision. In 2019, during a review, providers highlighted that children and young people weren't receiving the same quality of advocacy as adults. They also highlighted an increase in eligibility for young people for other statutory advocacy, including under the Care Act, the Mental Health Act and the incoming **Liberty Protection Safeguards**.

Children's statutory advocacy was then varied into the Total Voice Suffolk contract from April 2020. This 'whole life' approach means that the service can deliver seamless support to children and young people as they transition into adulthood, especially those with the most complex needs.

Each strand of work is delivered collaboratively by different configurations of the Total Voice Suffolk providers, who work together to ensure that the right support is provided at the right time. By working together, they pool an invaluable knowledge base and relationships with key statutory and voluntary sector teams across the county.

The flexible approach means that changes in the partnership have been made in a way which ensures consistency and service improvement. This means that the partnership now includes specialist user-led mental health provision and signing advocacy for d/Deaf people. Two providers also chose to step away from advocacy provision, which was facilitated by transferring staff to other providers, ensuring no loss of consistency for people who use advocacy services.

Considerable expertise is required to hold this complex matrix together. Each partner plays a key role in making this as straightforward as possible. VoiceAbility, as the lead partner, employs a Contract Manager to ensure effective co-ordination of resource and compliance with KPIs.

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. Resources have also enabled a substantial training programme for advocates across providers.

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

- A single point of contact for commissioners has reduced the resource needed for contract management and enabled rapid resolution of any issues.
- A single referral point, delivered through VoiceAbility's central hub, has reduced barriers to access and facilitated easier allocation of case work.

- A single database, used by all providers, has increased consistency of recording and improved local insights into unmet need. This has provided evidence required for innovations and additional investment as legislation has evolved.
- Improved ability to aggregate and identify low level concerns about practice and raise them accordingly with providers and commissioners.
- 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, increasing efficiencies and reducing travel time.
- A common training and best practice development programme for all partners and advocates has meant information, updates and briefings are 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 and referrers

The key benefits are:

- clearer accountability – through a single Contract Manager
- ease of access – one telephone number and one website saves people trying to contact the service both time and effort
- speed of response – everyone gets a same-day response with a clear indication of how their advocacy support will be progressed
- ability to identify advocates with specialist skills – meaning that people receive consistent support from multi-skilled advocates
- more consistent approach to advocacy – an evidence-based, outcome-focused model which combines VoiceAbility’s national expertise with partners’ specialist local knowledge, delivering better results for clients
- earlier resolution – the service can work with people more quickly, more appropriately and more effectively.

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
- commissioners and providers have worked openly and collaboratively throughout the life of the contract to meet emerging needs and respond to changes in legislation.

As a result, better advocacy is being delivered by more highly trained advocates to a greater number and diversity of people. 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.

> 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."
>
> **Partner**

And this has all meant better experiences for people in Suffolk:

> Having my advocate has made all the difference.
>
> **Person using the service**

social care
institute for excellence

Social Care Institute for Excellence
Isosceles Head Office
One High Street, Egham TW20 9HJ

www.scie.org.uk