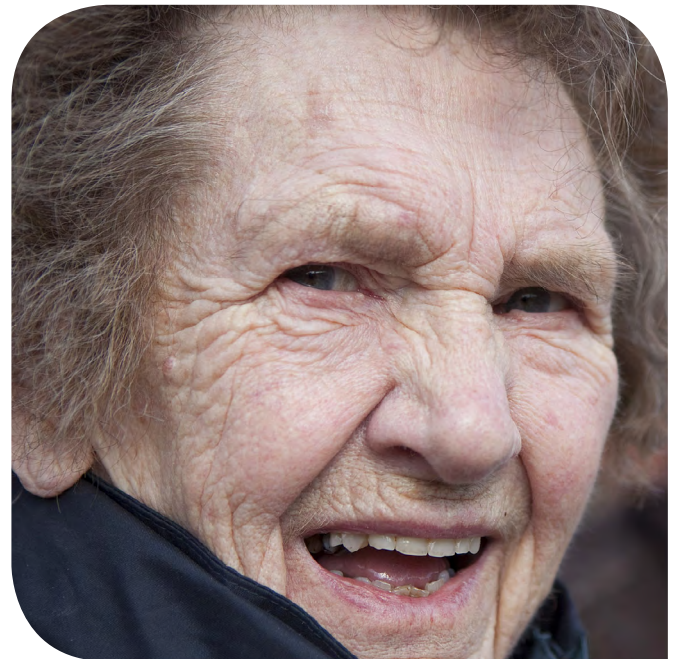
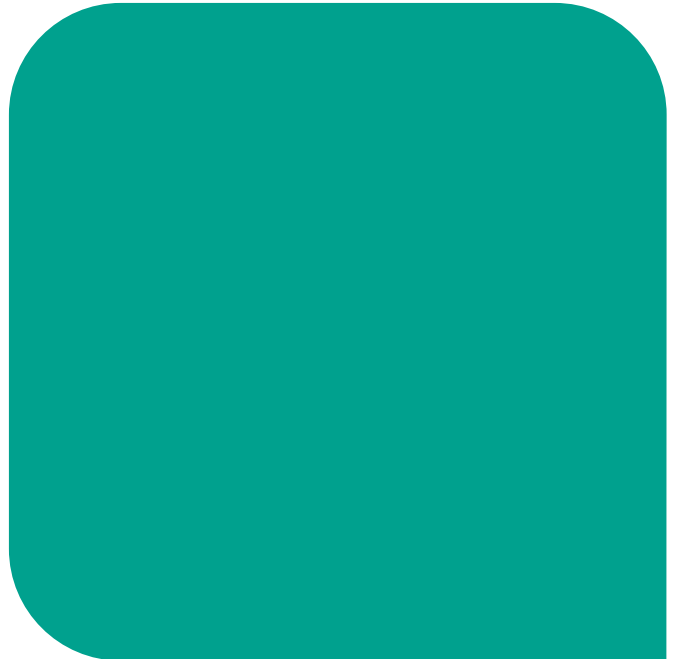




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Commissioning advocacy under the Care Act: Emerging good practice



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Social Care Institute for Excellence

Kinnaird House
1 Pall Mall East
London SW1Y 5BP
tel 020 7766 7400
www.scie.org.uk



Contents

Acknowledgements

Introduction.....	1
Key messages.....	2
Key findings about the implementation of advocacy under the Care Act.....	3
Effective commissioning of advocacy under the Care Act based on emerging good practice.....	4
Understanding what advocacy is and the need for independence.....	4
Practice example: Understanding advocacy is important in Essex.....	5
Embedding co-production in commissioning.....	6
Practice example: Co-production from the beginning in Kent.....	6
Signposting to the right service.....	7
Responding to local needs and diversity.....	7
Practice example: Assessing need and preferences for Care Act advocacy service in Slough.....	8
Supporting access to advocacy.....	9
Practice example: The Manchester Advocacy Hub.....	9
Practice example: A single provider model in Cumbria.....	10
Strategic and quality approach to commissioning.....	11
Meaningful and proportionate monitoring to measure outcomes.....	12
Practice example: Monitoring Care Act advocacy provision in Calderdale.....	13
How Advocacy under the Care act is being implemented.....	14
Statutory and non-statutory advocacy.....	14
Watchful commissioning.....	14
Needs assessments.....	15
Co-production.....	15
Models of advocacy provision being commissioned.....	15
Evidence of variation in spending on advocacy under the Care Act.....	16
Number of referrals to advocacy under the Care Act.....	16
Background and methodology.....	18
Background.....	18
Policy context.....	18
Previous research studies.....	19
Study purpose.....	20

Study methods.....	20
Limitations.....	21
References.....	22

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Introduction

This is a briefing for commissioners and providers of independent advocacy under the Care Act. It sets out emerging good practice and summarises the findings of new research from the Universities of Birmingham and Central Lancashire. This briefing builds on and expands SCIE's Commissioning independent advocacy under the Care Act 2014. The study included surveys of local authorities and advocacy providers. You can view further details of the [background and methodology](#).

Advocacy is rooted in a belief that disabled people should be able to determine what matters to them and the support they need to enjoy a good quality of life. The Care Act includes a new statutory right to independent advocacy for people who fit certain criteria. This new duty is being implemented in the context of reduced local authority budgets, the tightening of eligibility criteria and increasing demographic pressures.

This resource outlines what emerging practice looks like and how advocacy is being implemented in England.

Key messages

Six key steps to strengthen the commissioning of advocacy under the Care Act

- Understanding what advocacy is and the need for independence.
- Embedding co-production in commissioning.
- Responding to local needs and diversity
- Supporting access to advocacy
- Strategic and quality approach to commissioning.
- Meaningful and proportionate monitoring to measure outcome.

'We define everything as Care Act advocacy if they meet the threshold and it's about their life, they get an advocate... I think there is a mix-up about advocacy – it's not just about the law. We call it social care and community advocacy. It is difficult to define but if someone needs an advocate, they get it.'

(Commissioner, interview)

Key findings about the implementation of advocacy under the Care Act

- There was evidence of promising practice in the commissioning of advocacy under the Care Act but several local authorities had initially adopted a cautious 'wait and see' approach.
- Some local authorities were still to specifically commission advocacy under the Care Act.
- Under half of local authorities (47 per cent) reported involving people using or likely to use social care and family carers in the commissioning process.
- There was wide variation in the methods local authorities used for estimating likely demand for advocacy.
- The majority (60 per cent) initially commissioned a single advocacy provider, with 38 per cent commissioning a service 'hub' or partnership with a lead provider.
- Less than 10 per cent of the local authority sample reported spot purchasing as the only method of commissioning advocacy under the Care Act.
- More than half of providers considered arrangements for referral as not working well, often attributing this to frontline staff's lack of understanding of their duty to refer.
- In some areas, there had been fewer than 10 referrals since April 2015, and in others over 400.

Local authorities reported prioritising statutory advocacy as a result of financial austerity: 22 per cent of commissioners reported either stopping commissioning or reducing access to non-statutory advocacy during 2015/16.

Effective commissioning of advocacy under the Care Act based on emerging good practice

This section outlines six key steps to strengthen the commissioning of advocacy under the Care Act and illustrates some of them with practice examples.

Understanding what advocacy is and the need for independence

Everyone involved in social care locally needs to develop a clear understanding of advocacy, why it needs to be independent, its various forms, the legal context, its role in implementing the Care Act wellbeing principle and duties in relation to prevention as well as supporting peoples' involvement in their care. This includes capacity building and support for commissioners and frontline staff, including co-produced training, to develop an understanding of advocacy and their roles in promoting and supporting access and uptake.

Frontline staff not understanding advocacy was identified as a major barrier to access and uptake of advocacy under the Care Act and this may skew the assessment of need and demand.

Commissioners not understanding advocacy can result in commissioning advocacy services that are ill-equipped to provide meaningful advocacy. Relying solely on spot purchasing is an example of commissioning practice that is instrumental. It does not locate advocacy within a framework of promoting greater choice, control and ultimately wellbeing.

Similar to independent mental capacity advocates (IMCAs) and independent mental health advocates (IMHAs), independent advocates under the Care Act are expected to be appropriately trained, and hold the National Qualification in Independent Advocacy (level 3).

However, other advocates, for instance generic advocates or citizen advocates, who do not hold this qualification can support involvement in decision-making under the Care Act. Such advocates could be appointed as independent advocates under the Care Act and be working towards the qualification within their first year in the role. Some local authorities clearly understood this and were viewing Care Act advocacy within a broader understanding of advocacy.

'We define everything as Care Act advocacy if they meet the threshold and it's about their life, they get an advocate... I think there is a mix-up about advocacy – it's not just about the law. We call it social care and community advocacy. It is difficult to define but if someone needs an advocate, they get it.'

(Commissioner, interview)

Commissioners need to be knowledgeable about advocacy and the role it plays in both protecting individual rights and promoting wellbeing. They should understand:

- the different forms of advocacy including generic and citizen advocacy

- there can be an overlap between IMCA and advocacy required under the Care Act. This is a complex area but people who struggle with decision-making do not necessarily lack the capacity to make a decision regarding their care and support
- the importance of independence from service provision. This is critical as conflicts of interest can arise if the service providing advocacy also has a role in providing care and support to individuals. This does not mean that social workers, care managers or care providers cannot promote an individual's views but it does mean they cannot act as independent advocates
- advocacy under the Care Act services work well when there is an information and advice service in place to deal with a broad range of queries regarding social care, and means that the advocacy service is more likely to receive appropriate referrals.

Practice example: Understanding advocacy is important in Essex

An existing partnership involving eight advocacy services – Essex Advocacy Partnership with a lead national provider – was established prior to implementation of the Care Act, offering a strong foundation for development of advocacy under the Act. One partner said:

'In Essex we were already advocating for people to have advocates, for instance, on the back of Valuing People to make sure people were included and involved in decisions, it just wasn't called independent Care Act advocacy. The only difference is that now people have a statutory right to advocacy.'

(Provider)

Whilst this is being re-commissioned by 2018, such a partnership prioritises and values provision of all kinds of advocacy, not limiting it to 'statutory advocacy' only. Essex County Council aims to commission advocacy that is outcomes-focused, requiring services to show what difference advocacy is making to users.

'I hope we would have citizen, volunteer, peer advocacy to support people who have a long-term need for advocacy. It doesn't seem right that they should have a different advocate every time a need for advocacy under the Care Act is identified. That is where you'll get true and meaningful advocacy, and we're trying to grow that... If someone who doesn't know me comes along to represent me, how is that going to help me have a voice, to speak for myself ultimately?'

(Commissioner, interview)

Embedding co-production in commissioning

Advocacy under the Care Act should be commissioned in meaningful partnership with people who use services and carers. Co-production is not easy and there are fundamental differences that have to be negotiated, including roles, responsibility and accountability. For co-production to flourish, both within advocacy providers and in local authority commissioning, organisational structures and culture, staff values and attitudes may need to change and develop.

Co-production in commissioning is a leap up from consultation, involvement and engagement. It adheres to underpinning values and principles driven by the user movement. These values also form the bedrock of advocacy provision and so easily lend themselves to commissioning advocacy under the Care Act.

Practice example: Co-production from the beginning in Kent

In January 2015, the commissioners in Kent County Council invited people with support needs, carers, advocacy providers and commissioners to an event. One hundred people attended and two independent consultants, one with a learning disability, coordinated and facilitated the event: aiming for it to enable equal contributions from participants. Open Space and World Cafe approaches were adopted to discuss 'Help us understand what advocacy is' and 'What important things do we want to say about advocacy in Kent?' This 'blank canvas' approach inspired many but challenged some by its less structured approach.

Outcomes

- A steering group of people with support needs and carers was formed at the event to work with the commissioner to write the specification for advocacy services and define the outcomes.
- The Council awarded the contract on 1 April 2016 to an advocacy provider who sub-contracted with eight other providers to make up Kent Advocacy (hub model).
- Kent Advocacy provides a single point of access and assessment for all advocacy requests in Kent, and undertakes triage and prioritisation of referrals according to urgency, need and geography.
- The service receives referrals from people who historically were excluded from commissioned advocacy services, such as people with sensory impairments.
- A simple referral process, via a dedicated website, alongside other contact routes, makes referral accessible and easy.
- Decisions regarding Kent Advocacy are made collectively by all providers in the network, enabling a supportive environment for problem-solving, and sharing good practice.

- Commissioning continues to be guided by people who use the advocacy services.
Learning
- The model is based on people and their advocacy needs but co-production is hard. Enable people to reach you from wherever they are in the stage of their journey.
- Acknowledge the local authority is not the expert: 'let go' and trust the expertise of people who use advocacy services.
- Give time to talk, avoid jargon, keep language simple.
- Ask the market, the providers, who have the expertise and work together, not competitively.
- Develop a sustainable model. There is a risk in a hub model of 'putting all the eggs in one basket' but this is a managed risk, with regular service review and close working relationship between partners and commissioner.
- Consider how smaller organisations can contribute to the model – the solutions are often out there.
- Working with other local authorities can be challenging, particularly in relation to out-of-area referrals, where commissioning approaches differ. Local authorities naturally prioritise resources to local demand.

Signposting to the right service

The lead provider acts as a hub, directing access to the right advocacy service through the different partners. As one provider commented:

'The richness with commissioning different forms of advocacy is that it ensures all vulnerable people can access advocacy that is relevant and specific to their advocacy need, whether this is an appropriate family member, volunteer or a paid advocate. The Care Act guidance clearly identifies where the different forms of advocacy overlap and it is this that underpins the holistic approach. It is all forms of advocacy that should be supported, available and commissioned.'

(Provider)

Responding to local needs and diversity

Commissioners need to provide advocacy services that reflect and meet the diversity of the needs of local people. Commissioners should conduct needs assessments, using a range of methods, to embed equality and diversity into the scoping, design, provision and monitoring of advocacy services.

Limited needs assessment and lack of consideration of diversity risks a single provider being commissioned that is able to meet the needs of the majority, but does not provide

equal access to advocacy for all local people and further disadvantages minority groups.

Co-production with users, carers and the wider community, a population needs assessment and an equality impact assessment for advocacy will all support commissioning that responds appropriately to local need. This should include an analysis of demographic data, referral for assessment and support to the local authority, as well as events (open space events, focus groups, surveys) to identify the range of views and preferences for providing advocacy. Particular attention should be paid to:

- older people
- people from black, Asian and minority ethnic (BAME) communities
- people with learning difficulties, physical disabilities and/or sensory impairments.
- lesbian, gay, bisexual and transgender people
- asylum seekers
- carers.

The views of people from these groups may be overlooked and proactive measures need to be adopted to ensure they are included because they may have specific preferences for advocacy provision or face particular barriers in accessing advocacy. Partnership working between different advocacy providers can increase access to advocacy for marginalised groups and promote learning across the sector.

Practice example: Assessing need and preferences for Care Act advocacy service in Slough

The starting point was to redesign the service, to create a better advocacy service that was not just about advocacy under the Care Act but how advocacy is viewed by people using social care. Effort was put in at the beginning of the commissioning process to identify exactly what was needed. This included looking at relevant policy documents and good practice guidance as well as reviewing:

- the local joint strategic needs assessment
- who currently uses advocacy services
- what local people understand about advocacy and its 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 advocacy services and how they might choose to access services in the future
- what people consider to be a good local advocacy service, which meets their needs.

Slough Healthwatch [1] completed a review of current advocacy provision, on behalf of the local authority. It conducted focus groups and a limited number of one-to-one informal interviews with service users who had received advocacy services from current providers, to understand their experience of receiving advocacy and how the service can be improved. Information collected from this report supported in designing the new service as information was included in the service specification of the new service.

Reference

1. Healthwatch Slough (2015). [What Healthwatch Slough found out about advocacy services](#).

Supporting access to advocacy

Advocacy is a complex field and can sometimes be confusing for people who use services and professionals. Finding the right type of advocate and working out eligibility for statutory advocacy can be bewildering. Introducing a single point of access for all advocacy is one way that some local authorities have looked to ensure that people can access advocacy appropriate to their needs.

People should be able to access different types of advocacy according to what they need. There are overlaps between different forms of statutory advocacy and also informal advocacy (e.g. peer advocacy, generic advocacy, citizen advocacy and self-advocacy). All of these have a critical role to play in enabling people who use social care to have a greater voice and more control over their lives. Some areas favour the hub model, which provides a single gateway to a range of advocacy provision. They report that one critical advantage of this model is that it can be easier to respond to people's individual needs providing access to different types of advocacy through a range of specialist providers. It can also facilitate long-term relationships whereby a single advocate may adopt several advocacy roles (e.g. IMHA, IMCA, generic advocate) with an individual service user as their needs and eligibility for advocacy changes.

Local authority respondents and providers identified a lack of clarity about people who are placed out of their ordinary area of residence as problematic. It can result in a person not accessing an advocacy service, which in the context of high-profile failures in the quality of care, jeopardises wellbeing and safety.

Practice example: The Manchester Advocacy Hub

The initial driver for the recommissioning of the advocacy service was to better integrate services. The existing provision had grown organically and was consequently disjointed, with nine different advocacy contracts managed by six different providers. The decision was made to pull all the different forms of advocacy into one, in order to reduce the transaction costs of handling nine contracts, to provide a broader offer with clearer and easier access. Introducing a single gateway into advocacy was also seen as potentially providing a better understanding of the advocacy need in the city and improving the quality of provision.

Manchester City Council began a public consultation process which included an electronic survey, undertook workshops with service users and commenced soft market

testing with providers. There was support for the hub although some initial feedback suggested it was too focused on the statutory requirements for advocacy. The Council ensured the feedback informed the process and subsequently went out to tender for an organisation to provide a single gateway to a range of advocacy (hub model). The contract was awarded to a partnership between two local providers. A critical consideration in the decision-making was social value, for example, local knowledge, a track record in working in partnership with other third sector organisations, the development of self-advocacy and peer support models.

Learning

There are crossovers between different types of advocacy and a single gateway ensures greater flexibility resulting in fewer delays. A single gateway also means people are given a consistent service.

Advocacy services are part of an asset-based approach, empowering people and giving them the skills, knowledge and confidence to be able to advocate on their own in the future.

Whilst a hub model might work well in some areas, and particularly in an urban context, this may not be the most appropriate practice in all areas; for example, some rural areas that have a limited number of providers, and where understanding the nature of the dispersed population and geography is vital. Key to effective commissioning is recognising that 'one size does not fit all' and the local context (population, geography, local views and provider capacity) play a role in determining the appropriate model.

Practice example: A single provider model in Cumbria

Commissioning Care Act advocacy as part of a block contract from a single provider was 'paying dividends' in Cumbria, where this was seen as a 'cost-effective' and appropriate way to deliver 'seamless advocacy provision' across diverse localities. A separate contract is held by another organisation to provide IMHA services. Critical to success in providing advocacy under the Care Act was the successful organisation having a good understanding of local issues:

'The hub model wouldn't work in this area, it didn't seem feasible for us. From previous experience we knew that spot purchasing from a large number of providers for a proportion of the population over a wide geographical area might lead to services which were not cost-effective, could be fragmented and might lead to instability in the market.'

(Commissioner, interview)

'A local advocacy organisation already commissioned to provide a generic service won a four-year contract through competitive tendering to provide a package including Care Act advocacy, NHS Complaints advocacy, IMCA, and Healthwatch advocacy. The contract has some inbuilt flexibility allowing the provider to move funds between different types of advocacy depending on actual demand and subject to agreement with the commissioner. Past experience of delivering generic advocacy

meant the contract with this provider naturally transformed into providing Care Act advocacy.'

(Provider)

There is now no formal commissioning of non-statutory advocacy, apart from individual arrangements for some individuals, for example, when the courts have requested it. Bespoke advocacy was also recently commissioned for a group of people adversely affected by the flooding in Cumbria, in recognition of the impact on their services.

Success factors of its 'thriving local offer' from two providers (including the IMHA service) were the availability of a pool of people in the area willing to train as advocates, and the understanding and track record of the successful providers.

Strategic and quality approach to commissioning

Commissioners should apply a good practice approach to the commissioning of advocacy under the Care Act, drawing on existing SCIE guidance and **Commissioning for Better Outcomes: A route map**. This includes:

- working with advocacy providers to develop solutions and overcome barriers
- 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.

Providers valued having both a block contract to ensure stability, and flexibility in the contract to respond to changes in demand. For example, a block contract for the majority of hours or contacts and the remaining proportion either to be billed to the local authority on a spot-purchase basis or an allocation. This could be used flexibly across all types of advocacy to respond to fluctuations in demand.

Commissioners and providers emphasised the importance of positive working relationships between each other, which enabled a developmental approach to introducing advocacy. Eighty per cent of the providers who responded to the survey indicated they had been involved in the commissioning process. Some respondents felt that this built on an existing relationship which can be positive but care must be taken not to exclude smaller, less well-known providers, for example, community based-organisations representing minority groups. **[1]** Positive relationships were characterised by commissioners understanding advocacy well, committing to sustaining provision and being willing to seek shared solutions with the provider.

'We started from a low position but the commissioners were very open, it was a two-way process with open dialogue. There is a good level of referrals and steady growth. When there are problems or barriers, the commissioners are receptive and not defensive.'

(Advocacy provider interview)

Organisational 'churn', often as a consequence of austerity measures, can lead to turnover in commissioners who have a good understanding of advocacy and may result in an approach driven by contracting rather than commissioning.

Tendering for advocacy potentially favours larger organisations that have greater experience and capacity, and can result in smaller organisations no longer being viable. Associated with this, concerns were raised by providers about the lack of transparency in decision-making regarding awarding tenders. A limited choice of provider(s) can mean that there are potentially issues with the quality of provision.

Meaningful and proportionate monitoring to measure 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.

Commissioners described requiring a range of data for monitoring contracts, usually on a quarterly basis and, in some instances, monthly. This included access rates for advocacy, demographic detail and bespoke outcome measures as well as descriptive accounts of observations on trends in use of advocacy services, partnership working, co-production and case studies. Providers emphasised the importance of meaningful and proportionate monitoring. The opportunity to engage in dialogue with commissioners varied. Where this was evident it was clear that commissioners and providers were working together on meaningful outcome measures and using the information to improve services.

'We proactively provide feedback and are seen as a critical friend to the local authority. We send reports on issues arising that both impact on the provision of advocacy (e.g. referrals not being made) and issues arising from work with people. With the Head of Safeguarding/Quality we are currently developing a plan of how the local authority is to address the issues arising.'

(Advocacy provider survey)

Providers and local authorities emphasise the importance of advocacy being person-centred and achieving the outcomes that they want. There is a risk that Advocacy under the Care act could become overly focused on local authority processes of assessment, review and safeguarding rather than the person. Effective advocacy needs to be timely so that a person can access it when they need it and also needs to be focused on the person and the outcomes they want to achieve. A key outcome should be enabling the person to self-advocate through building skills, networks and capacity using advocacy as a key opportunity.

References

1. Carr, S. (2014). **Social Care for Marginalised Communities: Balancing self-organisation, micro-provision and mainstream support.**

Practice example: Monitoring Care Act advocacy provision in Calderdale

The outcomes used for monitoring were developed from a review of other local authorities' service specifications for advocacy under the Care Act; a review of good practice service specifications on the SCIE website and discussions with other commissioners.

The outcomes were then tested as part of market engagement. The provider is required to provide client feedback against the following five outcomes on a quarterly basis:

- percentage of individuals (service users and carers) who feel they have received information readily in respect of advocacy services and the service available in their particular circumstances
- percentage of individuals enabled to better understand and be involved in their care and support and health-planning processes and decision-making
- percentage of individuals who report an increased ability to negotiate arrangements and services to meet their needs
- percentage of individuals who feel that advocacy services have contributed to achieving their personal outcomes
- percentage of individuals who feel empowered to challenge decisions.

How Advocacy under the Care act is being implemented

This section looks at how advocacy is being implemented in England. It is based on the survey responses of 46 per cent of local authorities, a survey of advocacy providers and 23 follow-on interviews with commissioners and providers.

Statutory and non-statutory advocacy

Some commissioners distinguished between statutory and non-statutory advocacy and as other studies have identified, are prioritising the funding of statutory advocacy including advocacy over community and other forms of advocacy. Twenty-two per cent of commissioners reported that they had either stopped commissioning or reduced access to non-statutory advocacy during 2015/16. Viewing all advocacy as covered by the Care Act was identified as one way of protecting wider forms of advocacy from budget restrictions. The majority (87 per cent) of local authorities in the study were commissioning advocacy for their area only, with the remainder commissioning jointly with neighbouring local authorities, and in a small number of instances, with the clinical commissioning group (CCG).

Watchful commissioning

It was evident, that many had approached the introduction of the duty to provide advocacy under the Care Act cautiously; using the first year to better understand the need and demand, and to develop service specifications. Four out of five local authority respondents had developed a specification for advocacy. Not all, however, had as yet gone out to tender specifically for advocacy under the Care Act at the time of the survey (29 per cent extended an existing advocacy contract and 48 per cent had gone out to tender in 2015/16). The picture that emerged was one of a 'work in progress', perhaps unsurprising given the timing of this study:

'The contract is for another year, extension of an existing contract. We wanted to work with them (provider) in collaboration to understand impact of the cuts and how Care Act advocacy needs to develop. We'll be going out to the market tendering for Care Act advocacy in four to five months' time with an outcomes-based specification.'

(Commissioner, interview)

It was evident from interviews with advocacy providers that some local authorities have not specifically commissioned advocacy under the Care Act and that the advocacy provider is being expected to provide increased advocacy services without additional resource:

'We have always been able to provide a quick response for advocacy but currently have 50 people on the waiting list. Our advocates currently have an average caseload of 30 people but they are very experienced. We have asked for additional hours

to respond to the demand but have had no response from the local authority. We are now having to prioritise but some of our waiting list is due to spending time chasing social workers.'

(Advocacy manager)

Needs assessments

Seventy-eight per cent of local authority respondents had undertaken a needs assessment to estimate likely local demand for advocacy as recommended by SCIE's good practice guidance. This, however, varied from using quite crude measures to much more sophisticated evidencing of need. Likely need had variously been estimated with reference to local and national information and guidance, for example, the number of local community care assessments, past and current use of advocacy services, and the Department of Health's 2014 Impact Assessment. [1]

Co-production

Forty-seven per cent of local authorities stated they had involved adults with social care needs in the commissioning process for advocacy. Some who were in the process of developing their specification were involving users and carers as well as advocacy services in this, including a 'series of co-production events from inception of delivery model to writing of the service specification', in developing the new model, while others had engaged in consultation exercises and had relied on getting a steer from existing customer feedback mechanisms. Others indicated their intention to involve users and carers in the future:

'Although the answer to this question is 'no', we had involved service users in the original advocacy tender for IMCA/IMHA and general advocacy. It was this contract we extended to cover Care Act advocacy. We also ensured local service user groups were aware of their right to advocacy support under the Care Act.'

(Commissioner, survey)

Models of advocacy provision being commissioned

The majority (60 per cent) described the model for the provision of advocacy under the Care Act as a single provider model, that is, one advocacy service had been commissioned to provide advocacy. Another 38 per cent referred to partnerships and consortiums of advocacy services which they referred to as 'integrated advocacy service', 'partnership model', 'framework' or an 'advocacy hub model' with a range of contractual arrangements often with a lead provider acting as the gateway to other providers offering different forms of advocacy to different user groups. Spot purchasing according to need was a less common practice amongst the survey respondents than reported in other studies. [2]. Since April 2015, 27 per cent of respondents had changed advocacy provider due to arrangements being interim, learning together with the advocacy providers what was needed, and social care commissioning processes evolving, for example, to become more outcomes-focused. [3]

Evidence of variation in spending on advocacy under the Care Act

Commissioners and providers reported wide variation in the total spend on advocacy, ranging from contracts of under £25k to others over £200k. Comparing the size of contracts for 2015/16 and 2016/17 suggests a trend towards a reduction in contracts of under £25k, which may reflect the changing nature of advocacy commissioning as experience unfolds. While some local authorities are allocating relatively little resource to develop advocacy services, there was an indication that some are subsequently investing £150–£200k in advocacy. Nonetheless, concerns were expressed from providers about potential reductions in resources for advocacy alongside increasing demand.

It can be difficult to interpret this data however as some local authorities were unable to differentiate spending on advocacy from Care Act overall spend and it is unclear what the per capita spend is. As one commissioner told us:

‘Our advocacy contract is a “hub” approach, bringing in all statutory advocacy provision under one contract. The contract value is £635,000 per year for IMCA, IMHA, Care Act, NHS Complaints and non-statutory advocacy. The contract specifies indicative values for the number of hours of each form of advocacy. The aim of the advocacy hub approach is to work to be flexible to meet ebbs and flows in demand, hence the indicative value approach.’

(Commissioner)

Over half of providers (53 per cent) reported advocacy contracts with the local authority of 12 months or less. However, there was an indication that this is slowly changing: almost a fifth of providers had service contracts of three or more years and some future contracts were being planned to offer greater sustainability:

‘The contract will be for 3+2 years. That is, a three-year contract with the potential to extend for two years... This is the first time this Council has put the voluntary sector providers through a formal tendering process. Previously a lot of it was grant-funded but providers complained they had no security.’

(Commissioner, interview)

Number of referrals to advocacy under the Care Act

Many local authorities could not easily provide numbers of people who had had an advocate since April 2015. They said that this information was ‘not to hand’ or they were unable to provide an answer at this time, or simply that they did not keep such records. What was reported however, confirmed findings of earlier studies that while some areas have seen a dramatic increase in referrals for advocacy since the implementation of the Care Act, in many others rates of referral were far lower than expected. In some areas, there had been fewer than 10 referrals since April 2015, and in others over 400.

We found no evidence to suggest that rates of referral were linked to the model of provision. Many providers highlighted a lack of effective training for frontline staff in local authorities as causing the low number of referrals. Ninety per cent of local authority respondents on the other hand said that frontline staff in their area had been trained. However, providers were observing variation in the number of referrals between teams working with similar client groups in the same authority.

References

1. Department of Health (2014). As above. ↵
2. AAA (2015). As above. ↵
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Background and methodology

The Care Act 2014 requires local authorities to make independent advocacy available to eligible service users and carers. In October 2014, SCIE launched guidance to support good practice in commissioning independent advocacy. Early studies examining implementation indicated that referrals were lower than expected and therefore many of those potentially eligible for advocacy under the Care Act might not be receiving the service they are entitled to. In 2016, SCIE commissioned the Universities of Birmingham and Central Lancashire to undertake a rapid appraisal of how advocacy was being commissioned in relation to the Care Act and to identify the features of promising positive practice. This involved surveys of commissioners and providers; interviews; documentary analysis; and a roundtable discussion involving people with experience of using social care services, commissioners and advocacy providers to identify improvements in the commissioning of Care Act advocacy. The findings include practice examples, which were identified by advocacy providers and/or commissioners, or were highlighted by external organisations, as offering examples of promising practice.

Background

Advocacy has a long history and is rooted in a belief that disabled people should be able to determine what matters to them and the support they need to enjoy a good quality of life. It is broadly defined as enabling people to express their views and preferences, including supporting people and/or family carers to advocate for themselves as well as representing their views. Having an advocate to support and represent individuals' views, can increase self-determination, inclusion and the way that services are offered, thereby supporting empowerment, independent living and full citizenship. [1] [2] [3] Access to advocacy is specifically required when people's needs are not well understood, placing them at risk of further marginalisation and social disadvantage by their views being discounted, [4], [5] as consistently noted in relation to people with learning disabilities, people with ongoing mental health issues and frail older people.[6]

Policy context

Under the Care Act 2014, which came into force in April 2015, local authorities have a duty to promote wellbeing in everything they do and the statutory guidance highlights the importance of advocacy in achieving this. Section 3.9 of the guidance defines advocacy as 'supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need'. [7] However complex people's needs are, local authorities must ensure people are supported to express their views and helped to consider what options they have, which increases individuals' control and self-determination. The Care Act, therefore, places a duty on local authorities to offer support from an independent advocate, if required, to enable people to be involved in decisions about them and their care and support.

The duty to provide independent advocacy applies from first point of contact with the local authority and at all stages of assessment, planning, review, and in the case of

safeguarding enquiry or review. Local authorities have to make a judgement as to whether an individual has **substantial difficulty** in being involved, reflecting on any reduced capacity for decision-making, and secondly, if there is an **appropriate individual** to support them. If not and the condition of substantial difficulty is met, an independent advocate must be offered if the individual is involved in any of the following processes described in the Act.[\[8\]](#) [\[9\]](#)

- an adult's needs assessment
- a carer's assessment
- the preparation and/or review of an adult's care and support or support plan
- a child's needs assessment as they transition towards adult care
- a child's carer's assessment (therefore some people below 16 years of age)
- a young carer's assessment
- a safeguarding enquiry or safeguarding adults review
- an appeal against a local authority decision under Part 1 of the Care Act (from April 2016).

Previous research studies

A previous survey of advocacy providers by the Mental Health Foundation for the Advocacy Action Alliance [\[10\]](#) (AAA, 2015) reviewing early implementation highlighted low numbers of people accessing advocacy in some parts of England despite the new duty. While some local authorities have implemented the independent advocacy duty well, the overall picture reported was less positive and AAA found evidence of poor commissioning practices, including a predominance of spot purchasing of advocacy services. This found a mix of contracting arrangements operating across local authorities in terms of commissioning of single or multiple providers, and different types of contract. [\[11\]](#)

The majority of contracts (63 per cent) were for 12 months or less which was concerning given the specialist knowledge and skills required and the importance of developing long-term relationships with services and professionals. The failure to offer advocacy has resulted in legal challenges with local authorities having to re-do flawed assessments (see London Borough of Haringey [\[12\]](#)).

It has been suggested by McNicoll (2015) [\[13\]](#) that the low figures for referral to advocacy services may have reflected severe budget cuts facing local authorities, and that as a consequence they were not promoting advocacy or simply did not have the resources needed to train frontline staff about their advocacy duty under the Care Act. Further, analysis of Better Care funding plans undertaken by VoiceAbility and presented as evidence at the October 2015 Public Accounts Committee, showed that local authorities were spending significantly less on Care Act advocacy than predicted to meet expected levels of need as indicated by the Department of Health's 2014 Impact Assessment. [\[14\]](#) Furthermore, a recent review of the implementation of the Care Act for Carers found little evidence of advocacy for carers. [\[15\]](#)

Concerns about the impact of the introduction of independent advocacy under the Care Act alongside other types of statutory advocacy (i.e. Independent Mental Capacity Advocacy (IMCA), Independent Mental Health Advocacy (IMHA) and Relevant Paid Representative (RPR) roles under Deprivation of Liberty Safeguards (DoLS)) on the investment in advocacy in general have been raised despite encouragement for wider advocacy in the Care Act. The AAA study found evidence of reductions in overall advocacy provision in many local authority areas. This is underscored by a recent study of citizen advocacy, which found it to be seriously under threat due to a lack of funding.^[16]

Study purpose

In light of the findings of previous research and with the intention to revise its guidance for local authorities commissioning advocacy under the Care Act, SCIE commissioned this small-scale study to:

- identify models of commissioning Care Act advocacy in England
- identify promising practice examples
- engage with key stakeholders in identifying the wider policy and practice implications for commissioning independent advocacy.

Study methods

The study involved a survey of commissioning and provision to identify positive practice; follow-on interviews to gather further detail on the positive practice; analysis of local evaluation reports and commissioning documents provided by respondents and a round-table event of invited stakeholders to validate and explore the findings.

(1) Survey of commissioning and provision

Two separate surveys were undertaken: (1) an anonymised national survey of local authority commissioners in England to identify the core elements of the commissioning process. The survey was distributed by the ADASS regional leads and the responses represented 46 per cent of local authorities in England (i.e. 70/152); (2) a national survey of advocacy organisations providing Care Act advocacy with 49 responses representing 64 providers recruited primarily via the Action Advocacy Alliance, a network of 300 advocacy providers hosted by the Mental Health Foundation, and the Older People's Advocacy Alliance (OPAAL) UK.

Question areas across the two surveys were broadly similar, although tailored to the commissioner or provider context and covered commissioning arrangements; level of investment; advocacy being commissioned; access and uptake of advocacy and experiences of commissioning advocacy.

(2) Follow-on interviews

From the analysis of the survey responses, potential examples of positive practice were identified and if the respective organisations had agreed, individuals were contacted for a follow-on interview. Twenty-three follow-on interviews with commissioners (12), providers (10) and a national organisation (1), were undertaken to gather additional detail on positive practice. The lines of inquiry for these interviews covered:

- detailed description of commissioning model for Care Act advocacy in the local area
- who is involved in the commissioning process and how
- effectiveness of the current arrangements for commissioning Care Act advocacy
- criteria for assessing the success of commissioning Care Act advocacy
- main challenges to commissioning Care Act advocacy
- main challenges to providing effective Care Act advocacy
- recommendations for commissioning Care Act advocacy.

Respondents were invited to send evaluation reports and commissioning documents and a web-based search was also undertaken to identify tender documents.

(3) Roundtable event

The data from the different sources was thematically analysed and synthesised and then presented at a roundtable event involving invited stakeholders representing commissioners, advocacy providers, people using social care, Department of Health and SCIE. The format for the event covered considering the findings and the extent to which they resonated with people's experience. Participants were invited to develop recommendations for strengthening the commissioning of Care Act advocacy.

Ethical approval for the study was granted by the University of Birmingham Ethics Committee. Approval for the study was also given by the Research Group of the Association of Directors of Adult Social Services (ADASS).

Limitations

The study was limited by the time and resources available. Furthermore, as the focus was on identifying positive practice, the sample was not comprehensive and responses to the survey may reflect those local authorities where the commissioning of advocacy under the Care Act is more advanced. Finally, the findings the practice examples were not validated by data from a service user perspective.

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