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COMMISSIONING CARE ACT ADVOCACY: A WORK IN PROGRESS

Research Report



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TABLE OF CONTENTS

Introduction	3
Key Findings	3
Background	4
Study Purpose	5
A ‘work in progress’: The commissioning of Care Act advocacy	6
1. Understanding what advocacy is and the need for independence	8
2. Co-production in commissioning	9
3. Embedding equality and diversity in commissioning, service design and provision	11
4. Person-centred and outcomes-focused	11
5. Easy access to range of types of advocacy	12
6. Local needs, local solutions	13
7. Block and volume contracting	13
8. A positive relationship with providers	14
9. Meaningful and proportionate monitoring	14
Barriers to Effective Commissioning	15
Strengthening Commissioning	16
Conclusion	16
Study Methods	17
Acknowledgments	18
Acronyms and abbreviations	18
References	19

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Introduction

Local Authorities in England are required under the Care Act 2014 to make independent advocacy available to eligible service users and carers. In October 2014, the Social Care Institute for Excellence (SCIE) launched guidance to support good practice in commissioning independent advocacy. Early studies examining implementation highlighted lower than expected referrals for independent advocacy support and that many of those potentially eligible for advocacy under the Care Act might not be receiving it. In 2016, the Universities of Birmingham and Central Lancashire were commissioned by SCIE to undertake a rapid appraisal of how advocacy was being commissioned under the Care Act, and to identify the features of promising practice. This involved surveys of and interviews with commissioners and providers;

documentary analysis; and a roundtable discussion involving people with experience of using social care services and other stakeholders to identify improvements in the commissioning process.

Survey responses relate to 46% of English Local Authorities and 64 advocacy providers. Caution should be applied therefore when generalising from the findings. Practice examples included were either identified by providers and/or commissioners or by the external organisation involved.

A briefing based on this research is available on the SCIE website at:
www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/

Key Findings

- The study found promising practice in the commissioning of Care Act advocacy despite several Local Authorities initially adopting a cautious 'wait and see' approach: Forty-eight per cent of Local Authorities had gone out to tender since April 2015;
- Effective commissioning was linked to Local Authorities having a good understanding of the role of independent advocacy and recognising the importance of offering a range of advocacy, which should include generic and citizen advocacy;
- Just 47% of Local Authorities reported involving people using or likely to use social care and family carers in the commissioning process. However, several were yet to specifically commission Care Act advocacy;
- Local Authorities used different methods for estimating likely demand for advocacy using local and national information, and the Department of Health's Impact Assessment;
- The majority (60%) initially commissioned a single advocacy provider, with 38% commissioning a service 'hub' or partnership with a lead provider;
- Fewer than 10% of the Local Authority sample reported spot purchasing as the only method of commissioning Care Act advocacy, with both commissioners and providers referred to the value of spot purchasing in addition to block contracts to respond to variations in demand;
- More than half of providers considered arrangements for referral as not working, often attributing this to frontline staff's lack of understanding of their duty to refer;
- Both commissioners and providers recognised the importance of advocates being multi-skilled and able to undertake a range of advocacy roles to meet the need for advocacy;
- Local Authorities reported prioritising statutory advocacy as a result of financial austerity: 22% of commissioners reported either stopping commissioning or reducing access to non-statutory advocacy during 2015–16.

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 people⁶.

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 a 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).



Study Context

A previous survey of advocacy providers by the Mental Health Foundation for the Advocacy Action Alliance (AAA)¹⁰ reviewing early implementation highlighted low numbers of people accessing advocacy in some parts of England despite the new duty. While some Local Authorities had 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 contract¹¹. The majority of contracts (63%) were for 12 months or less, which AAA found 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 indeed resulted in legal challenges with Local Authorities having to re-do flawed assessments (see London Borough of Haringey¹²).

It has been suggested by McNicoll¹³ 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. Furthermore, 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 Assessment¹⁴. Another recent review found little evidence of advocacy for carers¹⁵.

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 funding¹⁶.

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:

1. Identify models of commissioning Care Act advocacy in England
2. Identify promising practice examples
3. Engage with key stakeholders in identifying the wider policy and practice implications for commissioning independent advocacy.

Emergent findings were presented at a SCIE roundtable event in June 2016 to validate our interpretations and identify how the commissioning of Care Act advocacy could be further strengthened. Further detail on the research methods can be found at the end of this paper.

Findings

A 'work in progress': The commissioning of Care Act advocacy

Some commissioners participating in this study defined Care Act advocacy as another form of statutory advocacy alongside IMCA, IMHA and RPR roles under DoLS, giving it the acronym ICAA (Independent Care Act Advocacy). Similar to IMCAs and IMHAs, independent advocates under the Care Act are expected to be appropriately trained, and hold the National Qualification in Independent Advocacy (level 3). However, advocates who do not hold this qualification, which may include some generic or citizen advocates, can still support involvement in decision-making under the Care Act. In this context, some Local Authorities were locating 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)

Some commissioners distinguished between statutory and non-statutory advocacy and, as other studies have found, the funding of statutory advocacy (including Care Act advocacy) is being prioritised 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.

The majority (87%) of Local Authorities in our 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). Most were commissioning a wide range of advocacy, with all indicating they commissioned IMCA services. Other forms of advocacy included advocacy for carers; generic advocacy for disabled people; domestic violence advocacy and advocacy tailored to particular groups; notably deaf service users; older people; those affected by dementia, people with learning disabilities and people experiencing mental health issues.

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. 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 4-5 months' time with an outcomes based specification.'

(Commissioner, interview)

It was however evident from some interviews with advocacy providers that some Local Authorities had not specifically commissioned Care Act advocacy and that the advocacy provider was 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)

Seventy-eight per cent of Local Authority respondents had undertaken a needs assessment to estimate likely local demand for Care Act 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 Assessment¹⁷.

CO-PRODUCTION

The SCIE (2015) guidance for commissioners emphasises the importance of co-production with users and family carers. From our survey, just 47% of Local Authorities stated they had involved adults with social care needs in the commissioning process for Care Act advocacy. Four out of five Local Authority respondents had developed a specification for Care Act advocacy. Not all, however, had, as yet, gone out to tender at the time of the survey (29% extended an existing advocacy contract and 48% had gone out to tender for Care Act advocacy in 2015–16). Some who were in the process of developing their specification were involving users and carers as well as advocacy services. They referred to a 'series of co-production events with people in receipt of social care services being involved in developing the new model to writing the service specification', while others had conducted consultation exercises and relied upon 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)

COMMISSIONING DIFFERENT MODELS OF PROVISION

The majority (60%) described the model for the provision of Care Act advocacy as a single provider model, that is, one advocacy service had been commissioned to provide advocacy to meet the Local Authority's advocacy duty. Another 38% 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 studies¹⁸. Since April 2015, 30% of respondents had changed advocacy provider for Care Act advocacy 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-focused¹⁹.

VARIATION IN SPENDING ON CARE ACT ADVOCACY

Information from both commissioners and providers showed wide variation in the total spend on Care Act advocacy, ranging from contracts of under £25k to others over £200K. Information from providers comparing contracts for 2015/16 and 2016/17 suggested a trend towards fewer contracts under £25k, which may reflect the changing nature of Care Act advocacy commissioning as experience unfolds. While some Local Authorities are allocating relatively little resource to develop advocacy services, there was an indication that a number are investing between £150K to £200k in Care Act advocacy. Nonetheless, concerns were expressed from providers about potential reductions in resources for advocacy alongside increasing demand.

However, data on the investment in Care Act advocacy from commissioners is difficult to interpret because it can be difficult, even impossible, to differentiate from overall spend on advocacy and it is unclear what the per capita spend is. 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, survey)

Over half of providers (53% of respondents) reported having contracts with the Local Authority to provide Care Act advocacy of 12 months or less.

Encouragingly, there was an indication that this was changing slowly: 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 3-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)

LOW REFERRALS FOR CARE ACT ADVOCACY

Twenty eight percent of Local Authority respondents indicated that they had reduced the level of funding and were now prioritising independent advocacy and other forms of statutory advocacy. Viewing all advocacy as covered by the Care Act was identified as one way of protecting wider forms of advocacy from budget restrictions.

It has not been possible to build an accurate picture of the use of advocacy services under the Care Act duty from the survey responses. Many Local Authorities were unable to provide numbers for those who had had an advocate under the Care Act since April 2015. Many stated that this information was 'not to hand' or they had been unable to provide an answer at the time of the survey, or simply that they did not keep such records. What information was provided however, confirmed findings of earlier studies. 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, while in others there had been over 400. We found no evidence to suggest that rates of referral were linked to the model of provision. It was the perception of many providers that a lack of effective training for frontline staff in Local Authorities was causing the low number of referrals, even though 90% of Local Authority respondents said that frontline staff in their area had been trained. Providers also reported observing variation in the number of referrals between teams working with similar client groups in the same authority.

Features of effective commissioning of Care Act advocacy

From the various data sources, it was possible to distil certain key characteristics or features that contributed to effective commissioning practice of advocacy.

1. UNDERSTANDING WHAT ADVOCACY IS AND THE NEED FOR INDEPENDENCE

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

- An understanding of the different forms of advocacy, all of which aim to promote the interest, views and choices of individuals so that they have a greater say in decisions about their life and this includes carer advocacy.
- The importance of independence from service provision 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 an advocate as they generally promote those views that they consider are in a person's best interests and in line with their organisational requirements.

- There can be an overlap between IMCA and advocacy required under the Care Act. This is a complex area but it should not be assumed that people who struggle with decision-making do not necessarily lack the capacity to make a decision regarding their care and support.
- Care Act advocacy 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. This is because advocacy is different from befriending, providing information and advice although these elements might be involved in advocacy.

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, and to speak for myself ultimately?' (Commissioner, interview)

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)

2. CO-PRODUCTION IN COMMISSIONING

Genuine co-production in commissioning, planning, delivery, monitoring and review was emphasised at the roundtable event and in several interviews. Co-production is a step 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 Care Act advocacy. Value-based working together (co-production) between professionals and service users based on advocacy values was highlighted by some interviewees as requiring effective collaboration; bringing together different perspectives with the emphasis on the service users and carers as experts. Two aspects of this are relationship and power-sharing.

Relationship: Co-production is rooted in the recognition of the experience and expertise of service users and carers as well as that of the professionals. The Care Act requires that the service user or carer is at the centre of care and support planning and provision. Effective commissioning of Care Act advocacy, therefore, adheres to the principle of 'Nothing About Us Without Us'. through the processes for the strategic, planning, delivery and monitoring of Care Act advocacy.

Value-based working together



Power-Sharing: Acknowledging power relations was seen as the starting point for redressing power imbalances and the recognition that true power-sharing is at a level above 'power-giving' and 'power-receiving'.

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. 100 people attended and two independent consultants, one with a learning difficulty, 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.
- April 1st 2016 the Council awarded the contract 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.

See also: Think Local Act Personal (2015). Co-producing a new advocacy service in Kent: Getting started. Available at: <http://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/stories-and-resources/Co-producing-a-new-advocacy-service-in-Kent-Getting-started/>

3. EMBEDDING EQUALITY AND DIVERSITY IN COMMISSIONING, SERVICE DESIGN AND PROVISION

There was agreement at the roundtable event that commissioners need to provide Care Act advocacy services that reflect and meet the diversity of the needs of local people. Commissioning in co-production with users, carers and the wider community, a population needs assessment and an equality impact assessment for advocacy will facilitate this. 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 Care Act 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.
- People with mental health problems
- 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 included²⁰ 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 Healthwatch²¹ completed a review of current advocacy provision, on behalf of the Local Authority, and conducted focus groups and a limited number of 1-2-1 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 into the service specification of the new service.making to users.

4. PERSON-CENTRED AND OUTCOMES-FOCUSED

Providers and Local Authorities we interviewed emphasised the importance of advocacy being person centred and as such achieving the outcomes that individuals want. It was suggested to us that there is a risk that Care Act advocacy could become overly focused on Local Authority processes of assessment, review and safeguarding rather than focusing on the person. Effective

advocacy needs to be timely so that a person can access it when they need it, and it 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 Care Act advocacy as a key opportunity to engage, with this aim in mind.

5. EASY ACCESS TO RANGE OF TYPES OF ADVOCACY

A consistent theme throughout the data was the importance of ensuring that people can access a range of types of advocacy according to what they need. There are overlaps between different forms of professional advocacy and also informal or volunteer advocacy (eg, 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. The hub model, which provides a single gateway to a range of advocacy provision is being favoured in some areas. One advantage of this model of providing Care Act advocacy is that it can

be easier to give people access to a range of different types of advocacy. It can also facilitate long-term relationships whereby a single advocate may provide different types of advocacy support to an individual service user. It may not, however, be suitable for all contexts and further research is needed to identify the extent to which access to advocacy is improved by the hub model, and focusing on the experience of the smaller advocacy partners within a hub model.

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, with the aim of providing a broader offer with clearer and easier access. The introduction of 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 upon 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 eg, 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.

6. LOCAL NEEDS, LOCAL SOLUTIONS

An assessment of the strengths and gaps in current provision alongside an understanding of needs and preferences for advocacy had enabled commissioners to develop an appropriate model for provision. Whilst a hub model might be appropriate in an urban context, this was not felt to necessarily be as relevant in some

rural areas with a limited number of providers, and where understanding the nature of the dispersed population and geography was vital. Key to effective commissioning is recognising that 'one size does not fit all and the local context (population and geography) 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 4-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.

7. BLOCK AND VOLUME CONTRACTING

Having both a block contract to ensure stability and flexibility in the contract to respond to changes in demand was valued by providers; for example, a block contract for the majority of hours or contacts (eg, 80%) and the remaining proportion (i.e. 20%) either to be billed to the Local Authority on a spot purchase basis or an allocation, which could be used flexibly across all types of advocacy to respond to fluctuations in demand.

8. A POSITIVE RELATIONSHIP WITH PROVIDERS

Commissioners and providers emphasised the importance of positive working relationships between commissioners and providers, which enabled a developmental approach to introducing Care Act advocacy. Eighty per cent of the providers who responded to the survey indicated they had been involved in the commissioning process. It was clear from some respondents that this built on an existing relationship which can be positive but care must be taken not to exclude smaller, less well known providers eg, community based-organisations representing minority groups . Positive relationships were characterised in terms of commissioners having a well-developed understanding of advocacy, commitment to the sustainability of provision and a willingness 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)

9. MEANINGFUL AND PROPORTIONATE MONITORING

Commissioners described requiring a range of data for monitoring contracts usually to be provided on a quarterly basis and in some instances monthly. The data required included access rates for advocacy under the Care Act, demographic detail and bespoke outcome measures as well as descriptive data of observations on trends in use of advocacy services, partnership working, user involvement and individual 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 (eg, 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)

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; 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:

- % 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
- % of individuals enabled to better understand and be involved in their care and support and health planning processes and decision-making
- % of individuals who report an increased ability to negotiate arrangements and services to meet their needs
- % of individuals who feel that advocacy services have contributed to achieving their personal outcomes
- % of individuals who feel empowered to challenge decisions

Barriers to Effective Commissioning

Commissioning Care Act advocacy presents a range of challenges and the following were identified during the study:

- Co-production is not easy and there are fundamental differences which 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, as well as staff values and attitudes may need to change and develop.
- 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 Care Act advocacy for all local people and further disadvantages minority groups.
- Lack of understanding of advocacy by commissioners can result in commissioning advocacy services that are ill-equipped to provide meaningful advocacy. Sole reliance on spot purchasing is an example of commissioning practice which is instrumental and does not locate Care Act advocacy within a framework of promoting greater choice, control and ultimately wellbeing.
- Organisational 'churn', often as a consequence of austerity measures, leading 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 Care Act 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.
- Lack of understanding of advocacy by frontline staff was identified in the survey as the major barrier influencing access and uptake of Care Act advocacy. This may skew the assessment of need and demand. Some teams are good at referring - others not. Some social workers will only refer people who lack mental capacity and overall, the understanding of Care Act is at a low level.
- 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.
- Increasing demand for Care Act advocacy in a context of initial uncertainty about demand, the increasing demand for RPRs under DoLS as a consequence of recent case law,²² and reducing resources.
- Both commissioners and advocacy providers reported that advocacy provision is increasingly being narrowed to provision of statutory advocacy by some Local Authorities, in response to austerity measures.

Strengthening Commissioning

At the roundtable event, which included people who use social care services, Local Authority commissioners and provider, the following were prioritised to address the identified challenges and strengthen the commissioning of Care Act advocacy:

1. Ensuring co-production, building on values and relationships as the foundation for commissioning Care Act advocacy.
2. Understanding advocacy, its core purpose and different forms with Local Authorities viewing it as central to transforming adult social care and a strand of implementing the Care Act well-being principle and duties in relation to prevention.
3. Improving needs assessments, using a range of methods, to embed equality and diversity into the scoping, design and provision of advocacy services.
4. Ensuring a single point of access for all advocacy so that people can access advocacy appropriate to their needs.
5. Working collaboratively with people using social care and advocacy providers to develop solutions and overcome barriers.
6. Incentivising providers to work together and with local communities recognising that partnerships take time and investment.
7. Realising the potential of market shaping and its role in building the capacity of user-led and community organisations to deliver Care Act advocacy.
8. Building the evidence for impact with meaningful outcomes (i.e. voice and choice) rather than outputs, supported by a simpler and agreed system for data collection.
9. Ensuring sustainability of provision by agreeing 3 year contracts as a minimum and, which have a degree of flexibility to respond to changes in demand.
10. Capacity building and support for commissioners and front-line staff, including co-produced training, to develop an accurate understanding of advocacy and their role in promoting and supporting access and uptake.

Conclusion

This study highlights concerns about the implementation of Care Act advocacy, whilst also identifying evidence of emerging promising practice in the commissioning of Care Act advocacy and the key features of good practice. Clearly, effective implementation requires action by Local Authorities including commissioners and front-line staff to

ensure that people who need advocacy are informed and able to access the appropriate form of advocacy. Action is also required by advocacy providers to widen their offer around advocacy, eg, peer advocacy and self-advocacy, and work in partnership with service users, and potential service users, to co-produce high quality advocacy provision that embeds equality and

diversity in service delivery. Finally, it is clear that revisiting the underpinning values and principles of advocacy will not only strengthen the commissioning and provision of advocacy but will also promote the well-being of people using social care.

Study Methods

The study involved a survey of commissioning and provision to identify positive practice; follow-on interviews to gather further detail on the emerging promising 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% 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 good 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 in June 2016 involving invited stakeholders representing commissioners; advocacy providers; people using social care; Department of Health and SCIE. The format for the event included reviewing the findings and the extent to which these resonated with participants' experience. Participants were also invited to develop recommendations for strengthening the commissioning of Care Act advocacy.

ETHICAL APPROVAL

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. The study did not include the views of people contacting or accessing Local Authority support. This is a clear direction for future research.

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Acronyms and abbreviations

AAA	Advocacy Action Alliance
ADASS	Association of Directors of Adult Social Services
BAME	Black, Asian and Minority Ethnic
CCG	Clinical Commissioning Group
DoLS	Deprivation of Liberty Safeguards
IMCA	Independent Mental Capacity Advocacy
IMHA	Independent Mental Health Advocacy
NDTi	The National Development Team for Inclusion
OPAAL	Older People's Advocacy Alliance
RPR	Relevant Paid Representative

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