HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Executive Member for Adult Social Care
Date:	17 September 2015
Title:	Advocacy Services
Reference:	6715
Report From:	Director of Adult Services

Contact name: Liz McGill

Tel: 01962 846458 **Email:** liz.mcgill@hants.gov.uk

1. Executive Summary

1.1. The purpose of this paper is to request permission to spend and to go to tender for statutory and non-statutory advocacy, with effect from 1 April 2016, to enter into a Section 75 agreement (NHS Act 2006) with NHS England to be the Lead Commissioner of Independent Mental Health Advocacy in two secure hospitals in Hampshire and to vary the Section 256 agreement with the Hampshire Five Clinical Commissioning Groups (CCGs). The contract will include:

- Independent Mental Health Advocacy (IMHA) as determined by the Mental Health Act 1983 (MHA)
- Independent Mental Capacity Advocacy (IMCA) and Paid Representative, as determined by the Mental Capacity Act 2005 (MCA)
- Independent Care Act Advocacy, as determined by the Care Act 2014
- Children's Advocacy, as determined by the Children Act 1989 and other children's legislation (see Integral Appendix A), on behalf of Children's Services
- General advocacy for vulnerable people with mental health problems, learning disability, physical disability and older people.
- IMHA and general mental health advocacy in secure hospitals on behalf of NHS England
- IMHA and general mental health advocacy in young people's in-patient on behalf of NHS England (subject to NHS England permission).

1.2. This paper seeks to:

- set out the background to the project detailing statutory requirements

- consider the finance for the project, the impact on the budget and the various funding sources
- demonstrate performance and the impact on the wellbeing of vulnerable people.

2. Contextual information

2.1. Advocacy is "taking action to help people say what they want, secure their rights, represent their interests and obtain services they need."
The Advocacy Charter – Action for Advocacy 2002

2.2. Hampshire County Council has a legal responsibility to arrange advocacy for eligible people under the MHA, the MCA, the Care Act and the Children Act and other children's legislation.

2.3. Specific qualifications through City and Guilds are required of advocates delivering MHA, MCA and Care Act advocacy.

2.4. Advocacy can be delivered on a 1:1 basis, as it would be for the statutory advocacy but also through groups and by peers. All advocacy has the aim of helping people, where they have capacity, to self-advocate in future.

2.5. Most advocacy is issue based and relatively short term in nature, with the exception of some of the learning disability advocacy, which supports people to be involved and represent others in groups and on boards, and the Paid Representative service for people who lack capacity and who have no friends or family.

2.6. Advocacy can be instructed or non-instructed when the person lacks the capacity to advise the advocate what they need their support for.

2.7. Statutory Advocacy has to be independent of the local authority and the NHS and is free to the individual.

2.8. <u>Mental Health and Mental Capacity Advocacy</u>

2.8.1 Hampshire County Council currently contracts with Solent Mind to provide IMHA, IMCA, Paid Representative and general mental health advocacy. The existing contract ends on 31 March 2015.

2.8.2 IMHA is a statutory requirement under the MHA 1983 available to people detained under Section 2, Section 3, Guardianship and Community Treatment Orders, conditionally discharged restricted patients and informal patients being considered for certain treatments, such as electro-convulsive therapy and neurosurgery. Responsibility for arranging this advocacy passed from the NHS to Local Authorities in 2013, together with additional funding which was not ring-fenced.

2.8.3 NHS England also contracts with Solent Mind to provide IMHA and general mental health advocacy to two secure hospitals in Hampshire – Ravenswood and Southfields. They have requested that this be included in the future advocacy contract.

2.8.4 IMCA is a statutory requirement of the local authority under the MCA 2005. There are two types of IMCA roles: to support or represent people who lack

capacity to consent to serious medical treatment or a change of accommodation and who have no appropriate relative or friend who could be consulted and to support or represent people who may be subject to the Deprivation of Liberty Safeguards (DOLS).

2.8.5 A Paid Representative is appointed when there is no family member or friend who could fulfil the role of representing and supporting the person who lacks capacity in all matters relating to DOLS, including, if appropriate, triggering a review, using an organisation's complaints procedures on the person's behalf or making an application to the Court of Protection.

2.8.6 Non-statutory general mental health advocacy has been commissioned by Hampshire County Council for many years. Due to the increased demand in the statutory advocacy recently, this has largely been confined to people known to secondary mental health services, although it would be beneficial as an early intervention to prevent people needing secondary mental health care and treatment. The main issues, for which people required advocacy support in the past year, were care and treatment, benefits and finance and housing. These issues impact on a person's wellbeing and mental health so it is important that people are supported to resolve problems in these areas to prevent deterioration in their mental health and the need for more intensive and costly services.

2.9. Care Act Advocacy

2.9.1 Since the Care Act came into force on 1 April 2015, this statutory advocacy for people with substantial difficulties in engaging with the local authority processes of assessment, care planning, review and safeguarding as well as accessing information and advice, has been provided by Hampshire Regional Advocacy Group (HARG), a consortium of local providers.

2.10. Children's Advocacy

2.10.1 Hampshire Children's Services currently spot purchases advocacy from Speakeasy and Choices, both members of HARG.

2.10.2 This statutory service is available to Looked After Children, Care Leavers, those on the edge of care, children placed in Swanwick Lodge Secure Children's Home and children and young people with Special Educational Needs and Disabilities, the latter up to the age of 21 or 25 if in full-time education. It can be instructed or non-instructed where the child lacks the capacity to instruct.

2.10.3 Southern Health NHS Foundation Trust (SHFT) is commissioned by NHS England to provide in-patient mental health services to children and young people in Leigh House. As part of this contract, SHFT currently contracts with NYAS to provide statutory IMHA and general mental health advocacy services in this hospital. This is being considered to be part of this advocacy contract, but is subject to NHS England agreement.

2.11. Learning Disability Non-Statutory General Advocacy

2.11.1 Until April 2015, local organisations bid for grant money (initially Learning Disability Development Fund, then Adult Services Learning Disability Grant Fund) to provide one to one advocacy, self advocacy, group advocacy and

person-centred planning for people with a learning disability or autism. Through the self advocacy, service users are able to participate in the Learning Disability and Local Implementation Groups (LIGs).

2.11.2 There are currently two one year contracts with Choices and HARG to deliver the above services which end on 31.3.2016.

2.12. There is currently limited access to non-statutory advocacy for older people and people with a physical disability.

2.13. A decision was taken to bring all types of advocacy together into a single contract for several reasons:

- consultation feedback
- more effective use of resources
- opportunity for continuity of advocate should a person require advocacy for different reasons
- potential to attract a wider market and thus secure the most effect contract

2.14 The only advocacy service to remain outside this contract will be the Local HealthWatch service which includes NHS Complaints Advocacy. It was felt that there were more benefits in linking this to other community provision than to amalgamating it into a larger advocacy contract.

3. Finance

3.1. There are various funding sources for the different elements of advocacy as shown in the table below. Figures are per annum based on 2014-15 spend for IMHA, IMCA and Paid Representative and 2015-16 budget for Care Act, children's advocacy and NHS England funded IMHA services.

3.2. The projected cost for IMCA in 2015-16 is £243K which is being funded through a one-off grant for DOLS from government. It is not yet known if this funding will be recurrent.

3.3. The current hourly rate for IMHA, IMCA and Paid Representative service is £25.71.

3.4. The Care Act advocacy budget is the maximum funding for the current one year contract. This is activity based, so the actual spend could vary at the end of 2015-16. The current hourly rate is £20.00. In June, the service was working at 35% of the maximum monthly contract value but demand has increased each month since April 2015.

3.5. It is highly unlikely that there will be a decrease in demand for statutory advocacy which the local authority is required to arrange. It cannot be undertaken as an in-house provision as legislation states advocacy must be independent. Where qualifications are required, organisations will reflect this through enhanced hourly rates for these types of advocacy in their bids.

Statutory advocacy	Non-statutory advocacy	Funding per annum	Funding source	Permission to spend
IMHA		£121,969	HCC AS	
		£25,000	Hampshire 5 CCGs	Confirmed under S256 to March 2017 and for 2017-18 for which a variation to the S256 will be required
IMCA		£90,412	HCC AS	
Paid Representative		£62,218	HCC AS	
Care Act		£300,000	HCC AS	
Children Act		£27,000	HCC CS	Confirmed
	General mental health advocacy	£59,756	Hampshire 5 CCGs	Confirmed under S256 to March 2017 and for 2017-18, for which a variation to the S256 will be required
	Learning disability person centred planning, self-advocacy and group advocacy	£296,981	HCC AS	
Total without NHS England funding		**£983,336**		

Statutory advocacy	Non-statutory advocacy	Funding per annum	Funding source	Permission to spend
IMHA (secure hospitals)	General mental health advocacy (secure hospitals)	£51,000	NHS England	Confirmed. S75 will be required
IMHA (in young people's in–patient hospital)	General mental health advocacy (in young people's in–patient hospital)	£40,000	NHS England	Still to be confirmed. S75 will be required
Total with NHS England funding		**£1,074,336**		

3.6. Learning Disability advocacy that was incorporated into the Care Act advocacy and the separate general Learning Disability advocacy contracts were all reduced by 14% in April 2015. It has been agreed that there will be no further reductions in the budget for these services.

3.7. The future contract will be let on an activity basis with maximum values for each type of activity.

4. Performance

4.1. The four types of advocacy currently commissioned by Adult Services have all shown increased demand since the start of the contract. The provider was requested to raise awareness and increase referrals from mental health services and care homes which they have achieved. See Appendix 1 for details.

4.2. In terms of IMHA the provider has a presence in all in-patient units, including private providers and all the Wellbeing Centres except one (Aldershot) which they are currently rectifying. They have worked with SHFT to ensure greater publicity of the service on the ward and improved access to patients. A further piece of work is underway with SHFT to raise awareness amongst clinicians and patients of the service for people on Community Treatment Orders due to the low referral rate for people subject to these orders.

4.3. It has not been possible to confirm the details of Hampshire people detained under the Mental Health Act so at this stage the percentage of people detained who have received an IMHA cannot be determined. Work will be undertaken with the CCGs and SHFT to ensure this will be available in future. The aim would be for every qualifying patient to be aware of the service and

how to access it and an automatic referral for an IMHA for those who lack capacity.

4.4. A future advocacy contract would require the provider to supply separate information for each strand of advocacy to ensure that appropriate use of each funding stream can be monitored and to provide the data that is required at a national level for IMCA and Care Act and to the Care Quality Commission for IMHA services.

5. Consultation and Equalities

5.1. A workshop was undertaken with the Care Act Service User and Carer Reference Group on 7 May 2015. See Appendix 2 for outputs from this consultation.

5.2. Three workshops were held in June 2015 with a range of stakeholders (see Appendix 3) who were asked what is working well with advocacy, what is not working well, what is missing from advocacy services and what should an ideal advocacy service look like. Outputs from the three workshops are shown in Appendix 4. The key findings are that non-statutory advocacy is strongly valued, variety of the types of advocacy is appreciated and the provision is thought to be of a high standard but information about who can access advocacy and how they do so is not as widely known as it could be. People want a single point of access for all types of advocacy in the future.

5.3. A full Equalities Impact Assessment has been undertaken – see Integral Appendix B. The key findings are that the new advocacy contract will have a positive impact in that it will make advocacy available to a wider range of vulnerable adults – older people and those with a physical disability – who currently only have access to statutory advocacy.

5.4. It is for the Executive Member as decision maker to have due regard to the need to: eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act and advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

6. Legal

6.1. Funding for IMHA and general mental health advocacy from the Hampshire 5 CCGs is obtained through the mental health Section 256 agreement which runs to 31 March 2017. There will need to be a further Section 256 agreement to cover further years.

6.2. In order for Hampshire County Council to act as Lead Commissioner of IMHA services in Ravenswood and Southfields, a Section 75 agreement will need to be consulted on and agreed.

7. Risks

7.1 It is still not clear whether NHS England want the provision of IMHA in Leigh House to be included or not. If so, it will form part of the S75 agreement, if not, it will not form part of this contract.

7.2 Should the delay extend beyond agreed timescales this would adversely impact on the procurement process for the services which Hampshire County Council is required to commission. The advertisement and tender documents will make clear that this provision could be removed from the specification.

7.3 The Section 75 agreement is not in place before award of the contract, thus delaying award and reducing the lead-in period for the new contract. Work has commenced on the agreement and consultation, which can be for a short duration due to the small numbers of people who need to be consulted.

7.4 There is a risk that demand for statutory advocacy will exceed the current funding levels. Work has been undertaken on projected demand for IMCA work, specifically with regard to DOLS and the Paid Representative role. At present this amounts to 18 hours per week for IMCA and 90 hours per week for Paid Representative but this is projected to increase to 49 hours for IMCA and 244 hours for Paid Representative. The additional demand in the current year is being funded by the £500K additional one-off grant from government for DOLS. It is not yet known if this will be recurrent. The Law Commission is currently consulting on DOLS but any potential change in legislation would not be in effect before this contact starts.

7.5 Work is similarly being undertaken to project demand for IMHA and Care Act advocacy services.

7.6 This will be mitigated by clauses in the contract that state:

- a review will take place if any of the activity reaches 10% of that particular funding stream, in order to determine from where additional funding will be acquired or prioritisation of referrals
- an element of the contract will cease should the particular funding source for that element be withdrawn
- a variation of the contract can occur should additional funding become available subject to it being within 10% of the current value.

8. Recommendations

8.1 That the Executive Member for Adult Social Care gives approval to go out to tender and spend and award a contract for statutory advocacy - IMHA, IMCA, Paid Representative, Care Act and Children's advocacy and for general advocacy for people with mental health needs, learning disability, physical disability and older people to commence on April 1 2016 for two years with an option to extend for one plus one year, with a value up to £2,148,672 for the two year contract and a maximum total contract value of £4,297,344.

8.2 That the Executive Member for Adult Social Care gives approval to enter into a Section 75 agreement with NHS England for Hampshire County Council to

act as Lead Commissioner for IMHA services in the secure hospitals and to vary the Section 256 agreement with the Hampshire 5 CCGs from 2017 to 2018 or 2020, depending on their funding agreement.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	Yes
Maximising well-being:	Yes
Enhancing our quality of place:	No

Other Significant Links

Links to previous Member decisions:		
Title	Reference	Date
Advocacy	6351	27.1.15
Grants to Voluntary Organisations 2015-16	6333	27.1.15
Direct links to specific legislation or Government Directives		
Title		Date
Mental Health Act		1983, as amended 2007
Children Act		1989
The Children (Leaving Care) Act		2000
The Adoption and Children Act		2002
Mental Capacity Act		2005
NHS Act		2006
Care Act		2014
Children and Families Act		2014
Working Together to Safeguard Children		2015

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

8.3 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

8.4 Equalities Impact Assessment:

Statutory advocacy is available to any qualifying person, regardless of gender, sexual orientation, race or marital status.

It is provided free of charge to individuals so will not disadvantage anyone.

In order to be able to support people to express their wishes and feelings or to represent their views, advocates will need to spend time with them and build an understanding. This could be in the person's home so will benefit those who live in rural areas and who have difficulty travelling.

Non-statutory general advocacy is currently limited to people with mental health needs or those with a learning disability. In the future contract general advocacy will be available to people with mental health needs, learning disabilities, physical disabilities and older people already known to Hampshire County Council Adult Services or as a preventative or early intervention measure to prevent their care needs from becoming more serious or delay the impact of those needs.

http://www3.hants.gov.uk/adult-services/adultservices-professionals/aboutas/as-equality-ia-archive.htm

2. Impact on Crime and Disorder:

8.5 This service is expected to have a positive impact on crime and disorder as it will support people to express their wishes and feelings.

8.6 It is accessible to people in HMP Winchester who meet the legislative eligibility.

3. Climate Change:

a) How does the proposal impact on our carbon footprint/energy consumption?

The statutory advocacy is demand led and it is not possible to predict from where and when demand will come. There are timescales built into the contract and certain elements require advocates with qualifications. This will make it difficult for providers to ensure that reducing the carbon footprint or energy consumption always takes priority.

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

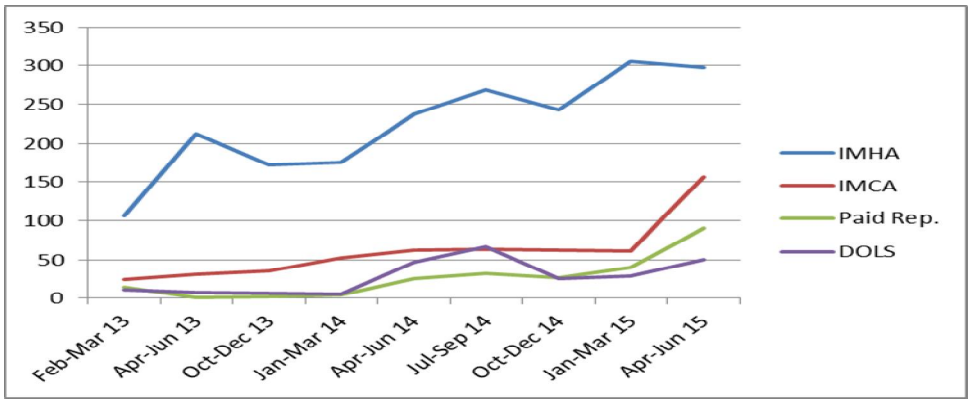
The contract will be monitored to ensure that, where possible, regard is given to minimising the carbon footprint and energy consumption.

Appendix 1

Performance Data for IMHA, IMCA, Paid Representative and general mental health advocacy

- The combined service has been commissioned from Solent Mind since February 2013. Prior to that, there were separate Adult Services contracts for general mental health advocacy, IMCA and Paid Representative and the Primary Care Trusts spot purchased IMHA, for which there is no reliable data.

Type	Feb-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Total
IMHA	106	213	data missing	172	175	237	268	243	305	297	2016
IMCA accommodation & serious medical treatment	24	31	data missing	36	52	62	64	63	61	156	549
Paid Rep.	14	1	data missing	2	4	26	32	27	40	90	236
DOLS IMCA	11	8	data missing	6	5	47	67	26	29	50	249
Total	155	253		216	236	372	431	359	435	593	3050



- There was a new manager of the service in October 2013. Data for the previous quarter is missing.

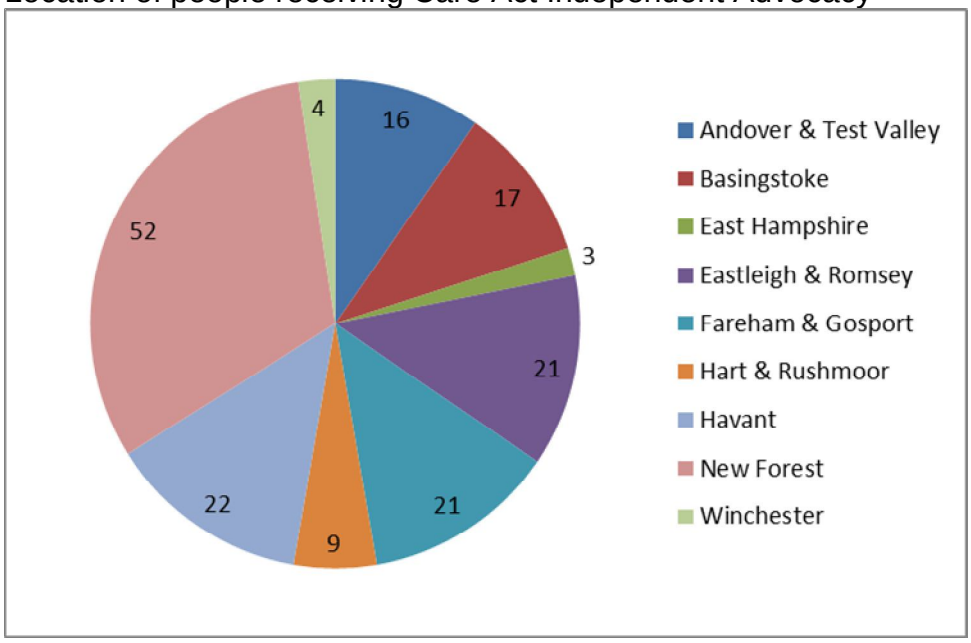
Performance data for Care Act Advocacy

- The service commenced on April 1 2015 and is provided by HARG and Solent Mind. The figures shown below are an amalgamation of referrals to both services, although predominantly to HARG.

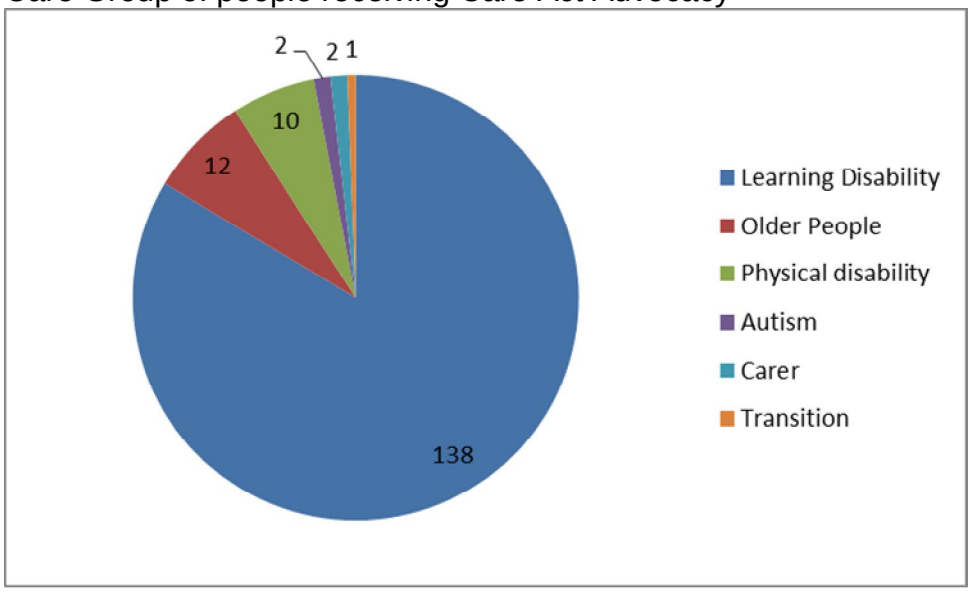
April 2015	75
May 2015	37
June 2015	43
July 2015	38

- April figures include people already referred to the provider whose advocacy was categorised as Care Act advocacy when the Act came into force.
- Regional data for April and May show that Hampshire has the highest number of referrals (115) of the 18 local authorities. The next highest was Southampton at 69. There were several councils with no referrals. The ratio to 100,000 adult population in Hampshire is 10.8, which is the fourth highest, behind Southampton at 35.1, Isle of Wight at 16.7 and Slough at 12.4.
- Since the commencement of the main contract with HARG, the geographical area they live, the nature of their disability and the breakdown of the process for which people need advocacy are shown in the tables below.

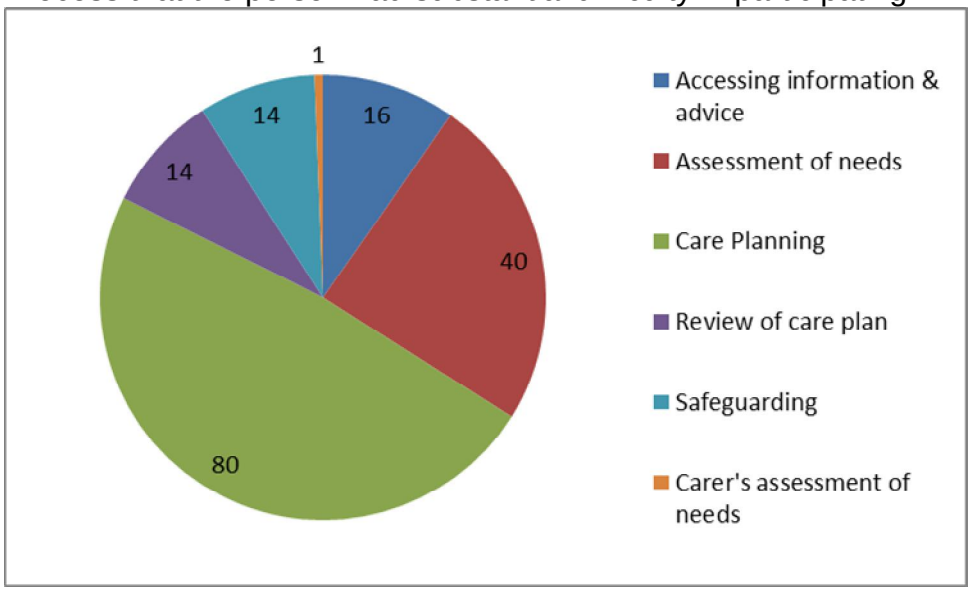
Location of people receiving Care Act Independent Advocacy



Care Group of people receiving Care Act Advocacy



Process that the person had substantial difficulty in participating in



Appendix 2

Outputs from Care Act Service User and Carer Reference Group

- Advocacy needs to respond quickly for someone in hospital or in a crisis
- Should advocacy be identified on admission?
- Will there be enough budget to manage demand?
- How does someone appeal if they feel they need an advocate and were not offered one?
- Will the advocate be the same person every time?
- How do you ensure the family's views about mental capacity are listened to, as they know the person better than the Care Manager?
- How do you know you need an advocate?
- Information about advocacy needs to be in plain English and available in other languages
- Information about advocacy needs to be on websites, with Community Services organisations, community groups, at GP surgeries, in hospitals
- Information needs to be up to date
- It should be available at the point of diagnosis
- Personal visits by advocates necessary
- Advocates need to have knowledge about specific conditions e.g. dementia
- There is a lack of awareness about advocacy
- How do carers find out about advocacy when they are too busy caring?
- Capacity can be variable so need for advocacy could be temporary or on-going

Appendix 3

Organisations present at the 3 workshops in June 2015

Age Concern Hampshire
Age Concern New Forest
Alzheimer's Society
Basingstoke Mencap
Carers
Carers Together
Chaos Support
Choices Advocacy
Citizen Advice Bureaux
Department of Health
Disabled People's Voice Hampshire
Disability forum
Enham Trust
Governor at a Special School
Hampshire Children and Family Alliance
Hampshire County Council Adult Services
Hampshire Romany
Hampshire Wellbeing Service
HealthWatch
Just Advocacy
Loddon School
Minstead Training Trust
Motor Neurone Disease Association
New Forest Disability Information Service
No Limits (South) Ltd
Older Person's Community Independence Service
Parent Voice (Winchester, Fareham & Gosport & Havant cluster)
Parkinson's UK
Redclyffe House
SCOPE
Service Users
Solent Mind
Solicitor
Speakeasy Advocacy
Surrey & Borders NHS Foundation Trust
Older People's Forum
Young Epilepsy
Winchester Area Community Action

Comments were also received from people unable to attend the workshops, including a number of service users with a learning disability whose voices were represented at the workshops by advocacy providers.

Appendix 4

Advocacy Workshops June 2015

Information has been collated from the three workshops held on 4th, 5th and 8th June 2015 together with information from people invited but unable to attend.

What is working well?

- Advocates are of a high standard, effective & give a positive experience x11
- Specific advocacy providers liked x5
- Availability/accessibility x4
- Independence & impartiality of advocates x4
- Advocates listen to what people say, are respectful of people's views and empower people, they are trusted by people x4

- Non-statutory advocacy x3
- Generic advocacy helps people not supported by mainstream advocacy especially as gateway to those worried about dealing with Adult or Children's Services x3
- Self advocacy x3
- Advocacy groups x3
- Person-centred planning
- Informal and peer advocacy
- Citizen's advocacy
- Advocacy within carers' groups

- Advocates qualified
- Training requirements for advocates
- Regular support, supervision and training for advocates
- Advocacy providers adhere to same principles across all types of advocacy

- Information about advocacy is easy to use
- Advocacy works well where it is known about
- Advocacy providers active in local areas so people know who to contact
- Awareness raising about advocacy services

- Consultation and being involved in process about advocacy x4
- Good working relationship with commissioners

- Evidence of better outcomes for service users of statutory services x2
- Advocates support people to remain independent

- Advocates are non-judgemental and offer safe environment for people to express themselves
- Advocates are objective and supportive

- Waiting times not too long
- Cases prioritised appropriately

- Advocacy model working well
- Mixed model of advocacy

- Support carers' rights x3
- Person centred practice of advocates x3
- Quick response x3
- Advocacy providers work well together ensuring consistency for people x2
- Flexibility of advocacy services on limited resources x2
- Specialist knowledge of advocates e.g. understand processes of appeals & courts x2
- Separate advocacy for service user and carer x2
- Advocates with local knowledge x2
- Able to build up relationship with advocate x2
- Advocates give Social Workers evidence to challenge decisions
- Regular communication by advocates with Adult Services
- No cost to people
- If advocacy cannot be provided organisations signpost to other services
- Ability to work with person until situation resolved
- Volunteer advocates
- Consideration of advocacy provided by non-commissioned organisations
- Law to back up need for advocacy i.e. Care Act 2014

What is not working well or is missing?

- Lack of knowledge, publicity and advertising about where to get help and advice and in different media x22
- Clear and easy to read information
- No single point where clear picture of advocacy in Hampshire
- Lack of knowledge of non-commissioned advocacy
- Information out of date e.g. on HCC website & paper copies x5

- More training for professionals and public x2
- Training for paid carers about advocacy

- Compulsory advocacy training for all health/social care professionals, in particular for professionals diagnosing people – they need to know what support is out there x5

- Advocacy offered where it is needed e.g. hospital/GP x4
- Advocacy needs to be in Job Centres x2
- Housing and other statutory services out of loop
- Needs health involvement – did not attend today
- Variable support from CCGs

- Local Authority understanding of advocacy services
- Continued awareness/training when changes occur to legislation/advocacy x2
- Lack of advocacy for older people, people with a physical disability, people not accessing services, diversity groups, Armed Forces & service families and children x14
- Specialist advocacy e.g. language, disease/disability specific x2
- Gaps in services geographically x4

- Funding/lack of priority for non-statutory advocacy from commissioners x3
- Statutory advocates trumps community/non-statutory advocacy x2
- Non-statutory advocacy is very limited x2
- Access to “low level” advocacy
- Universal advocacy in localities
- Need more peer support groups
- Not many carers would qualify for advocacy under Care Act
- Carer’s organisation not commissioned to provide advocacy
- More resources needed for parent carers
- Existing advocacy services are limited in who they can support & what they do
- Advocacy services can only support people they are commissioned to support. This can be difficult for referrers and the person as there is still an advocacy need that can’t be picked up
- Lack of support for prevention and peer support

- Prevention & early intervention would help x4
- Advocacy often called in at crisis point
- Access to emergency advocacy
- Some needs are urgent – wait could make the situation deteriorate
- In hospitals it can take time to put advocacy in place – means person has longer stay

- Need advocate to have your rights explained to you/involvement of advocate when the Care manager comes to do the assessment x2
- Lack of clarity about boundaries & Social Workers not having confidence in what an advocate can bring x2
- Social workers using advocacy as a fall-back service due to lack of capacity
- Advocates being drawn into other aspects of client's life
- Lack of consistent buy-in from Social Workers to advocacy

- Need to involve parents of person who lacks capacity
- More time needed for advocate to spend with parent to get to know the person
- Advocates need more time to get to know person, their family circumstances and what they need
- Left to family members to keep in touch with advocate

- Making initial contact can be difficult – can take a few phone calls – once set up it works well
- Waiting lists for allocation
- Not easy to access advocacy

- How do non-statutory advocacy services maintain quality?
- How do people know it is good quality advocacy?
- Cost for training (non-commissioned advocacy?)

- Limited choice x2
- Would prefer to have advocate from another non-commissioned organisation

- Funding for advocacy not held by individual
- Direct payment to pay advocacy service of your choice

- Loss of voluntary advocacy services
- Adult service will not engage with non-commissioned advocacy services

- Limited access to legal aid for solicitors
- Lack of help with quantity of benefit changes for which advocates not commissioned

- Funding decreasing but demand increasing x4
- Lack of collaboration/signposting/joint working x3

- Single point of access/say information only once x3
- Insufficient advocates x2
- Advocates having to work to someone else's timescales
- No acknowledgment of skills of peer advocates and service user peer support
- Not having continuity of same advocate x2
- Not easy to find the right organisation to help
- Yearly funding and spot purchase contracts can be difficult to manage. It makes keeping skilled, qualified, experienced advocates difficult
- Cases not individuals – one size does not fit all
- Need separate advocate for service user and carer
- Need to be better organised
- Consistency of advocate sometimes needs to be ongoing for a period of time
- Are HCC providing government scrutiny and transparency?
- More understanding of organisations is needed
- People often don't know what they need
- All the changes result in inconsistent availability
- May not always be person centred
- Less bureaucracy
- Who pays for what?
- Carer participation
- Should be an opt-out service. At the moment advocates rely on referrer's knowledge, services and eligibility (?IMHA)
- Joined up working by other professionals
- Mapping of advocacy services – waiting for report from Hampshire Disabled People's Voice
- Access to advocacy for appeals
- Digital access e.g. Skype
- Work to build confidence of individual
- Advocacy signposting to other services
- Lack of recognition for volunteer/citizen/peer advocacy
- Fear of public that advocacy may not be impartial
- Use of untrained workers

Future model for advocacy

- More money from prevention to be spent on non-statutory services to support people who don't meet the criteria for statutory advocacy but need support to prevent them reaching crisis point or statutory need
- Protect advocacy funding

- Local, independent and free advocacy available to all - Rolls Royce service – ‘everything for everyone’
- Acknowledgment of and investment in non-statutory advocacy
- Funding the gaps in service provision
- Routinely offered
- Carers own advocacy service
- Support for parents and carers

- Use as a preventative measure for health and social care services
- Clear presence within current health services where advocacy may be useful/vital

- Availability of direct payment for individuals to pay their chosen advocate
- Choice of who the advocate is and from which organisation
- Choice to change advocate/advocacy provider without repercussions if you are unhappy with the service

- Single point of access, made up of specialist services delivered by experts – skilled qualified advocates should be available but choice and flexible access is important
- Knowledge of specialist needs of people
- Easy for people to access
- Available everywhere geographically
- Mobile advocacy
- Central office with smaller hubs

- Consortium format, led by an organisation without a vested interest, to encourage a range of advocacy, working together and separately
- Advocacy Brokerage Service, based in local communities – triage and refer to the best service
- Advocacy under one umbrella

- Not always issue based – could be complex needs, single occasion, generic and specialist
- Peer advocacy – provided by experts by experience, should be acknowledged, recognised and made available
- Self advocacy should be encouraged and supported
- Mixed model of advocacy to include group, peer and 1:1

- Trained and qualified advocates
- Regular training/updates for advocates

- Professional training for advocates
- Quality Mark
- Advocates support each other
- Qualified , trained and voluntary advocates provided with supervision to support them in their roles
- Minimum training standard of NVQ2

- Information about advocacy services needs to be improved – who they are, what they provide, where they are, when you can use them, who can access them and how to access them for public and professionals
- Simple to use, easy to understand and up to date information, not all on web
- Easy read information (BSL, Makaton, PECS, etc)
- Person centred with no time limit per person
- Confidence building in individual before anything else

- Regular visits to Day Centres
- Offices in community venues
- Multi-agency meetings
- Improved working with statutory services and other local projects
- Dedicated advocacy working with CAB
- Involvement with DWP
- Improve GP knowledge of advocacy
- Use of drop in sessions and information spreading consultants to raise awareness of advocacy
- Proposals that come as a result of this workshop should be identified and an opportunity given to people to comment on them before commissioning takes place
- Tender process – checking they can provide what they say they can

- Basic information for unpaid/peer advocates on statutory rights of individual FAQ factsheets – cost saving/service avoiding, training
- Social Enterprise to check quality, provide scrutiny
- Locally based organisation, part of the local community with local knowledge and good management support and supervision
- Reassurance, accountability and reliability for the service user
- Clear procedures followed by all professionals
- Mechanism for handover between advocates
- Preparation for transition/parent carers to hand over to
- Time for advocates to spend with people to understand their specific needs
- Increase in number of advocates available to limit waiting lists

- Not pay as you go contracts, no zero hour contracts for advocates
- Use of social networking
- Improve pairing process
- Prompt response by advocacy service to update on waiting list
- Same advocate throughout client need
- Different ways to access service
- Flexible

Quotes from Service Users and Care Manager

“Advocacy really helped me, without my advocate, I wouldn’t have moved. I been here 14 months now and I’m happier. 100% happier.”

“They didn’t listen to me on my own, I’d been telling them but they listened to you.”

“Some staff don’t treat me right, and I can get help.”

“They treat me like I’m an adult, they treat me like a grown up not a kid.”

“My advocate goes to all my meetings for me and tells everyone what I want.”

“We have a group of physically disabled service users who are in their 20s, 30s and 40s who still live with their parents and in a lot of ways are still treated like children and seem to have little control over what they do, how they spend their money, etc. Up until the recent changes with the Care Act there has not seemed to have been any advocacy support available for these people if they wanted it.”