From: Andrew Ireland, Corporate Director for Social Care, Health and Wellbeing

To: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Decision No: **15/00063**

Subject: **COMMISSIONING OF ADVOCACY SERVICES FOR VULNERABLE ADULTS**

Classification: **Unrestricted**

Past Pathway: Social Care Health and Wellbeing DMT 18 March 2015
Adult Social Care and Health Cabinet Committee 10 July 2015

Future Pathway: Cabinet Member Decision

Electoral Division: Countywide

Summary:

There is a mixed economy of advocacy provision across Kent for vulnerable adults provided through grants and contracts. The Care Act has placed new duties on the local authority to provide advocacy services and changes to Deprivation of Liberty Safeguards (DOLs) have led to increase in demand and requirements for accountable, timely services. Alongside this emerging picture of demand several of the advocacy services are ending in April 2016. This has provided an opportunity to rethink what the Local Authority and the public need from advocacy services and, with approval, commission a new model.

Recommendation:

The Cabinet Member for Adult Social Care and Public Health is asked to:

1. **AGREE** To the re-commissioning of advocacy services for vulnerable adults

2. **AGREE** to delegated authority for the Corporate Director, Social Care, Health and Wellbeing to authorise the letting of the contract.

1. Introduction

1.1 Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to:

- Have their voice heard on issues that are important to them
- Defend and safeguard their rights
- Have their views and wishes genuinely considered when decisions are being made about their lives

1.2 Kent County Council Adult Services has a history of commissioning both statutory and non-statutory advocacy services. These services have been commissioned using both contracts and grants on an ad-hoc basis to meet

specific local need, or to meet requirements of legislation for statutory advocacy. This range of services is currently being delivered via 17 different providers. Services are not aligned or standardised and some client groups are under-represented and have fallen through the gaps between services.

1.3 Statutory advocacy provision is governed by legislation and is therefore reasonably well structured and managed. The non-statutory provision, mainly grant funded, is a collection of different interpretations of advocacy and is therefore less clear cut in terms of what is delivered, by whom, and to what standard.

1.4. New requirements under the Care Act 2015 and the ending of current NHS Complaints Advocacy Contract and Independent Mental Capacity Advocacy (IMCA) contract in April 2016 have provided us with the opportunity to revisit the current model and commission something different that works for people regardless of client categories and to ensure consistency of supply and quality. We have worked closely with users of advocacy services, Advocacy providers and practitioners to design a new way to deliver advocacy services.

2. Financial Implications

2.1 By bringing together the current spend on Advocacy across grants and contracts, together with £482k of new money from the Care Act Grant, officers have identified a budget of up to £1.49m which could be used to re-commission Advocacy services. This spend is set out in Appendix 1.

2.2 There will be impact on a number of voluntary sector organisations where their activity will be decommissioned and their funding for advocacy delivery will be reallocated to the advocacy contract. These organisations are aware of this and have been involved in a range of co-production events and discussions with commissioners.

3. Links to KCC's Strategic Framework

3.1 Strategic Outcome

Older and vulnerable residents are safe and supported with choices to live independently

Particularly Supporting Outcomes:

- Those with long term conditions are supported to manage their conditions through access to good quality care and support
- People with mental health issues and dementia are assessed and treated earlier and are supported to live well
- Families and carers of vulnerable and older people have access to the advice, information and support they need
- Older and vulnerable residents feel socially included
- Residents have greater choice and control over the health and social care services they receive

4. Scope of Proposed Advocacy Contract

4.1 The scope of advocacy covered in this document is limited to:

- Statutory provision: IMCA, IMHA, Care Act Independent Advocacy and Health Complaints Advocacy; and
- Specialist community advocacy for people with particular support or communication needs due to disability, frailty or other vulnerability. The type of advocacy used should depend on what is best suited for the person who seeks it, rather than belonging to a particular client category.

4.2 The Learning Disability Advocacy service is outside the scope of this report. There are still two years remaining on the existing contract with Advocacy for All, which is providing a value for money and high standard of service. Following discussions at DMT it was agreed that before the end of the LD contract we will undertake an options appraisal and stakeholder engagement to consider the most appropriate options to re-commission the service.

5. Statutory responsibilities

5.2 Community advocacy exists to ensure vulnerable adults are supported to understand and explore choices and make their views known when dealing with issues relating to housing, employment and welfare benefits. Local authorities also have a number of statutory duties, established in legislation, to ensure people can access advocacy**:**

- The Mental Capacity Act 2005 introduced the right to an Independent Mental Capacity Advocate (IMCA), which gives some people who lack capacity a right to receive support to make specific decisions.
- The Mental Health Act 2007 introduced the Independent Mental Health Advocacy (IMHA) service to safeguard the rights of people detained under the Act and those on community treatment orders and to enable qualifying users to understand the legal provisions to which they are subject and to exercise their rights to participate in decisions about their care and treatment.
- The Health and Social Care Act 2012 introduced the Health Complaints Advocacy Service. Responsibility for commissioning the Health complaints advocacy service transferred from Department of Health (DoH) to local authorities, from 1st April 2013. The aim of this service is to support people who want to make a complaint about a health service, delivered through the NHS or privately sourced.
- The Care Act 2014 introduced a new statutory duty, from April 2015, in provision of Independent Advocacy to strengthen the voice of people and their carers going through assessment, care and/or support planning and care review processes, as well as those people who are being supported through the adult safeguarding process. Care Act Guidance suggests that advocates should be trained and qualified to a certain standard which will be included in our specification. Temporary arrangements have been put in place with current Providers of IMCA until end of March 2016.

6. Gaps in existing provision

6.1. There are identified service gaps in the current advocacy provision. It is proposed that these unmet needs will be covered by remodelling the provision, and apportioning the existing funding pool according to need in each CCG area. Factors for consideration will include: population, and prevalence of certain conditions, such as dementia, learning disability and mental health needs. The following areas have been identified:

- **Sensory impairments** – there is no commissioned advocacy for people with sensory impairments. This service is spot purchased on an individual needs basis, and is not currently universally available.
- **Autistic Spectrum Conditions** (ASC) – Currently only people with ASC and diagnosed Learning Disability can be supported though the LD contract. People with ASC at the high functioning end of the spectrum do not qualify.
- **Dementia advocacy** is currently only available in West Kent, provision needs to be accessible across the county.
- There is low level of funding to support people with **physical disabilities**, through peer support advocacy. The advocates are not professionally qualified, but are able to support people with disabilities using own knowledge and life experiences.
- **Prisons** – the duty to involve people in their care and support planning and therefore to an Independent Advocate applies in all settings, including prisons.

7. Advocacy and Safeguarding

7.1 Advocacy is an integral part of the safeguarding process, and the Care Act now makes it a statutory duty to provide individuals with an independent advocate, regardless of whether they are assessed to lack capacity. Historically there have been issues with referrals to advocacy during safeguarding, partly due to the fact that some practitioners are not aware of what advocacy provision is available and how to make a referral. The fact that we currently commission advocacy from 17 providers explains some of the confusion.

7.2 It is our intention that as part of re-commissioning advocacy provision, we will standardise the referral to advocacy during the safeguarding process. This will enable the authority to simplify the process for practitioners, provide better and timely support of an advocate during the safeguarding process and therefore give greater control and influence for the individual going through the safeguarding process.

8. Demand and population trends

8.1 Increases in the whole population figures indicate that there are likely to be significant increases in the number of people who may need to access advocacy services. The highest needs are expected to be for older persons over 85 years old, people with dementia, learning disability or mental health needs. Further work will be carried out to assess the need for people with sensory impairments, Autistic Spectrum Conditions, and for people in custody. There is significant increase in current demand for IMCA DoLS services following legal rulings on the meaning of deprivation of liberty. The Equality Impact assessment has shown that there will be positive impacts for people with protected characteristics having access to advocacy services.

The proposed model

8.2 Two co-production events were held with stakeholders in February and March 2015 and further events have also taken place with people who have experience of using advocacy services and Providers to develop the model. The emerging approach is to create a prime contractor hub model where all referrals are received and triaged from a central access point, and

sub-contracting a network of local advocacy partners who have trained qualified advocates with specialist skills, such as British Sign Language, understanding of autism or supporting people with dementia. This model should help to secure the skills of small, local providers whilst giving scale to ensure best value, quality control and ease of access for the public and professionals. The tendering process is underway with implementation from 1 April 2016.

9. OTHER OPTIONS CONSIDERED

9.1 Do nothing, i.e. continue to grant fund existing grant funded services, and contract as per existing arrangements. The main risks of this approach are;

- The local authority will not be Care Act compliant and may not be able to cope with demand.
- There is no additional resource to meet identified gaps in provision, the service will not be able to meet the needs of people, currently excluded, who may need advocacy.
- The existing arrangements may be in breach of procurement law, as the level of funding will exceed EU thresholds

9.2 Commission a range of specialist provision, providing a number of different contracts through different providers, separating IMHA, IMCA, Care Act, Health Complaints and variety of Community advocacy services – whilst this model leads to strong service identity; it does not address the gaps in provision, and heavily relies on the good will of providers to link up their services. It also increases management overheads as we replicate back office functions.

9.3 Generic provision – contract with a single provider. This will remove barriers to access and provide a simplified access route, but it can lead to loss of specialist skills and providers may lack the communication skills needed to facilitate people's involvement. Furthermore, commissioning of a single generic organisation may destabilise the existing market and create the risk of losing potential replacements for the service.

10. Cabinet Committee Comments

10.1 The 10 July 2015 Adult Social Care and Health Cabinet Committee considered the proposed decision and the recommendation report. Officers introduced the report and explained the rationale behind the decision.

10.2 The Committee resolved that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Health, to re-commission advocacy services for vulnerable adults, and delegate authority to the Corporate Director of Social Care, Health and Wellbeing to authorise the letting of the contract, be endorsed, taking into account comments made by the Committee.

11. Recommendation

The Cabinet Member for Adult Social Care and Public Health is asked to:

1. **AGREE** to the re-commissioning of advocacy services for vulnerable adults

2. **AGREE** to delegated authority for the Corporate Director, Social Care, Health and Wellbeing to authorise the letting of the contract.

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Background Documents
None

Appendix 1 – Current Spend on Advocacy Services

Advocacy Service	Statutory	Client Group	Coverage	Funding Type	End Date	Extension Period	Funding 2014/15 £'000	% of Total Spend	Notes
IMCA	Yes	All	Countywide	Contract	31/03/2016	2 years	£125	8%	Projected forecast
IMHA & Community MH	Yes	All	Countywide	Grant	31/03/2016		£487	33%	Includes £39K for secure settings and out of area placements
Care Act IA	Yes	All	Countywide	Contract	31/03/2016		£482	32%	£482k identified for 15/16 -
NHS Complaints	Yes	All	Countywide	Contract	31/03/2015		£237	16%	Arrangements from April 2015 tbc
Dementia	No	OPPD	WK	Grant	31/03/2016		£44	3%	
CROP (OP)	No	OPPD	Kent except DGS	Grant	31/03/2016		£20	1%	Total grant £99.7k for IA & A
CARM (StOP)	No	OPPD	Romney Marsh	Grant	31/03/2015		£23	2%	Ends 31 March 2015
PD	No	OPPD	Countywide	Grant	31/03/2016		£76	5%	
Total							£1,494	100%	