9 March 2022	ITEM: 17 Decision: 110613
Cabinet	
Commissioning Report - Advocacy	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Deborah Huelin - Cabinet Member for Adults and Communities	
Accountable Assistant Director: Les Billingham – Assistant Director Social Care and Community Development	
Accountable Director: Ian Wake – Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

This report details the proposed commissioning of statutory and non-statutory Advocacy services and details the legislative framework we are required to operate to safeguard vulnerable people. The report also outlines the proposed changes to existing arrangements to ensure they are more responsive and streamlined. The new approach will also address current issues with securing advocacy for those service users placed in a neighbouring borough.

1. Recommendation(s):

1.1 That Cabinet agree that the new Advocacy contract is procured in line with the contents of this paper.

2. Introduction and Background

2.1 Advocacy is complex but can commonly be defined as;

> "Taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice."
>
> **(The Advocacy Charter, 2018)**

2.2 Advocacy is most commonly provided to people who have difficulty in understanding/retaining information or the options available to them. Advocacy ensures the person is listened to, understood and respected.

2.3 As advocates help people to have a voice and ensure their rights are upheld within social care, health and education settings, they are required to be delivered independently of these organisations. However, the Local Authority is largely responsible for the commissioning of Advocacy.

2.4 There are two main types of advocacy – Instructed and Non-instructed.

2.4.1 Instructed advocacy is where the advocate is directed by the person at all times and tries to support the person to be able to self-advocate.

2.4.2 Non-instructed advocacy is where the person they are advocating for lacks mental capacity and can therefore not direct the advocate in some or all of the decisions. This type of advocacy is usually a statutory requirement to ensure the individuals rights are being upheld, such as Independent Mental Capacity Advocacy (IMCA).

2.5 Due to the introduction of new or amended legislation which transferred statutory responsibility to the Local Authority for the commissioning of Advocacy we have different commissioning arrangements in place. These arrangements have now all been aligned to end 30th September 2022 to enable the Council to have a consistent commissioning approach in the future.

2.6 Currently we have the responsibility to commission the following statutory advocacy provision;

2.6.1 **Care Act Advocacy** (a requirement under the Care Act 2014). Advocacy must be available to support someone who does not have an appropriate family member or friend who can support them and would have ***'substantial difficulty'*** in taking part in social care assessment, carer's assessment, care planning or a safeguarding investigation without assistance.

2.6.2 **Independent Mental Health Advocacy (IMHA).** The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act. This is a specialist advocacy role and these advocates have legal rights which are not available to other advocacy roles. There are various patients who qualify for an IMHA but in the main it is used by people detained under the Mental Health Act.

2.6.3 **Independent Complaints Advocacy Services** (ICAS –Health and Social Care Act 2012). The responsibility for commissioning this was transferred to local authorities in 2013. This service provides practical support and information to anybody who wishes to make an NHS complaint.

2.6.4 **Independent Mental Capacity Advocacy** (IMCA – a requirement under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs) 2009. IMCAs are a legal safeguard for people who lack the capacity to make specific and important decision about where they live and serious medical

treatment. IMCAs are mainly instructed to represent people where this is no one independent of statutory services such as a family member of friend who could represent a person's wishes and views.

Please note that Deprivation of Liberty Safeguards (DoLs) are to be replaced by the Liberty Protection Scheme (LPS). This change should have occurred shortly after the start of the pandemic but has been repeatedly delayed. As such, the Council has extended current arrangements in anticipation of this change (as at this point in time we are unsure when and the implications of the introduction of LPS will have upon demand).

2.7 Although Care Act Advocacy, IMHA, ICAS and IMCA are statutory requirements and important legal safeguards for vulnerable people, the availability of some non-statutory advocacy is also important as there are many people who don't meet the strict legal criteria who need and benefit from independent advocacy. Although not routine, we have had to spot purchase a small amount of non-statutory advocacy (largely around finances) since the last procurement and as such any future commissioning arrangement needs to include this facility.

2.8 We currently have 3 contracts in place with two organisations and further spot purchase arrangements in place for IMHA and out of borough advocacy. We spend between £185k and £200k per annum (varies due to demand in spot purchase arrangements).

3. Issues, Options and Analysis of Options

3.1 We have a legal requirement to commission statutory advocacy services and have extended current arrangements in order to align existing arrangements. As stated in 2.6.4, another reason for this extension is the delay in the introduction of LPS. As we are still unsure when the LPS guidelines will be published and its implementation date we are unable to extend further and have had to now progress with a procurement.

3.2 Historically, in line with best practice, the Care Act Advocacy and IMCA contract was separated into two 'lots' to support small and medium sized organisations to be able to tender. However, although this was done with the best of intentions, this decision has led to some service users having multiple advocates within their health and social care journey. Obviously, having inconsistency in advocates is not helpful for people who may have issues with either understanding/retaining information or have been assessed as not having capacity.

3.3 Although more common with the cross over in Care Act advocacy and IMCA, it is also possible for somebody in receipt of IMHA to also have an IMCA from another organisation.

3.4 Existing providers and health and social care professionals have all indicated that our current arrangements, including the separation and contracting of

services across different organisations, is not in the best interest of service users.

3.5 As such, our preferred option is for all existing arrangements to be tendered as one contract opportunity. All advocates will be expected to be appropriately trained to undertake whatever level/type of advocacy is required and to be alongside the service user throughout their journey.

3.6 In order to ensure stability whilst also minimising the risk of increased demand when LPS comes into effect, we will be requesting the tenderer to submit bids on an 'as is' basis, whilst also providing a submission on a potential increase of 25% and 50% on the current IMCA component of the contract. We will also be issuing the contract for 3 years with the possibility of two further 1 year extensions. This allows us to terminate existing arrangements if the LPS has a significant impact on current advocacy demand but to retain the possibility of a longer contract should it be working well and the impact of LPS be minimal.

3.7 We are currently unsure whether Thurrock CCG will wish to access the contract when LPS is introduced (as they may have additional responsibilities) or whether they will commission this on a Mid and South Essex (MSE) footprint. As such, we will ensure the contract contains the provision to allow health colleagues access to our arrangements should they require it.

3.8 The contract will also request the successful provider to carry out advocacy within neighbouring authority areas for those placed out of borough (but nearby). This is another component that has traditionally been spot purchased. We are currently experiencing difficulties in securing out of borough advocacy as the advocacy organisations operating in those areas (largely Kent, Essex and Southend) generally do not have additional capacity. We will have to continue to spot purchase those further away as it would not be financially viable for a local organisation to provide advocacy to service users who are living in specialist placements far away e.g. Yorkshire.

4. Reasons for Recommendation

4.1 It is a requirement that we commission statutory advocacy services.

4.2 We have delayed the recommissioning of existing advocacy arrangements to allow us to align existing contract end dates and in anticipation of the implementation of LPS (which to date has still not occurred). We are unable to extend further.

4.3 Current arrangements are complex and not in the best interest of service users as they can end up with multiple advocates and organisations within their journey.

4.4 We are having difficulty in securing spot purchase advocacy for service users placed in neighbouring authorities.

4.5 As such, we are recommending that we combine all existing contracted and spot commissioned advocacy services (with the exception of advocacy for those placed outside of neighbouring authority boundaries) to ensure a better experience for service users and to secure provision.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 In order to gain increased understanding of the effectiveness of existing arrangements and to inform any potential changes, we have consulted a number of stakeholders:

- In October of this year we attended the Social Work Managers team meeting to ascertain their views.
- In November we met with the Deputy Manager - Process and Systems and with the Adults Safeguarding and Legal Intervention Team Manager that oversees IMCA referrals.
- In December we met with the Operational Manager of Pohwer, the organisation currently responsible for providing both IMCA and ICAS advocacy support.
- Also in December we met with the Chief Executive Officer of Thurrock and Brentwood MIND, the organisation responsible for providing both Care Act advocacy and spot purchased IMHA advocacy support.
- We are currently in the process of involving people that have been in receipt of advocacy support over the last 3 to 6 months as we see them as experts by experience. We should be able to give a verbal update to O&S on the outcome and include the findings in the eventual Cabinet report.
  The views of all of the above will go on to inform the service specification.

5.2 The report was presented to HOSC on the 13 January 2022 where it was agreed by Members to recommend to Cabinet the reprocurement of the Advocacy service.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The delivery of advocacy services meets many corporate and community priorities. However, the commissioning of these services support Thurrock Council's 'People' priority in particular. The aim of this tender is to address current issues with inconsistencies of staffing and to assist vulnerable people to make informed choices. This meets the following two objectives contained within the People priority;

- high quality, consistent and accessible public services which are right first time
- communities are empowered to make choices and be safer and stronger together

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

There are no current financial implications as existing levels of provision are budgeted for. However, should the introduction of LPS result in additional demand then there is a potential risk of increased funding being required.

7.2 Legal

Implications verified by: **Courage Emovon**

Principal Lawyer/Contracts Team Manager

The commissioning of this service enables the Council to meet its statutory obligations and duties as outlined in section 2 of this report. Any proposed procurement of Advocacy service must comply with the Council's Contract Procedure Rules and the Public Contracts Regulations 2015 and Legal services is on hand to advice on any implications arising from the proposed procurement and this report.

7.3 Diversity and Equality

Implications verified by: **Natalie Smith**

Strategic Lead - Community Development and Equalities

By commissioning this service we are seeking to support the most vulnerable in society to have their rights protected and their voice heard. We are addressing consistency of staff issues caused by the separation of contracts and have sought views from people delivering, referring to or using the service about these improvements.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- N/A

9. Appendices to the report

- None

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