

Feedback from provider engagement for Adult Social Care
Advocacy services re-commission

28th March 2018

1. Introduction

- 1.1 Brighton and Hove Adult Social Care Commissioners invited Providers to attend a pre-tender engagement event on the 28th March 2018 that was advertised on the contracts finder website (<https://www.contractsfinder.service.gov.uk/Notice/452a61d0-ffec-4072-8f8a-14286644760d>). Representatives from 13 advocacy providers attended the event and were a mixture of local, regional and national organisations (details of the organisations are included in Appendix A).
- 1.2 Providers were given a brief presentation of the local context and feedback from the Advocacy Needs Assessment 2017 (slides included in Appendix B).
- 1.3 Discussion groups then took place to look at opportunities for pan Sussex work, providing a central point of access whilst retaining specialist provision, different models for delivery of services including single provider and partnership models with a lead provider and considering whether advocates can provide more than one statutory role. The key points are summarised in this report together with the proposed model of delivery for advocacy services. Comments from the groups are included in Appendix C.

2. Question 1 *Can advocates provide more than one statutory role? Do some roles fit together better than others?*

- 2.1 Providers gave feedback that the benefits of advocates being able to provide multiple roles are the continuity for the person, it helps to build trust, avoids duplication and provides a more seamless and personalised service. Examples were given of autism people particularly benefitting from this approach, as it can be more difficult to cope being transferred between different advocates. There was also agreement in the challenges of this approach including the differing skills required for different advocacy roles, training and cost implications for services and concern that having multiple roles for advocates may impact on the quality of service including the loss of some specialist skills. Some providers were concerned that smaller organisations

would not be able to deliver an advocacy service providing multiple roles due to the higher cost and larger teams that would be needed.

- 2.2 Considering specific advocacy roles that may fit together, there was consensus from the majority of Providers who attended the event that the Independent Mental Capacity Advocacy (IMCA) function fits well with Independent Care Act advocacy (ICAA). The benefits of this were considered to be providing continuity to the person and a more seamless and personalised approach to support. There was mixed feedback about the benefits of Independent Care Act Advocacy (ICAA) and specialist community advocacy sitting together. Similar benefits were considered in terms of providing continuity of support for a person who may access community advocacy and ICAA following on from this which may lead to a further need for community advocacy as things progress. However, it was also considered that the focus and time and resource allocation for community advocacy may be impacted if provided with ICAA, as it's a statutory function and would likely take priority.
- 2.3 As a result, a potential issue was identified of statutory advocacy functions being prioritised and better resourced by a service with advocates also providing community advocacy. It was suggested that ring fencing funding for community advocacy could help mitigate this risk otherwise this could adversely impact on the responsiveness of the service with regards community advocacy.
- 2.4 It was considered that the IMCA and Independent Mental Health advocacy were too disparate in their statutory function and the knowledge and skill base needed for an advocate to deliver both. It was suggested that the IMHA and community mental health advocacy could sit well together given the routes of access would likely be the same and the specialist knowledge and skills needed from advocates to support this client group.
- 2.5 There was some feedback that the IHCAS statutory function did not link with other advocacy roles other than in cases where advocacy for parents of children with learning disabilities progressing through the Court process as it was suggested that Health Complaints often run in parallel to this process.
- 2.6 It was highlighted that support for people with Learning Disabilities, Autism and hearing impairments can require more time and resource due to communication difficulties and the specialism that advocates need to support these people.

3. Question 2 *Central point of access – how do we provide a one stop shop without losing specialist provision?*

- 3.1 The importance of being clear about what a central point of access/ 'one stop shop' is in the service specification was highlighted in feedback.
- 3.2 There was some consensus about the benefits of a central point of access (CPA) including enabling a more responsive service when factors such as capacity of providers can be considered (absence, leave, waiting lists etc.) to promote a more responsive service. Providers also advised that this would prevent delays in identifying incorrect referrals e.g. a person requiring an IMCA rather than an ICAA, which we are aware is an ongoing issue. It was also fed back that the CPA needs an appropriate allocation of resources to function effectively.
- 3.3 Allowing for more than one route of access into the central point was highlighted as essential. The argument for this was put forward on the basis that often a person will already be in contact with a specialist community organisation, who commonly identifies the need for advocacy and can support the person to be referred into the central point of access. Providers also advised that a person is likely to make contact with a community organisation rather than the central point of access, this being especially true for people with specialist needs. Connected to this was the concern of losing some added value with specialist organisations providing advocacy in tandem with other services offered. There was also an overall apprehension about how peer and group advocacy would be supported if there is a central point of access.
- 3.4 The importance of the CPA not just being digitally accessible was discussed and drop-ins at community centres and hubs were recommended to enable equal access for people with specialist needs including people with hearing impairments. In addition, it was proposed that an interpreting service needs to be provided at the CPA and budgeted for.
- 3.5 Feedback highlighted the importance of trained and skilled advocates with knowledge of specialist community organisations in Brighton and Hove to be able to triage referrals and ensure signposting to community resources as appropriate. As well as some signposting, it was advised that the central point of access would involve some information and advice and that this is a wider remit than the advocacy role so this needs to be considered.

4. Question 3 *Are there opportunities for more pan Sussex work?*

- 4.1 There was a general consensus from Providers that statutory advocacy duties could work well pan Sussex with some challenges highlighted that would need to be considered. It was proposed that pan Sussex statutory advocacy services could offer staff greater flexibility and potentially incorporate a wider specialist skill set of advocates given the larger geographical area covered. An example provided related to increasing access to advocates trained in BSL given the additional barriers people with hearing impairments face in accessing advocacy services. Other benefits suggested included reducing the potential for 'handoffs' between different areas and local authority boundaries which would offer a more cohesive and personalised service for people accessing statutory advocacy.
- 4.2 There was a consensus from providers that specialist service provision would be challenging to provide pan Sussex. The main issues raised were; that not all specialist and smaller organisations currently operate pan Sussex and those that don't may not be have the capacity and resources to do this which would exclude them from bidding for a pan Sussex service. Also that there is the challenge of different demographics, priorities and strategic approaches by Adult Social Care pan Sussex and the three local authorities this covers.
- 4.3 If specialist advocacy is to be provided pan Sussex, it was proposed that each locality would need its own specialist advocacy service that could meet the unique needs of people living in each area to ensure that people from groups with specialist needs would not be disadvantaged or unsupported in each area.

5. Question 4 *Single Provider v partnership with Lead provider model*

- 5.1 The general consensus was a preference for a lead provider model rather than a single provider doing everything. This includes feedback from organisations that have contracts to deliver advocacy within both models. It was acknowledged that a single provider may provide a more straightforward process and improve communication across the board and have budgetary and resource benefits. Also that single providers are still able to link in with specialist and community organisations and that this can be a reciprocally beneficial relationship where specialist organisations can benefit from the knowledge and experience of the single Provider.
- 5.2 However, there were several concerns about this model. The main concern was that this would exclude specialist community providers from the bidding of the contract and that people would not have the choice of advocacy provided by a specialist

community organisation. This was considered as compounding access issues and quality of support for people with hearing impairments, autism, learning disabilities in particular. In addition, it was raised that specialist providers have the local knowledge of services and provide social and added value that would be lost if there was a single provider model.

- 5.3 Feedback about a partnership with a lead provider model was focused around the attributes needed from both with a focus on flexible working arrangements. The need for Lead Providers to be transparent, resilient, well resourced, able to absorb financial risk, good management and leadership were highlighted as important. Also the importance of due diligence in the tender process to ensure that the lead provider has a proven track record of working effectively with partnership arrangements and sub-contracting to specialist community organisations was highlighted.
- 5.4 Regarding partnership arrangements, the importance of flexibility across specialist community organisations was highlighted; both with regards to accepting referrals and working with other partners to avoid 'hand offs' between services or people being categorised by virtue of their primary need/ age. Also that a partnership arrangement with specialist community organisations ensures that people have choice and specialist support from organisations and prevents specialist knowledge and networks being lost including knowledge of local services and key professionals to contact with the Local Authority, CCG and NHS.
- 5.5 The preventative element to community advocacy was also highlighted as a consideration to retaining this in the re-commission, supporting people to avoid a crisis arising and the impact that this has on other part of Adult Social Care including the impact on assessment teams and funding.
- 5.6 Providers fed back that commissioners need to carefully consider the language in the service specification about the roles and responsibilities of the lead provider and specialist community organisations in a partnership.

6. *General feedback from feedback from group discussions for Commissioners to consider*

- 6.1 The need for assessment teams to promote advocacy services with clients and have a good understanding of advocacy services, referral processes and specialist community services was highlighted as important to the effectiveness of the advocacy service.

- 6.2 The importance of notifying providers of a pan Sussex model with lead provider and/or a partnership was highlighted as this will impact on which organisation could bid as lead provider and form partnerships. It was also stressed that Commissioners need to give providers sufficient time to discuss and explore partnership arrangements so that this is meaningful and that organisations values align.
- 6.3 One of the providers asked about advocacy for children and young people. The Youth Advocacy Project provide advocacy to young people in Brighton and Hove www.bhyap.org.uk and there is a Council run service too.

7. Recommendation

Having considered the feedback from the Advocacy Needs Assessment 2017 and the engagement work to date with service users and providers, the following model is being recommended for the advocacy re-commission in April 2019.



The proposal is that a Lead Provider directly provides IMCA across East Sussex, Brighton & Hove and West Sussex and ICAA for Brighton & Hove and West Sussex. The Lead Provider could either directly provide or sub-contract with specialist community advocacy organisations to provide IHCA, Specialist Community Advocacy and a combined IMHA and Community Mental Health Advocacy. Spot purchase arrangements would need to be in place for specialist providers of deaf, bilingual and autism advocacy. It is expected that a subcontracting arrangement would be the most effective model as it would retain the specialist knowledge held by community providers.

Discussions are also currently taking place with West Sussex regarding joint commissioning of some of the other advocacy provision.

Appendix A: List of provider organisations that attended the workshop

Royal Association for Deaf People

Possability People

Rethink Mental Illness

Impact Initiatives

Age UK Brighton & Hove

seAp

Speak Out

POhWER

Brighton & Hove Impetus

MIND Brighton and Hove

Voiceability

MindOut

Sussex Interpreting Services

Appendix B: Presentation to Providers Engagement Workshop



Provider Engagement Workshop Advocacy Procurement 28th March 2018

Anne Richardson-Locke, Commissioning & Performance Manager
Natasha Gamble, Commissioning Support Officer
Steve Dillow, Procurement Category Specialist
John Reading, Community & Equalities Third Sector Manager
Amanda Waller, CCG Commissioning Project manager



Agenda

- ▶ 1:00 Introduction & background
- ▶ 1:15 Discuss Q1
- ▶ 1:30 Discuss Q2
- ▶ 1:45 Discuss Q3
- ▶ 2:00 Discuss Q4
- ▶ 2:15 Break
- ▶ 2:45 Feedback
- ▶ 3:30 Close




Current provision

8 different types of advocacy provided by 7 community and voluntary sector providers (total £648k):


- Independent Mental Capacity Advocacy (IMCA)
- Independent Mental Health Advocacy (IMHA)
- Independent Care Act Advocacy (ICAA)
- Independent Health Complaints Advocacy (IHCAS)
- Community Mental Health Advocacy
- Specialist Community Advocacy (OP, MH, LD, PD)
- LGBT Community Advocacy
- Trans Advocacy

All contracts expire on 31st March 2019




Advocacy Needs Assessment

Advocacy user feedback:

- ▶ People were very positive about advocacy services, their advocates & the impact on their quality of life
 - ▶ Continuity of advocate is important to people
 - ▶ LGBT users particularly value a specialist service whilst some other users don't want to be categorised by client group
 - ▶ Lack of capacity, high thresholds and lack of awareness were highlighted as barriers to accessing advocacy
 - ▶ Need for a quick response to assess urgency & prevent crises
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Advocacy Needs Assessment

Referrer feedback:

- ▶ Majority of referrers very or fairly satisfied with advocacy services
 - ▶ Like other areas very low numbers of Care Act referrals & referrers experienced greater difficulty in accessing Care Act Advocacy
 - ▶ Referrers unsure where to refer when clients have multiple needs
 - ▶ Hand offs between organisations where people need more than 1 type of advocacy
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Advocacy Needs Assessment

Recommendations:

- Raise awareness of advocacy and advocacy services through better promotion with a clear description of the offer available to: users, referrers and other services
- Clear care pathway that specifies levels of service and expected timescales
- Single point of access and duty system
- Consider co-location of advocates with referrers (works well with IMHA at Millview)
- Commission different types of advocacy to include group, peer and self-advocacy



Drivers

- Increase in demand predicted – but less money
- Good practice :
 - Single point of contact to triage and prioritise referrals
 - Single provider or partnership with a lead
 - Innovative and flexible provision making best use of technology
 - Network of providers working collaboratively not in competition



Engagement

- Independent engagement as part of JSNA
- Further engagement with BME, hearing impaired and older people, and people with autism
- Early engagement with the current and potential providers today
- Further engagement with providers to follow on from this event



Timetable for procurement:

Task	Deadline
Engagement with users and providers	1 st March - 30 th April
EIA	April
Draft service specification/s	April-May
Health & Wellbeing Board sign off	June
Tender issued	June - early July
Tenders received back	Late August
Evaluation / moderation 6 weeks	September - mid October
Tender award + standstill period	October
Contract mobilisation	November - March
New contract starts	April 2019

Areas for discussion with market

- ▶ Q1. Can advocates provide more than 1 statutory role? Do some roles fit together better than others?
- ▶ Q2. Central point of access – how do we provide a one stop shop without losing specialist provision?
- ▶ Q3. Are there opportunities for more pan-Sussex work?
- ▶ Q4. Single provider v partnership with lead provider?

Appendix C: Feedback from workshop groups

Q1. Can advocates provider more than one statutory role? Do some roles fit together better than others?

Care Act and IMCA roles appear to sit together well and provide continuity for the person

IMCA and IMHA considered too disparate and conflict of interest concern raised

IMHA and community MH advocacy could sit together given routes of access but some feedback that IMHA needs different skill set

IHCAS difficult to link to other roles

Advocacy for people with LD and health complaints works well together as these roles often run in parallel

Provides continuity for the person, builds trust, avoids duplication and provides a more seamless and personalised service. Exemplified given of people with autism particularly disliking being transferred to different advocates

A potential issue was raised in terms of some roles being prioritised over others e.g. the IMCA role have a time limit on allocation and higher volume of referrals and concern that if advocates are providing more than one roles, others would be lower priority and therefore less responsive

Community advocacy may get lost amongst statutory roles; suggestion of ring fencing funding for community advocacy

Community advocacy to be included with statutory to help continuity of support eg. A person receives community advocacy, required ICAA and following a crisis may then need community advocacy

Some feedback that community advocacy needs to be separate from Care Act

Potential issue with advocacy for people with LD/ Autism taking longer due to communication difficulties and the specialism advocates need to support these groups

Differing skills required for different advocacy roles could be an issue, training can be expensive. Will advocates be paid more? Example of Voiceability who had training to act as IMCA/ ICAA and IMHA. Smaller providers concerned they won't be able to provide this.

Will having multiple roles for advocates impact on quality of service and less specialised skills within a role?

Look at Essex model of commissioning advocacy

Difficulties in recruitment of advocates

Higher cost and bigger teams needed – smaller organisations can't afford/do this

Q2. Central point of access – how do we provide a one stop shop without losing specialist provision?

Allow for more than one route of access;

- through specialist organisations who may already be working with the person and can identify a need for advocacy that the person may not and make referrals on behalf of clients
- not just online; phone, drop in at community centres/ hubs
- accessing advocacy via specialist organisation can provide social value with some people going on to volunteer with the organisation

A local based single point of access for each authority if services are pan-Sussex enables knowledge of and signposting to local services/ community assets where needed

Central point of access needs trained and skilled advocates to provide effective triage. Example of Kent model given with a contact centre and triage by trained advocates

The role for advocates on CPA is wider than advocacy role; also signposting and advice?

CPA can provide a more responsive service when factors such as capacity of providers can be considered inc. absence/ leave/ waiting lists. Also prevent delays by identifying incorrect referrals eg. The person requires an IMCA rather than an ICAA.

An interpreting service needs to be provided at CPA and budgeted for to provide equal access to all.

Specialist need can mean that these people are excluded as can't use phone/ digital e.g. deaf community wouldn't be able to access a central point of contact

Be clear about what a central point of access means in the Service Specification

Clear expectations from Commissioning and Procurement set out in service specification about how partnership should work and what role/ responsibilities the Lead Provider has

Test partnership model and ask for evidence as part of evaluation

It needs appropriate allocation of resources for the Provider that operates the central point of access. Managing this is challenging

Partnership benefits from having a lead provider and 'single point of contact'

'No wrong door'

People often access advocacy via community services/ specialist organisations

Peer support groups/ advocacy?

Support groups can influence service provision

If client has specialist needs, then specialist providers need to work together to determine how best to support the person

Advocates in central point of access need to have local knowledge of specialist services

Examples of this in operation in others LAs;

Northampton – Total Voice

Suffolk – Voiceability with 5 specialists in partnership, upskilled the local providers

Q3. Are there opportunities for more pan-Sussex work?

Consensus that statutory duties/ advocacy could work well pan-Sussex

Many organisations operating locally in Brighton and Hove could offer a Service pan Sussex but not all specialist organisations do

Concerns that social/ added value will be impacted and local knowledge of specialist local services/ community assets lost

Pan Sussex with some local provision considered a good model e.g. the Lead Provider operating Pan Sussex with specialist partnership in each locality (ESCC, WSCC and BHCC). This will also tackle issues with difference in demographics and environment

Pan Sussex provision could work with links into local organisations

Pan Sussex service could prevent some local/ smaller Providers being able to bid for the contract

Pan Sussex could offer staff greater flexibility and potentially wider specialist skills of advocates given the larger geographical area covered e.g. those trained in BSL

Wider geographical coverage will mean more funding and sustainability of smaller specialist providers

Reduces potential handovers

Cultural challenge of differences between areas/ LAs

Q4. Single Provider v partnership with Lead provider model?

Organisations that have both models appear to prefer partnership with lead provider model as it's a more effective way of delivering specialist support and providing more choice for people.

Lead Provider needs to be transparent, resilient, well resourced, financially viable and able to absorb potential financial risk, good management and leadership

Lead Provider can offer support to specialist orgs in the partnership to deliver and they can learn from each other

There would need to be flexibility for people with multiple needs across the partnership to provide the most responsive and personalise service – not categorising people where avoidable

Partnership with lead provider prevents specialist knowledge and networks being lost including knowledge of 'go to' people for various issues within the LA/ CCG/ Housing

Minority groups have difficulty accessing advocacy services and it's likely they would access an advocate via the specialist service they are familiar with/ already engaged with.

Benefit of partnership with lead provider giving people the benefit of somewhere in the community they can go

Group/ collective advocacy may be difficult to deliver by a single provider

A single provider can work with local more specialist organisation in the area to make use of their knowledge and expertise

People don't want to be 'handed off' between services or 'pigeon-holed' according to their primary need/ age etc but other feedback was that the risk of hand off is a false expectation of the partnership model

Single Provider can make communication with stakeholders/ commissioners easier as single point of contact and may have budgetary and resource benefits

Consideration needs to be made to what the community and people using the service would prefer

Commissioners to carefully consider language in service specification re lead provider and partnership and do due diligence with lead providers about track record of working/ engaging with specialist providers and that they have the resources, can absorb risk, well managed and well led and resilient.

Be careful that the lead provider subcontracts well with smaller providers – be fair!

Important of trust across all providers

Specialist providers have the local knowledge of what's available and provide social and added value

General feedback:

Idea of 'opt out' approach to advocacy but could create capacity issues

Social workers to promote advocacy and always consider advocate for assessments

Social care teams/ referrers to understand the advocacy service and processes

Pan Sussex models will impact on which organisations could bid as lead provider and form partnerships so needs to be decided on ASAP

Providers need sufficient time to discuss/ explore partnership so that this is meaningful and values etc align

Need to retain community advocacy – preventative element

People like to be offered a specialist advocate

Concern that specialist providers won't all be able to provide service pan Sussex

Importance of collating data re referral demand in order to get required resources/ funding