Strengthening the role of advocacy in Making Safeguarding Personal

Contents

1. Introduction and aims of the work

This briefing is generated by a series of structured conversations with advocacy providers across England.[1] This was carried out on a modest scale with an intention to encourage wider multi agency national and local conversations. The briefing connects with messages in recent multiagency work on safeguarding enquiries and concerns.[2] Some of the messages are also underlined in a user-led qualitative research study which explored the experience of targeted violence and abuse and of adult safeguarding with 23 people who have been victimised because of their mental health status.[3]

The briefing offers support to those who have duties to commission and arrange advocacy services and to the advocacy sector in its delivery, including in defining both advocacy and Making Safeguarding Personal (MSP). It builds on an earlier publication (LGA/ADASS, December 2017)[4] which aimed to help shape the role of advocacy in MSP. Significantly the earlier work aims to clarify the strong connection between the responsibilities and core principles of advocacy and of MSP[5] and the potential contribution of both to effective safeguarding.

This work is part of the adult safeguarding workstream of the Care and Health Improvement Programme (CHIP). The CHIP provides support to councils in England for social care, integration and health and digital improvement, as well as supporting the Transforming Care programme for people with learning disabilities and/or autism. It is the sector-led improvement programme for care and health co-produced and delivered by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), funded by the Department of Health and Social Care.

The National Development Team for Inclusion (NDTi) was commissioned to support this work. Sections one and two of this briefing provide a clear summary of the background and core messages. Section three and the appendices are helpful in supplementing this and support further understanding of the issues and acting on them.

Aim and rationale for this work

The aim is to support strengthening the role that advocacy (of all types) can play in safeguarding adults and specifically in MSP.

The intention is to generate multi agency conversations based on this briefing and through this to stimulate local action to address some of the core messages that emerge, in order to enhance safeguarding outcomes for people. Local action will benefit from support at regional and national level, eg from the NDTi; the national Safeguarding Adults Board (SAB) Chairs network and the principal social workers network. The action planning tool set out in Appendix 1 can form a basis for planning action at local, regional and national levels.

Conversations with advocacy providers that have informed this briefing explored enablers and barriers to involvement of advocacy in safeguarding adults to find out:

• What works?

• What gets in the way?

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1   Conversations with 28 advocates, some of whom also managed advocacy services, from 18 advocacy providers across England, covering 33 local authority areas

2   See LGA/ADASS www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

3   Research Study: Carr S, Hafford-Letchfield T, Faulkner A, et al. 'Keeping Control': A user-led exploratory study of mental health service user experiences of targeted violence and abuse in the context of adult safeguarding in England. Health Soc Care Community. 2019;27: e781–e792. Main findings available here https://onlinelibrary.wiley.com/doi/10.1111/hsc.12806
Podcast produced with Sarah Carr, Tina Coldham independent mental health user consultant, trainer and researcher and Jane Lawson, LGA; produced by Esi Hardy, Disability Inclusion Trainer and Consultant available here https://soundcloud.com/rip-ripfa/safeguarding-concerns-a-service-user-perspective

4   www.local.gov.uk/sites/default/files/documents/25.30%20-%20Chip_MSP%20Advocacy_WEB_2.pdf

5   See section three , LGA ADASS 2017 www.local.gov.uk/sites/default/files/documents/25.30%20-%20Chip_MSP%20Advocacy_WEB_2.pdf

- What are the key issues we need to address?

- What might the range of stakeholders do to strengthen understanding of the advocacy role and to develop its potential contribution in safeguarding adults?

These conversations indicate a clear need for greater partnership acknowledgement and understanding that the provision of advocacy is a statutory duty. Alongside this that the value and potential contribution of advocacy at all levels to MSP is significant. Developing a clearer understanding of the definition and purpose of advocacy and the legal rights and responsibilities associated with it needs to be central to local action planning and improvement in practice.

Advocacy; the statutory context

Alongside the requirements of the Mental Capacity Act (2005) and the Mental Health Act (1983) in relation to advocacy, the Care Act (2014) requires local authorities to arrange an advocate for anyone who has 'substantial difficulty' being involved where there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer.[6]

This might be in assessments, care and support planning, reviews and safeguarding situations. The Care Act (2014) makes clear that local authorities have a responsibility to consider a person's need for an independent advocate from the first time they make contact and through all subsequent contacts.

This is set out in Sections 67 and 68 of the Care Act (2014). The Care and Support Statutory Guidance (DHSC, 2020) indicates that each local authority must; "arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or safeguarding adult review (SAR)," where the above conditions are met.[7]

The Care and Support Statutory Guidance (DHSC, 2020) underlines the value of advocacy support in sensitive safeguarding situations, which are often daunting and present difficult decisions; where people are often demoralised, fearful, or embarrassed.[8]

Suggested next steps

The following will be necessary to support taking this briefing forward in practice:

- Local and national dissemination and discussion of the core messages in section two of this briefing across key groups including: advocacy providers; those who commission advocacy; principal social workers; safeguarding adults board (SAB) chairs; and sector leaders.

- As a result of these discussions, identify what needs to be done and by whom to ensure a greater and more effective role for advocacy in MSP, including identification of:

  ○ national steps that can be taken to enhance consistency of approach and effectiveness.

  ○ key local issues. Planning and carrying out local actions accordingly across stakeholders.

- Collate and disseminate best practice examples for inclusion on the LGA and NDTi websites alongside this briefing.[9]

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6   Care and Support Statutory Guidance 7.4
7   DHSC, (2020), paragraph 14.10
8   DHSC, 2020, 7.28
9   See appendix one, an example template to support local areas or regions in identifying and addressing issues within and across sectors

The definition and purpose of advocacy

"Advocacy is taking action to support people to say what they want, secure their rights, pursue their interests and obtain services they need. Advocacy providers and Advocates work in partnership with the people they support and take their side, promoting social inclusion, equality and social justice."[10]

Independent advocacy is an essential component of local services and support for people who are at risk of exclusion. Having access to advocacy support will be important to many people in order to help them say what they want, secure their rights, represent their interests and obtain services they need – in relation to the health, social care, education systems and beyond.

The provision of independent advocacy, in all its forms is based on a set of underpinning principles and values. These are set out in The Advocacy Charter which was developed by Action for Advocacy and published in July 2002. This was then updated in 2014 and again in 2018 by NDTi.[11]

Across England, local authorities have the responsibility for ensuring provision of a range of independent advocacy for adults and are required to commission:

• Advocacy under the Care Act 2014[12]

• Independent Mental Capacity Advocacy (IMCA)[13]

• Paid Relevant Person's Representative (Paid RPR)[14] [15]

• Independent Mental Health Advocacy (IMHA)[16]

• NHS Complaints Advocacy[17]

More information about different types of independent advocacy can be found in Appendix 2.

Methodology

Conversations with advocates from across England were held, taking the form of semi-structured focus group discussions on teleconference calls.

Overall, we spoke with 28 advocates, some of whom also managed advocacy services. They were from 18 advocacy providers across England, covering 33 Local Authority areas.

See Acknowledgments for a full list of provider organisations who took part in the focus group calls.

The Covid-19 pandemic had an impact on this work. The period of lockdown started halfway through the conversations and, as advocacy providers were having to quickly make adjustments to working practices, there were fewer advocates who joined the later conversations.

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10 The Advocacy Charter, NDTi 2018
11 https://qualityadvocacy.org.uk/resources/advocacy-charter
12 Care Act (2014)
13 Mental Capacity Act (2005)
14 Mental Capacity Act (2005)
15 Deprivation of Liberty Safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice (2008)
16 Mental Health Act (1983)
17 The Health and Social Care Act (2012)

2. Core messages

These core messages are based on the conversations with advocacy providers[18] that informed this briefing. They are not representative of all providers or areas. However, whilst there were some regional variations, overall, conversations evidenced similar experiences and there are some clear and consistent emerging themes. These themes can helpfully form a basis for local multiagency discussion and development and bring in the voice of local advocacy providers.

Advocacy providers, in partnership with colleagues in health and social care, have developed some effective strategies to address issues, however this was often seen to be reliant on personalities and local knowledge of individuals and teams. Positive examples of steps to support development on the themes is set out in section three and Appendix 2.

These messages are not intended as guidance to prescribe exactly what must be done but are offered as support to develop practice.

Messages relating to the need for advocacy to be better understood

for advocates to be involved in appropriate and timely ways that take account of people's legal rights to advocacy and the statutory duties to refer.

1. There is a need for clearer understanding across organisations of the independent advocacy role in MSP. This includes understanding that this is a statutory role[19] and what the duties in respect of this are.

2. Advocacy needs to be considered right at the start of safeguarding involvement, not as a last resort.

3. The extent to which advocacy is considered and requested where a Section 42 enquiry (Care Act, 2014)[20] is triggered, needs to be understood. Indications are that there may be a low level of referrals for advocacy support in these enquiries in some areas. If experiences of providers involved in conversations to inform this briefing represent a wider trend, then this needs to be investigated and where/if necessary, addressed.

4. Where an individual is believed to lack mental capacity to make their own decisions in relation to the specific issues that require advocacy support, it is necessary to complete a mental capacity assessment prior to referring for advocacy. Indications from this piece of work are that there is insufficient emphasis on this by some local authority and health partners ahead of a referral for advocacy support.

Messages relating to a need for increased clarity, consistency and transparency across agencies

in relation to roles and responsibilities in safeguarding, and definition of what constitutes a safeguarding concern.

5. There needs to be transparency and clarity about what a safeguarding concern is and the basis for decisions made by local authorities when a concern is referred to them. Referrers and the local authority need a common language and understanding of terms that are central to adult safeguarding. This makes constructive challenge possible.

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18   28 advocates, some of whom also managed advocacy services, from 18 advocacy providers across England, covering 33 Local Authority areas
19   See 'statutory context', p4
20   Section 42: Enquiry by local authority. This section has no associated Explanatory Notes (1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Seemingly non-negotiable 'thresholds' are unhelpful. This shared definition and understanding of safeguarding concerns (and of advocacy) will support individuals and professionals in making decisions.

6. Adult social care teams need to give feedback to advocates who make referrals of safeguarding concerns. Referrers need to receive feedback about the decisions made (consistent with data protection legislation) and assurance that, where an issue is not pursued as a safeguarding concern, identified risks to wellbeing and safety are being addressed.

Messages relating to making the most of the significant contribution that advocacy can make

in safeguarding people in health and social care provider settings.

7. Advocates have a regular presence in closed provider environments such as care homes, hospitals, mental health wards and treatment and assessment units. They provide additional safeguards in the prevention and identification of abuse and/or neglect. The potential contribution of advocacy to safeguarding in these environments can be further supported and enabled, including through commissioning of advocacy that has a focus on and supports this important aspect of the role.

8. Through their role in care provider services, advocacy providers can identify patterns and themes of safeguarding issues and concerns. There needs to be robust practice as well as systems in place across agencies to make sure these are raised appropriately with health and social care teams, commissioners, contract managers,

the regulator and SABs. The patterns and themes identified by advocates need to be heard and acted upon.

Messages relating to a partnership approach to governance

that supports the potential role of advocacy in effective safeguarding and in MSP.

9. Safeguarding is an integral part of governance of all organisations. There needs to be reporting and assurance on it from all partners. Advocacy's contribution to this information and assurance requires a focus and a response from organisational leaders and SABs. Advocacy providers can:

    • evaluate and report on the extent to which the provision of advocacy supports effective safeguarding outcomes for individuals

    • report on the extent to which partners fulfil statutory duties in relation to advocacy and safeguarding

    • bring to the attention of SABs, issues that are connected to SABs wider safeguarding responsibilities in relation to prevention and support.

10. Advocacy providers, in partnership with commissioners, can develop consistent and robust outcome recording and reporting practice across the sector. This will support understanding of the impact of advocacy for individuals, for health and social care and the wider community.[21] Then this can form the basis of reporting into multiagency governance structures. The NDTi outcomes framework can support this development.

21 NDTi Advocacy Outcomes Framework www.ndti.org.uk/uploads/files/Advocacy__framework.pdf

11. It is important that providers and commissioners of advocacy are listened to when they collate and contribute what they know about broader safeguarding issues in a local area to local intelligence and governance systems. Robust recording and reporting systems support this.

12. There is a need to consider the role of advocacy in relation to SABs and how this can be used to best effect. Achieving clearer multi agency understanding of the independent advocacy role in MSP is part of this. Relationships of advocacy providers to SABs were reported[22] as varying in effectiveness.

13. The views of people who use services and their carers will maximise effectiveness of independent advocacy and inform improvements in safeguarding. Advocacy providers can help, both through providing direct support to people to engage with the SAB and by bringing the wider experiences of people supported through advocacy. (Co-production is a fundamental principle of independent advocacy).[23]

Messages relating to the part commissioners play in supporting the advocacy contribution to effective safeguarding.

What needs to be addressed?

Issues in relation to the commissioning of advocacy are central to enabling advocacy to deliver effectively, including on MSP. Issues about commissioning have already been outlined in the above core messages.

The following are, however, significant and acting on these will strengthen advocacy's contribution to MSP.

14. Commissioners of advocacy have a key role in making sure that those most in need of advocacy support, receive it. Commissioners influence the level of availability and the focus of that resource. There needs to be development of commissioners in understanding of both advocacy and safeguarding. Support to establish consistent good practice in carrying out the role in the context of safeguarding adults is needed.

15. Commissioners are key partners in the governance of safeguarding adults. Making robust links between commissioners of advocacy and SABs is important. Commissioners receive regular (usually quarterly) reports from advocacy providers. They can collate and contribute to wider local intelligence systems what they know from these reports about broader safeguarding issues in a local area. Some of this information has direct relevance to identifying local safeguarding priorities, including for prevention. It also provides insight into the extent to which cross sector professionals carry out their statutory roles in relation to advocacy and safeguarding adults. Partnerships can play their part in identifying which information from commissioners will support effective safeguarding arrangements.

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22 Reported in conversations with 28 advocates from18 advocacy providers across England, covering 33 Local Authority areas.
23 Advocacy Charter, Empowerment Principle: https://qualityadvocacy.org.uk/resources/advocacy-charter

3. Developing understanding of the core messages and ideas for action

In this section key aspects of conversations with advocates in relation to each core message are shared to support further local and national conversations and to highlight where advocates indicated what might be done about the issues. This is by no means exhaustive.

At the start of discussing each cluster of core messages, and again in setting out what might be done about these issues, extracts are included from conversations with advocates that form the basis of this briefing.[24]

Potential actions discussed are for a range of groups to consider including:

- advocacy providers
- commissioners of advocacy and contract managers
- safeguarding adults boards
- safeguarding leads in local authorities
- principal social workers
- quality and performance management professionals
- those working in health and social care provider settings
- The Care Quality Commission
- Healthwatch.

(Appendix 1 sets out a framework for local conversations and deciding on actions).

Core messages one to four

Messages relating to the need for advocacy to be better understood across sectors; for advocates to be involved in appropriate and timely ways that take account of people's legal rights to advocacy and the statutory duties to refer.

Throughout conversations we heard that there continues to be a need to strengthen and deepen the understanding that health and social care staff have of independent advocacy and the role that it plays within MSP (and more widely). Advocates reported the need for continued awareness raising with health and social care teams to increase visibility and awareness of advocacy. The effective involvement of advocates helps to make safeguarding personal.

"Advocacy is not thought about very much when it comes to safeguarding."

"There is a sense that the local authority thinks advocacy can hinder, that it can get in the way of things that professionals have to get done."

"Advocacy is a statutory right not an optional extra. There is not enough knowledge about it amongst social workers."

"The idea of the Care Act is that the person is part of the entire process and their outcomes are looked at with them at the very beginning and we /they follow that through right to the end. This rarely happens."

"We had only one or two referrals in the last few months for a Section 42 enquiry advocate. We need much more involvement. We are not getting the referrals through that we would expect."

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24 Conversations with 28 advocates, some of whom also managed advocacy services, from 18 advocacy providers across England, covering 33 local authority areas

Issues for further consideration

Advocacy is a statutory right for some people who are the subject of safeguarding concerns. It is an integral part of practice and duties in adult social care. It is sometimes seen as an optional extra or even a hindrance. The extent to which the duty to refer for independent advocacy support ought to come into play in safeguarding situations and the extent to which it is provided is largely unknown. This needs to be the subject of further local and national analysis. The lack of understanding about advocacy is likely to contribute to a picture where not everyone who should, receives advocacy support in safeguarding.

There is a need for enhanced knowledge about the advocacy role and function across sectors including amongst social workers, SAB members, commissioners of advocacy and others. The high turnover of personnel in these roles means that advocacy organisations need to rebuild relationships and raise awareness about the role on an ongoing basis. This requires significant resource.

> Considering the need for advocacy, and then referring appropriately, should be a first thought when safeguarding concerns are raised. Where advocates become involved later in the process, this gets in the way of supporting the person to think about their outcomes, share their views and wishes or to be involved in decision making about protective measures or safeguarding plans that might be put in place.

If a safeguarding enquiry needs to start urgently then it can begin before an advocate is appointed but one must be appointed as soon as possible. All agencies need to know how the services of an advocate can be accessed and what their role will be.[25]

Referrals for advocacy support where a Section 42 (Care Act, 2014)[26] enquiry is triggered, were seen to be low in some areas represented in the conversations that formed part of this work. Advocates reported that, even when they have themselves identified and raised a safeguarding concern, they often had to be proactive in following this up with social workers to ensure referrals for advocacy support within safeguarding enquiries are made. Not all safeguarding concerns trigger a statutory safeguarding enquiry and not all situations where a safeguarding enquiry takes place will reflect a duty to secure advocacy support. However, the two duties in respect of advocacy support and safeguarding enquiries reflect criteria that may well overlap in individual situations. This would be a correlation worth exploring in local data and audit to see whether advocacy support is offered in line with rights and responsibilities where enquiries are triggered.

Advocates also reflected on specific areas of confusion about statutory responsibilities to refer. For example, they described issues in receiving appropriate referrals for advocacy involvement when the local authority delegates safeguarding adults' enquiries to a provider organisation.

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25   7.27 Care and Support Statutory Guidance, DHSC (2020)

26   Section 42: Enquiry by local authorityThis section has no associated Explanatory Notes
(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) (a)has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
(2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

In these circumstances the responsibility to refer for advocacy support will still lie with the local authority,[27] but advocacy organisations aren't always receiving these referrals. This is an area for development and monitoring.

Referrals for advocacy support in relation to safeguarding often lack the necessary information about the person's capacity to make decisions in relation to the presenting issues, including a lack of completed mental capacity assessments, which are required for IMCA referrals.

What helps in addressing the issues

"As a starting point we offer training for social workers so they understand what advocacy is."

"Perhaps the local authority could be encouraged to have the person opt out of advocacy support in a situation, therefore increasing advocacy referrals…The idea would be that when a person meets the criteria for advocacy support, the local authority has to refer unless that person opts out."

"We have worked hard with our networking. Referrals have increased by 40 per cent in the last two years due to regular face to face meetings with the safeguarding team. A key part is an 'engagement protocol' which we wrote and asked the safeguarding teams to sign up to as an agreement."

Developing strong working relationships between advocacy providers and social workers, social care practitioners, commissioners, safeguarding leads and SABs was seen to be fundamental in ensuring understanding of the statutory duties to refer people for advocacy support. Advocates were clear that when they were able to build mutually supportive working relationships, they were more likely to:

• get appropriate and timely referrals

• be kept up to date and included in communications

• support safeguarding processes effectively

• ensure people have full opportunities for engagement in processes

• ensure people's views and wishes were considered in decision making.

Some advocates reported a positive impact on timely referrals and on the number of referrals for advocacy support in safeguarding, where they are actively engaged in the SAB and its subgroups and have positive relationships with the safeguarding manager and / or the SAB Chair.

Awareness about advocacy at first point of contact for example in contact centres or a Multiagency Safeguarding Hub (MASH) helps.[28] This means that the individual is informed of potential rights to advocacy from the start. A potential need for advocacy can be indicated too on someone's 'case' notes as a prompt for professionals.

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27 See Care and Support Statutory Guidance, DHSC (2020) including paragraph 14.10
    The Care Act requires that each local authority must:
    • make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect (see para. 14.16 onwards). An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by who.
    • arrange where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them (see chapter 7 on advocacy)
28   As reflected, Care and Support Statutory Guidance, DHSC, 2020, paragraph 3,31; 6.22; 6.33.

Other actions that helped:

- advocates attending MASH meetings in a consultative capacity

- local interagency safeguarding governance groups established to bring together key stakeholders to reflect on and address issues, themes and trends

- regular awareness raising with health and social care teams

- including information about advocacy in social worker training/qualifications as well as in induction

- student social workers on placement with advocacy providers

- periodic cross attendance at team meetings to raise awareness of common issues and to address these together. For example, a safeguarding lead joining an advocacy team meeting, advocacy providers joining social care team meetings

- advocacy providers supporting social workers to make appropriate referrals by providing guidance and training and responding to feedback about ease of referring.

- supervision for social workers looking at appropriate use of advocacy

- systems and processes prompting social workers to remember to refer for advocacy support

- considering 'opt out' approaches to referring people for advocacy support where eligibility criteria are met

- working with SABs to review the data they collected, looking at the number of referrals to advocacy and further action as well as the percentage of Section 42 (Care Act, 2014) safeguarding enquiries that were supported by advocacy involvement and analysing where advocates should be involved.

It is significant in this context that some advocates advised that contracts do not always allow adequate time for training and reflective practice, or awareness raising, including in relation to safeguarding.

Core messages five and six

Messages relating to a need for increased clarity, consistency and transparency across agencies in relation to roles and responsibilities in safeguarding, and definition of what constitutes a safeguarding concern.

"There is inconsistency across different local authority areas in responses to safeguarding concerns that we raise. We would like to see more consistency."

"There is a need for clear guidance on when an issue is a safeguarding concern and what you do if it isn't, but nevertheless someone is at risk."

"There is a gap where we might think there is a safeguarding concern and we report it and then the local authority 'threshold' gets in the way."

"Safeguarding Adult Reviews often talk about 'passing the buck'. That's a real issue. Not being afraid to go further up the line is important (escalation). If necessary, I will go to the service commissioner. Sometimes when we escalate, we are in a 'rinse and repeat cycle'."

"We don't hear back on outcomes and whether an issue is investigated or not. We don't always get to hear about risks going forward."

"The way we look at this is that we don't need to know the personal detail but just…has it been taken on and are there protective measures in place?"

Issues for further consideration

There is a lack of clarity and consistency across sectors about what constitutes a safeguarding concern. Variation in practice in provider settings was specifically described in respect of when providers dealt with issues inhouse and when they referred these to the local authority (or were happy for advocates to do so). For example, in relation to mental health settings, where some were described as being 'reluctant' for advocates to refer concerns to the local authority, others were proactive in referring issues out and informing advocates of progress. Advocates also described experience with other care settings where safeguarding concerns were not always reported as they should be to the local authority. It was felt that this was in part due to a lack of clarity and understanding about what is and is not a safeguarding concern and what should be referred to the local authority.

Advocacy providers noted differing approaches and 'thresholds' for deciding what is or is not a concern. These are not always clear. Sometimes individual circumstances require conversations rather than set 'thresholds'.

Advocates were concerned about situations where an element of 'passing the buck' between professionals was evident and the issue went round in circles with no resolution to the level of risk. In this context they underlined their commitment and duty to ensure issues are responded to appropriately.[29] [30] However, the lack of clarity about what is a safeguarding concern and what are the alternative pathways for resolving issues, makes challenge more difficult.

Advocates referred to the need for this individual responsibility to sit alongside robust governance across partner organisations and led by SABs to gain assurance on the effectiveness of responses to safeguarding concerns raised and whether risks are adequately addressed.

Some advocates described a lack of feedback or updates in relation to the progress of a safeguarding issue and that they often needed to chase social workers to find out the current status of the situation. Advocates reflected that this may be because their role is often overlooked; professionals don't remember to include them on an ongoing basis. There might also be concerns about information sharing.

What helps in addressing the issues

"In our local authority area, we all worked together to ensure shared language, for example with police and social workers. A robust document was created. We have a really good framework to help with this."

"We prefer a conversation before we raise a safeguarding concern. We found before that, nothing we raised seemed to reach the bar, so a conversation helps."

"In 'murkier' and less clear-cut situations that don't sit neatly anywhere…what helps is being able to call the safeguarding team and talk through the situation anonymously."

"There is a need for clear guidance on when an issue is a safeguarding concern and what to do if it isn't, but nevertheless someone is at risk. Guidelines need to include supporting less clear-cut situations that don't sit neatly anywhere."

29 Advocacy Code of Practice, https://qualityadvocacy.org.uk/wp-content/uploads/2018/05/Code-of-Practice-1.pdf

30 Advocacy Quality Performance Mark, https://qualityadvocacy.org.uk/wp-content/uploads/2019/06/Assessment-Workbook_V4_V1.1_2018-19-For-Reference-Only-1.pdf

What helps includes:

- conversations and relationships with colleagues across organisations. For example, checking out concerns (anonymously) with colleagues in the safeguarding team or MASH

- regular meetings between advocacy providers and the safeguarding team, so issues and progress can be explored. This was seen to be helpful even when things were working well

  "Even when everything is going well, we check in proactively and recap where things are at. It's a chance for shared reflection and learning for all."

- clear local guidelines that are consistent with national policy and legal responsibilities underpinning a consistent local multi-agency approach to defining safeguarding concerns and responsibilities. A shared language and understanding of policy and procedure.

- Robust oversight and governance.

- Supporting advocates by:

  ◦ ensuring safeguarding training is incorporated into advocates induction programmes

  ◦ ensuring safeguarding refresher training is mandatory for all advocacy staff on a regular basis

  ◦ supervision, appraisals, mentoring and coaching for advocates including in relation to safeguarding and MSP. A standing safeguarding agenda item in supervision sessions

  ◦ creating opportunities for advocates to shadow each other

  ◦ ensuring time and space for reflective practice including learning from case law and incidents such as the events at Whorlton Hall hospital[31]

  ◦ internal newsletter that highlights what is happening in the safeguarding arena. Updates on developments and progress.

Core messages seven and eight

Messages relating to making the most of the significant contribution that advocacy can make in safeguarding people in health and social care provider settings.

"There is a preference to deal with issues in-house, minimise and block referral to safeguarding teams. This is a real challenge and an area needing exploring."

"We have IMHA presence on mental health wards. If we see abuse on wards we would raise with the local authority."

"The one setting we do find challenging is mental health wards where you have told a ward manager who says, 'We are on it, you don't need to do anything else.'"

Issues for further consideration

Advocacy can provide an additional safeguard to people. For example, Independent Mental Health Advocates (IMHAs) in mental health settings, Independent Mental Capacity Advocates (IMCAs), Care Act Advocates and Paid Relevant Person's Representatives (RPRs) in care homes and supported living environments. Whilst not their core function, the presence they are able to maintain enables advocates to see issues and concerns that occur both for individuals and more systemically on a daily basis.

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31 Whorlton Hall, an independent hospital in County Durham where patients with severe learning difficulties and autism were reported in 2019 to have suffered abuse. An independent review was published in January 2020 www.cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall

Advocacy providers are therefore able to provide important information about quality and practice concerns in provider services. There needs to be greater consistency and clarity about how this information should be recorded, shared with and used by local authorities, health partners, Care Quality Commission (CQC) and others.

There was a range of practice reflected in conversations with advocacy providers in respect of the approach to recording, monitoring and reporting practice and safeguarding concerns as well as keeping track of themes and trends. Development of greater consistency and sharing best practice across the advocacy sector would be welcomed.

Particular concerns were raised about potential gaps in access to advocacy in provider settings, where people are placed out of area and where the potential for isolation and need for safeguarding may be greatest. Clarity about who commissions an advocate in these situations is crucial. Advocacy must be commissioned with an understanding of the local circumstances in which the individual is currently resident.[32]

What helps in addressing the issues includes:

"If we raise things on a ward round with all professionals then wheels start turning. When we talk to an individual nurse sometimes it is not referred on."

"We do weekly drop-ins."

"We deliver the relevant person's representative (RPR) role under DoLS so we have advocates who go into care homes. As we do that, all the time we see things in people's notes that should have been raised as a safeguarding issue. We raise that with the care provider manager and then the advocate goes back and checks they have raised it as necessary with the local authority."

"We are developing something where an advocate visits a care home once a fortnight to be a presence, but this is not commissioned by the local authority, the care home purchases it as an opt in."

Multi-skilled advocates (eg. IMHA, IMCA and Care Act qualified) can work with people across issues and settings and are able to build up: a good understanding of the person, the way they communicate and what is important to them, local knowledge of particular settings, as well as developing effective working relationships with professionals within these[33]. Where commissioning facilitates this, this is positive.

Some advocacy providers felt that 'whole home' approaches to advocacy support are beneficial where one or two advocates provide advocacy support to all those who require it within a particular setting. Others highlighted the need for advocates not to become 'overly familiar' and the need for fresh eyes. Some organisations described rotation of advocates between settings on a bi-annual basis to make the most of the benefits whilst mitigating the risks.

Issues and patterns of concerns need to be identified, shared, and acted upon within robust systems. This is everyone's responsibility. Advocacy providers can develop consistent and robust practice, recording and reporting across the sector to make sure those issues identified are followed up appropriately. SABs will want to make sure that they hear about local issues in these environments through engaging with advocacy providers as well as commissioners of advocacy.

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32   See Care and Support Statutory Guidance, 2020, paragraph 7.29
33   See 7.65 and 7.66 Care and Support Statutory Guidance, DHSC, 2020

To assist in this, 'practice concern forms' have been developed with safeguarding teams in some areas. These are completed by advocates and shared with safeguarding teams to help build a picture of quality issues, which may, when viewed as a broad pattern, amount to a safeguarding concern, but which individually may be addressed through an alternative pathway. Reporting on provider service themes and trends in quarterly monitoring reports to commissioners as well as finding ways of feeding these reports in to safeguarding teams, quality teams and SABs is important.

Facilitated national forums to support advocacy providers to share and develop best practice were seen to be helpful, although not currently routinely available. Some advocacy qualification training providers offer regular webinars to reflect on best practice and changes to policy. NDTi has been able to bring advocacy providers together in relation to specific projects.

Funding for non-statutory community advocacy (see Appendix 2) is seen as beneficial especially in terms of prevention and early intervention, where this is commissioned. There needs to be more learning about the impact of having and not having this resource available within local communities (including within provider services). Advocacy providers need to have time allocated within contracts to do this work.

Local multi-agency governance arrangements that support the sharing of themes and trends of concerns in provider services and facilitate taking robust action where this is needed. These arrangements need to be inclusive of advocacy partners, CQC and/or Healthwatch who have intelligence to share.

Core messages nine to thirteen

Messages relating to a partnership approach to governance that supports the potential role of advocacy in effective safeguarding and in making safeguarding personal.

"This is a huge issue. We believe having the right governance drives the right behaviours."

"Not being afraid to go further up the line is important (escalation). If necessary, I will go to the service commissioner."

"On the safeguarding adults board, a lot is about people reporting what they have done; very little is about 'let's look at this situation… what could we have done?'"

"There are clearly so many concerns where someone needs help and the support services are not always there. For example, people talking about suicide and sometimes no one is there. It is a regular thing that we are told something is not safeguarding but then there isn't another service offered instead."

"There are outcomes commissioners need, on the other hand, there are meaningful outcomes to the person – different interpretations of what's important"

"Quantitative data is recorded on outcomes, but it is down to audits and digging deeper to find out further impacts"

"It's not clear what it [the information] is used for. It seems to be a tick box exercise – quantitative not qualitative. But even in terms of quantitative information, where does it go? Because advocacy is a statutory duty and there are often low numbers of referrals."

Issues for further consideration

Conversations indicated that a focus on action at all levels of governance will be helpful, from internal advocacy provider recording, to how this connects with commissioners, contract managers and SABs. A focus on impact for the individual is needed, but also on broader health and social care issues that advocacy providers pick up on in the wider community. Information and data collected and passed on needs to be used for constructive development.

There was variation in practice and methodology amongst advocacy providers in respect of recording and reporting of individual advocacy outcomes. Whilst some providers have robust and sophisticated reporting and governance systems, there is a lack of consistency in the way information about issues, trends, numbers of referrals, and outcomes is collected and shared. Many feed this information into monitoring reports (usually quarterly, but not always) for commissioners.

There is little consistency in the information requested by commissioners and contract managers according to conversations with advocates. There is an emphasis on outputs over outcomes and impact. This may reflect difficulties in understanding the nature and value of the advocacy role. The NDTi outcomes framework[34] is not widely used. This has the potential to support greater consistency and good practice in collecting and using information across all providers.

There is variation too in respect of how advocacy providers collate information about broader safeguarding issues in the local area, either in relation to health and social care provider services or safeguarding issues in the community. This is important information that needs to be collated and contributed to wider local intelligence and governance systems.

Commissioning and contract monitoring of advocacy providers sometimes requires reporting of these wider issues and themes but not consistently so. Neither is it clear how the information submitted to commissioners or contract managers connects into wider governance systems, for example into SABs.

There was clear motivation amongst advocates involved in shaping this briefing to enhance practice, recording, and reporting in respect of these wider issues. For example, advocates drew attention to an increase in requests for advocacy support from individuals in crisis. (For example, an increase in contact from people experiencing mental health crises). A reduction for some advocacy providers in funding of non-statutory, community advocacy (see Appendix 2) means that those seeking this help are often ineligible for advocacy support. Where this coincides with reduced availability in some aspects of community health and care support services, individuals can be left at risk. Advocates want and need consistent systems within which to share these broader concerns about local issues that may cause safeguarding issues. This kind of intelligence from advocacy providers is vital in ensuring discharging of wider multi agency safeguarding responsibilities across partner organisations. It needs to inform commissioning of advocacy too, so that where necessary greater investment in non-statutory, community advocacy may be considered.

Advocacy providers experiences of engagement with SABs varied, in terms of how they were involved and included, as well as how SABs functioned overall. Many advocates reported that SABs worked best when there was opportunity for shared learning and reflection as well as local action planning.

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34   NDTi Advocacy Outcomes Framework www.ndti.org.uk/uploads/files/Advocacy__framework.pdf

It was suggested that a focus is needed not just on hearing information from the range of partners but on putting this together to form a view of what needs to be done and being accountable as a partnership for positive development on prominent concerns and issues.

What helps in addressing the issues:

"Discussing blocks and barriers at a governance level helps. It abstracts issues from becoming personalised. It becomes a shared responsibility; part of what we all need to do."

"It needs the SAB chair to reach out and be interested in different points of view."

"We keep a log of all concerns raised, including niggles, concerns, gut feelings. These are all written down and considered. We have a safeguarding lead on our board of trustees who has a total overview."

"We keep track of low-level issues in team meetings. We keep a log from that and spot patterns."

"We highlight soft intelligence that might precipitate a quality check on a provider. We might tell a commissioner who then links with the quality team."

"We look at trends and report back in quarterly contract monitoring meetings. We have a good relationship with the quality management team."

What kind of information helps?
- Data and information that demonstrates both impact on individuals and local need.

- Qualitative information and case studies; telling people's stories to demonstrate real impact and outcomes for people. Encouraging, empowering and supporting people to tell their own stories.

- Moving away from ticking the box to say a person was referred for advocacy and so their voice was heard to 'what difference did the advocacy support make?' The NDTi outcomes framework[35] is being used by some.

- Local, multiagency audits and digging deeper on specific issues that come to light.

- Robust and consistent systems for recording and collating information and clear routes for sharing this so that it makes a difference.

Learning from the information across agencies
Opportunities for shared learning help, within and beyond the SAB. One area described a local multi agency learning and development opportunity which brought together organisations to reflect on an issue via case studies, for example a person who is hoarding. Each organisation reflected on their role with the person within the safeguarding issue. This helped all agencies to understand roles and responsibilities and how to work jointly to address the safeguarding issue.

Establishing relationships with local teams so there can be mutual awareness raising and challenge.

Establishing connections to make information feed development
The importance of the role of the SAB Chair was mentioned by advocates and the extent to which the Chair is interested in hearing from all members of the SAB.

Advocacy contracts that acknowledge and include the importance of attending the SAB; supporting advocates to be members of SABs and subgroups.

SABs responding to information from advocates and advocacy commissioners. This might include analysis of:

- the numbers of section 42 enquiries undertaken in their area and of those the number where advocates had been involved in supporting the person

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35   NDTi Advocacy Outcomes Framework www.ndti.org.uk/uploads/files/Advocacy__framework.pdf

- the extent to which SAB partners fulfil their statutory role both in respect of advocacy and safeguarding

- how advocacy made a difference to processes, involvement of the person and outcomes of the enquiry

- issues, themes and trends identified by advocacy providers (and others) that impact on safeguarding responsibilities in the broadest sense.

Core messages fourteen and fifteen

Messages relating to the part commissioners play in supporting the advocacy contribution to be effective. What needs to be addressed?

"We have been proactive in how to improve and be effective, but commissioners are not asking for this information. This is the wrong way around. So, advocacy providers (not commissioners) are sometimes driving this. Commissioners tend to listen to us as experts in terms of what needs to be reported on."

"We provide qualitative data because it adds more value, but it's not necessarily requested. We struggle to collect quantitative outcomes. A lack of commissioner means this is not noticed, it's not clear what the information is being used for. It seems to be a tick box exercise."

"Commissioners change three times a year sometimes, so there is no consistency to build up a relationship."

"We have a good relationship with commissioners and can have a conversation to justify the time needed."

"We are scrutinised and have to provide a quarterly report with extensive requirements, including quantitative data for all areas of

advocacy as well as comments and views from staff and people supported. This has been beneficial for getting the funding we need."

Issues for consideration

Commissioning practice is central to enabling advocacy to deliver effectively, including on MSP. Aspects of each of the core messages in this briefing are significant for commissioners. There is no need to repeat all of this here, but some points merit emphasis as follows.

Advocates underlined the need for commissioners of advocacy to have a good understanding of the aims and value of advocacy and the statutory duties attached to it. If understanding is limited this can substantially limit the service in its ability to be effective.

Robust commissioning and the relationships commissioners have including with providers and with SABs needs to be a central focus in developing advocacy's part in MSP.

There needs to be greater consistency in the information commissioners request and in the way in which it is used to inform the nature and amount of advocacy funded and wider developments locally, including in identifying local safeguarding priorities. Not all commissioners request quarterly reports. Some ask for six monthly or even annual reports.

This means there may be missed opportunities for dialogue and responding to themes and issues in a timely way.

A clear finding throughout this work and in the briefing is that some advocates spend considerable time addressing some of this briefing's core messages. They must sometimes do this outside of the parameters for which funding is awarded by commissioners. For example, in constantly raising awareness about

advocacy and the statutory rights and duties attached to it; in attending and or making links with SABs to establish effective working relationships and to advocate for effecting systemic change where they identify the need for that in their work. In the course of working one to one with individuals, they regularly attend to broader issues both in provider services and in the community. They do what they can to bring these to the attention of a range of organisations.

In order to maximise the role they can play in safeguarding adults and specifically in MSP, commissioners need to recognise and consider all of this in making decisions about funding arrangements. There is a need too for commissioners to have consistent and effective mechanisms for collecting and sharing information from advocacy providers. This needs to be developed alongside advocacy providers and through engaging with people who may need advocacy support.

As mentioned above, commissioners need to ensure that advocacy provisions extends to those who are out of area.

What helps in addressing the issues

"Good relationships with commissioners so that we can have a conversation to justify the time needed."

"It is worth nurturing the relationship with the commissioner and using data and qualitative information. It's been key to capture evidence so that we can secure more funding for more staff."

"Flexibility. We have professional (non-statutory) advocacy which helps where situations don't neatly fit into statutory advocacy."

"Having the same advocate all the way through (IMHA/IMCA/Care Act). As a commissioning model this is really important. Threading the person's story through. People don't want a long string of people all asking the same thing."

"It would be helpful if the SAB asked us to tell them about patterns of concerns."

"Development of commissioners in understanding advocacy and the rights and responsibilities relating to it."

What helps, includes:

Quarterly reporting between advocacy provider and commissioners, consistent across all local authority areas. Further development and roll out of the NDTi outcomes framework[36] with involvement from both providers and commissioners of advocacy alongside people who may need advocacy support would support this.

Systems that support commissioners and providers to take joint responsibility for bringing key information from the quarterly reports to the attention of those who can do something to address issues and themes (for example, relating to: provider services; community resourcing, responses and associated risks; the carrying out of statutory duties in respect of advocacy and safeguarding on the part of professionals across agencies).

Commissioners engaging with and sharing the 'bigger picture' issues that emerge from advocacy reporting to them. This includes commissioners attending the SAB at least annually to share relevant information from advocacy providers.

When there is a joined-up approach to commissioning and delivering advocacy, this helps to develop effective service delivery. For example, many advocates referred to greater effectiveness

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36 NDTi Advocacy Outcomes Framework www.ndti.org.uk/uploads/files/Advocacy__framework.pdf

where one advocate can act as RPR, Care Act advocate and IMCA for the same person. This can facilitate representing the individual's views more robustly in relation to safeguarding.

The key messages for commissioners of advocacy in a Social Care Institute for Excellence publication (SCIE 2015)[37] include the above. It is well worth revisiting these. Messages from the advocacy providers who participated in conversations to inform this briefing, indicate that there is still some way to go in achieving these.

Taking action on these core messages

Advocacy providers in all regions welcomed the opportunity to take part in this piece of work. There was lively and constructive discussion and positive ideas for development were generated and shared.[38] These are reflected in all of the above core messages.

The intention is to stimulate similar, local and or regional conversations to identify issues, actions and possible improvements. Local action will benefit from support at regional and national level.

Appendix 1 sets out a template for drawing up local and regional action plans and for developing practice.

These discussions and actions are for a range of groups to take forward including:

- advocacy providers
- commissioners of advocacy and contract managers
- safeguarding adults boards
- safeguarding leads in local authorities
- principal social workers
- quality and performance management professionals
- those working in health and social care provider settings
- Care Quality Commission
- Healthwatch
- NDTi
- advocacy training providers.

This is everyone's business.

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37 www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/key-messages.asp
38 The key messages from these conversations are shared in sections 2 and 3.

Appendix 1–taking action

What can be done and by whom?

In this section an example template is set out for local areas or regions to use to identify and address local issues within and across sectors. Potential actions discussed are for the whole range of groups to consider.

Frequently raised issues set out below represent a sample from the conversations we had as part of this work (much more detail is included in section three of this briefing). These issues are set out under the headings used in this briefing of clusters of core messages (see sections two and three).

The tables show just a few examples for action. It may be that some localities will decide that the same issues are live for them and they want to plan and take action on these. Some may generate alternative local priorities and begin to develop associated actions. We would support the sharing of wider learning and action to develop practice in advocacy and safeguarding through use of the LGA and NDTi websites.

Example action plan illustrating possible actions from conversations across advocacy providers.

> **Action relating to the need for advocacy to be better understood; for advocates to be involved in appropriate and timely ways that take account of people's legal rights to advocacy and the statutory duties to refer.**

An issue for exploration and action.
Conversations indicate that there are potentially fewer referrals than might be expected for advocacy support when a Section 42 enquiry (Care Act, 2014) is triggered by the local authority.

What needs to be done?
Need to understand the reality of how many people are referred for advocacy support when these statutory enquiries are triggered.

Analysis needed of the number of Section 42 enquiries in the locality.

Of these, how many referrals were there for advocacy support? Through for example, audit can it be ascertained how many people involved in Section 42 enquiries might have had a right to advocacy support? Therefore, is this an issue locally?

If it is, set out a plan to address this.

Who has a role in this locally?
SABs: local authority and health commissioners of advocacy, social workers and safeguarding adults leads in the local authority, local advocacy providers.

Could wider (national / regional) action support development?
Discussion amongst the national SAB Chairs group can ascertain if there is an issue that needs to be addressed across regions or nationally.

Consider information included in the Safeguarding Adults Collection[39] (SAC) (collected directly from councils). Look at voluntary submissions alongside statutory submissions from councils. How far does this reflect this issue? Could it do so to a greater extent?

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39 A data collection relating to safeguarding adults from NHS Digital and published annually. For example,
    https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2018-19-england

Action relating to the need for advocacy to be better understood; for advocates to be involved in appropriate and timely ways that take account of people's legal rights to advocacy and the statutory duties to refer.

A further issue for exploration and action

There needs to be a focus for the range of SAB partners on developing better understanding of the significance of advocacy in MSP and the duties attached to this. Advocacy is a statutory right not an optional extra. Advocacy providers suggest that there is not enough knowledge about it amongst a range of professional groups including commissioners, social workers and SAB members. There is feedback to suggest that advocacy is not considered sufficiently when it comes to safeguarding adults.

What needs to be done?

Through use of evidence from advocacy providers' recording and reporting, target specific groups of professionals locally who most need support in this.

In relation to the identified groups roll out a programme of awareness raising as set out in section three of this briefing including through, staff supervision and training. Consider developing systems and processes that might prompt social workers and others to remember to refer individuals for advocacy support where there is a duty to do so.

Make sure commissioners are included in development and awareness raising about advocacy.

Monitor the impact of this to inform further development activity.

Who has a role in this?

All groups including advocacy providers and commissioners, social workers, SABs, health and social care providers.

Could wider (national / regional) action support development?

There will be interest at national level in monitoring development of understanding of and take up of advocacy support, especially in view of recent Safeguarding Adult Reviews (SARs) where advocacy support has not always been forthcoming.[40]. The findings will act as a catalyst for a national focus, especially if a current review of SARs notes this issue.

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40   Winterbourne View, A Serious Case Review, Flynn, M. 2012 https://hosted.southglos.gov.uk/wv/report.pdf

Action relating to a need for increased clarity, consistency and transparency across agencies in relation to roles and responsibilities in safeguarding, and definition of what constitutes a safeguarding concern.

An issue for exploration and action.

There is a lack of clarity and consistency about what constitutes a safeguarding adults concern within the health and social care sector (including within advocacy providers). This is reflected across sectors and in local multiagency and local authority protocols. It is reflected in what is and is not taken forward as a safeguarding concern when advocacy providers refer issues to the local authority.

What needs to be done?

Share the forthcoming LGA/ADASS framework[41] on making decisions about what constitutes a safeguarding concern. Take local steps to ensure it is embedded in practice. Actively monitor and review how it works in practice with feedback including from the advocacy sector.

Audit practice across agencies in this respect.

Act on the messages from monitoring and review of practice.

Who has a role in this?

SABs and local authorities will take a lead, with engagement required across all sectors in disseminating and rolling out in practice the two frameworks on making decisions about safeguarding concerns and safeguarding enquiries.

Could wider (national / regional) action support development?

National data collection and local information will show the extent to which the frameworks are reflected in practice and should form the basis for local monitoring on this issue.

Action relating to making the most of the significant contribution that advocacy can make in safeguarding people in health and social care provider settings.

An issue for exploration and action

Advocates are in a strong position to pick up on patterns and trends of concerns in provider settings in health and social care. How can we make the most of this in safeguarding adults? The extent to which there is robust recording and reporting of this both internally and outward to partner agencies is variable.

What needs to be done?

Make sure that trends and patterns are identified through robust and consistent recording within advocacy providers.

Define local reporting mechanisms to make sure the recorded intelligence reaches the right partner agencies so as to ensure appropriate action is taken to safeguard people.

Who has a role in this?

Advocacy providers in following best practice examples

NDTi sharing best practice frameworks for achieving this

SABs

Commissioners of advocacy through presentation of themes emerging from advocacy providers' quarterly reporting.

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41 This will be available here www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal. Anticipated publication summer 2020.

Action relating to a partnership approach to governance that supports the potential role of advocacy in effective safeguarding and in MSP.

An issue for exploration and action

There is a need to develop more consistent recording and reporting to support understanding the impact of advocacy for individuals, for health and social care and the wider community.

What needs to be done?

NDTi has already developed an outcomes framework for advocacy. It is not widely or consistently used at present. This can be further developed, for example by a consortium of advocacy providers and commissioners with people who may access advocacy support, to inform commissioning and providing of advocacy as well as making the links to safeguarding adults.

Who has a role in this?

Advocacy providers, commissioners and people who use services and their carers, SABs can be involved, contributing local perspectives into the framework.

Could wider (national / regional) action support development?

NDTi will have a key role in updating and promoting use of the framework. Resources need to be identified to support this.

Providers, commissioners and SABs will want to make the most of its use in informing advocacy provision and development as well as the links across adult safeguarding.

Appendix 2–about independent advocacy

Advocates help people to:

- understand, protect and promote their rights

- access information and advice to understand systems and processes for example in health and social care

- access services or support

- express their views about what is important to them or any concerns they may have

- be involved in and at the centre of decisions about them and their lives

- explore choices and options to make decisions

- tell people what they want.

Advocates work in partnership with people who access the service. They aim to be 'instructed' or directed by the person at all times and to enable the person to 'self-advocate' as far as possible; it's an empowering relationship.

The advocate will always represent the person and their interests. Advocates don't do things or talk to people without their partner's consent and they don't withhold information that others have shared. They support people to get the information they need and to consider their options. They support people to be listened to, respected and understood. Advocates seek to support people to have as much choice and control in their lives as possible.

Non-instructed advocacy

Some people may lack the mental capacity to make some decisions or to instruct their advocate in either some or all of the work that the advocate is undertaking with them. This is particularly the case in some forms of statutory advocacy, such as Independent Mental Capacity Advocacy (IMCA). Advocates still work hard to understand what is important to the person, ensure they are able to be a part of and influence decisions being made and that their rights are upheld. In such situations, this is known as 'non-instructed advocacy',

i.e. where a person is unable to instruct their advocate. The non-instructed advocate will still seek to uphold the person's rights; ensure fair and equal treatment and access to services; and make sure that certain decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.

Statutory advocacy

Advocates providing statutory advocacy have clearly defined roles and functions. They support specific people in pre-defined circumstances with particular decisions or activities. People accessing statutory advocacy have a legal right to do so.

Across England, local authorities have the responsibility for ensuring provision of a range of independent advocacy for adults and are required to commission:

- Advocacy under the Care Act 2014 – supporting people who may have substantial difficulty to be involved in their Care and Support Assessments, Care and Support Planning, Care and Support Reviews as well as supporting people who are subject to Section 42 safeguarding enquiries, where there is no other appropriate individual available to provide support and representation.

- Independent Mental Capacity Advocacy (IMCA) – supporting people who don't have appropriate friends and family to consult and who lack the mental capacity to make decisions about where they live, serious medical treatment, deprivations of liberty (DoLS) and safeguarding.

- Paid Relevant Person's Representative – supporting people subject to DoLS authorisations, to understand restrictions and their rights and supporting them in all matters relating to the deprivation of liberty safeguards (DoLS).

- Independent Mental Health Advocacy – supporting people who are subject to the

Mental Health Act 1983, to understand and promote their rights under the Mental Health Act and more generally, understand their care and treatment and express their views.

• NHS Complaints Advocacy – supporting people to make complaints about NHS services.

Non-statutory advocacy
Advocacy providers may also deliver 'non-statutory' advocacy in a variety of forms this could be called community advocacy, general advocacy, professional advocacy, issue-based advocacy, peer advocacy, volunteer advocacy, citizen advocacy as well as support to self-advocates.

Anecdotally, we understand that non-statutory, issue-based or community advocacy is being commissioned to a much lesser extent over recent years. This view was supported by the advocacy providers we spoke with during the development of this briefing.

The lack of non-statutory advocacy may have an impact on the role advocates can play in the prevention of abuse and or neglect.

Acknowledgements

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please contact us on 020 7664 3000.
We consider requests on an individual basis.

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