

Care Act 2014

Consultation on Draft Regulations and Guidance – the provision of Advocacy

Introduction

The requirement to place Advocacy on a formal footing is generally seen as extremely positive and is welcomed across the sector.

The recognition that additional resources will be required to provide the necessary levels and to ensure timely and equitable access is critical.

The primary link between independent Advocacy and an individual's capacity is broadly welcomed as this should ensure that the most vulnerable and those least able to navigate the system are most supported. In this the links with the Mental Capacity Act are a helpful framework.

Inevitably descriptions or definitions of functions are extremely difficult. As a starting point the term Advocacy has at least quasi legal, formal and informal meanings. Anything that can be done to clarify this would be helpful.

Similarly, the description of determining the circumstances in which a person would need to have an independent advocate appointed to support their involvement is confusingly written due to the number of caveats and circumstances on which this depends. Any clarity or more simplified language would be welcome (paragraphs 6.27 – 6.30)

There is perhaps some tension in the current drafting between prescriptive step by step descriptions of process rather than more specific clarity of the circumstances where Advocacy should be applied. Emphasis on conditions rather than process would be welcomed.

While practice guidance will assist in the implementation of the Act, the regulations should be as clear as possible, recognising that this will refer to adults and children and to Carers who themselves may have a range of conditions and circumstances.

Specific Issues

The following points have been summarised from discussions and submissions.

- The Mental Capacity Act (MCA) is not yet universally understood or even fully implemented in a number of settings including statutory, third sector, private sector at both commissioner and provider level. Therefore, to build the Advocacy provisions on the foundations of the MCA may be a little unsure, and will take time.
- A particular key challenge will be access to appropriate Advocacy at the very earliest point of an individual's contact with care services. The provision of Advocacy is inevitably part of a continuum that includes information, signposting, advice and so on, much of which may be provided by a range of

agencies and should not be seen as entirely separate from the Advocacy determined by the Act. In a similar way the complexity of advice, advocacy and representation requires some further clarity.

It is also important to recognise that Advocacy may be important at various stages of a person's care pathway.

- It needs to be recognised that current provisions for Advocacy or requirements in commissioning and contractual arrangements may need some considerable work at local level. There are concerns about the required timescales and the capacity of the market to fulfil these duties and the additional resource demands that much of this will require should not be underestimated.
- As a key principle and best practice there is a strong view that Advocacy should be provided to people who meet the requirements for Advocacy and where they may be receiving care jointly from adult social care and the NHS (including Continuing Health Care).

Put simply, it is not the complexity of the care arrangements that may require Advocacy but the individual's capacity/understanding. In such circumstances the availability and flexibility of pooled or joint budgets is vital to achieve equitable cost and burden sharing.

The potential benefits of this are:

- Dealing with the person holistically, provides a seamless service
- Effective partnership working for health and social care addressing needs together. This should lead to better communication and continued care to achieve joint outcomes
- Avoids duplication
- Effective joint commissioning arrangements
- Reduces communication break-down
- Better for the person, family and Carers to have to deal with a single independent advocate

These benefits, or similar, might usefully be referred to in the Regulations/Guidance.

- Independent Advocacy for Carers is welcomed. We refer particularly to:
 - Section 10(7) (a) (carrying out carer's assessment)
 - Section 25(4) (a) and (b) (preparing support plan)
 - Section 27(3) (b) (i) and (ii) (revising support plan)
 - Section 61(3) (a) (carrying out child's carer's assessment)
 - Section 64(3) (a) and (b) (carrying out young carer's assessment)

The read across in Regulation(s) to Carers may need some fine tuning.

As a part of this consultation the following points have also been made.

- The following appears to be inconsistent:
 - Section 7.24 states that an independent advocate “cannot be someone who is already providing the person with care or treatment in a professional capacity or on a paid basis.... This means it cannot be, for example, a GP, or a nurse, a key worker or care and support worker...”
 - Section 17.68 states that “Local authorities should agree with leaders of custodial services how the Advocacy scheme will work in their establishments, including the possibility of training some prison staff to act as advocates.”
- Current provisions for Advocacy across the country vary and while understanding the need to achieve consistency there is some concern that a prescriptive requirement to arrange Advocacy in all the situations listed may reduce local flexibility.
- There is particular concern about the existing role and responsibilities of Independent Mental Capacity Advocates (IMCA) as provided for in the MCA and the Independent Mental Health Advocates (IMHA) under the Mental Health Act and how this will dovetail with Advocacy in the context of the Care Act.
- Coupled with this there are some concerns that while the principle of independent Advocacy is very important it may inadvertently add an extra relationship/person for the service user/carer to engage with, adding a layer of complexity and cost into the current case management arrangements and potentially de-skill key workers/case workers.
- While not seeking undue bureaucracy, monitoring, regulation engagement or even dismissal of formal advocates could be considered in regulations, in the interests of consistency.
- The issues of handling confidential information, both in current situations and when cases are closed, should be considered.
- Key requirements between the local authority responsibilities for Safeguarding (both children and adults) should be more explicitly drawn out, particularly with reference to formal Advocates’ responsibilities in this regard. We welcome the fact that sections 14.51 - 14.52 make reference to Making Safeguarding Personal, and would reiterate that advocacy must ensure service users’ outcomes are articulated and supported in this regard.

As an aside one respondent said that it should be a requirement that the Safeguarding Adults Board annual report should be reported to the Health Overview and Scrutiny Committee.

- In relation to s.67 (3) (c) and (d), it would be useful to make reference to how advocacy could be used to support service users and families making informed choices as to how they meet the requirements of the care cap, yet still retain the level of choice and control they wish whilst funding their own support below the cap threshold
- While not yet concluded, the emerging policy in relation to the proposed Appeals system will need to carefully consider and take account of the roles and functions of Advocacy and it is proposed that ADASS will continue to work with the Department and others in the development of this policy over coming weeks.

Sound Advocacy will have its origins in the provision of good and understandable information the requirement of this provision should be more explicit for authorities and their partners (the information should include health care as well) to ensure that information is readily available in appropriate formats.

The needs of service users and Carers in minority communities and in “seldom heard” groups should not be assumed; councils should ensure that they engage with and consult with those providing care in all parts of the community.

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