

Adult Advocacy Needs Assessment 2017

**Brighton & Hove City Council
Public Health Intelligence Team**

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EXECUTIVE SUMMARY

Introduction

This needs assessment uses a combined epidemiological and corporate approach to identify the need for advocacy in Brighton & Hove. It has utilised a literature review; a review of data and both community and stakeholder engagement to inform the report.

The definition of Advocacy that we have used in this needs assessment is that used in the Advocacy Code of Practice². Advocacy services in Brighton & Hove are provided by a wide variety of organisations across the City and are funded by multiple agencies. The scope of this needs assessment are the communities currently being provided for under the aegis of the existing contracts with Brighton and Hove City Council (BHCC) and Brighton & Hove NHS CCG based on the 2014 Commissioning Prospectus.

Strengths of the report include a comprehensive period of independent community engagement and a thorough and wide-reaching stakeholder engagement, with a good uptake of involvement from those referring into and providing advocacy services. It was therefore possible to produce a comprehensive view of the need for advocacy services within scope. However there is ambiguity around the meaning of the term advocacy and limits to accurately define populations who may have a need for advocacy services.

What does advocacy mean?

Advocacy is a broad concept and covers a range of different expertise. Individuals are able to advocate for themselves, family and friends can advocate on behalf of another person, health and social care professionals can sometimes advocate informally on behalf of their client and professional advocates are able to provide expert support when needed. Access to advocacy can be affected both by how health and social care professionals assess the advocacy needs of their clients and also referral processes into service, hence these have both been included within the scope of this needs assessment.

Certain forms of advocacy operate within a statutory framework guided by legislation drawn from the Mental Capacity Act, the Mental Health Act and the Care Act.

Within the City advocacy is currently delivered by specialist providers; by statutory provision as detailed above and also as a community service. Specialist community services commissioned at the time of writing include provision of advocacy for those with: mental ill-health (including specialist LGBTQ mental health service); sensory and/or physical disabilities; learning disabilities; language needs; those who are older people; vulnerable adults with autism; and people who are trans.



Evidence of best practice

Evidence from the research literature around advocacy identifies that support can come in many forms and that delivery is shaped by the type of advocacy needed. The sector is diverse and there is no 'best' form of delivery. All forms of advocacy should encourage self-advocacy. Evidence exists that access to advocacy by particular groups can be problematic and the use of referral systems that automatically enrol a client with advocacy services (sometimes referred to as an 'opt-out' rather than 'opt-in' access) was suggested as a way of addressing this. Key themes that emerge from the review of innovative services include the integration and co-ordination of services and aligned to this the use of partnership working and the flexibility of provision.

Using data to describe advocacy needs in Brighton & Hove

The data evidences the need for advocacy support for the existing communities of need for whom specialist provision is currently provided, however it is accepted that there may be other communities who may also have a need for advocacy support. Brighton & Hove is particularly characterised by the high number of individuals with mental health problems in the City. Though there are proportionately fewer older people living in the City when compared with England and the South East there are a higher proportion living alone.

These data do not identify the intersection of multiple factors that can affect an individual's requirement for advocacy support. The provision of advocacy is also in part determined by social factors such as family and friends acting in an advocacy capacity.

Data from the Projecting Older People Population Information (POPPI) system and the Projecting Adult Needs and Service Information (PANSI) system predicts that the sizes of all populations they measure that are currently supported by advocacy services are likely to rise between 2014 and 2025.

It can be seen that the largest rises in numbers are expected in older people, adults with moderate or serious physical disability and those with hearing impairment. It can be seen that the largest percentage rise is expected in those adults with hearing loss (19.9%) and it is unclear how their needs are being met with regard to BSL interpreters. It is also unclear whether people with additional language needs are able to access some advocacy services.

Community research

Advocacy services in the city are not well-known about amongst people in need and the lack of a high profile seems to be the result of a combination of lack of understanding of the word (advocacy), a lack of awareness and proactive referring to advocacy services by core NHS and social care services (including GPs and Adult Social Care staff) and a lack of specific resources devoted to local promotion of these services.



The current use of advocacy services is amongst people with complex combinations of needs, including multiple conditions and disabilities, who are trying to live independently within the city, but are likely to be socially isolated. Service users report that much current use relates to navigating increasingly complex access routes into health and social care systems, increasingly complex processes for receiving disability and other benefits and diminishing housing choices that are affordable, safe and secure.

The potential need for advocacy is likely to be significantly greater than current usage suggests, given the low profile of these services locally within the health and social care system.

Most advocacy users consider advocacy to have had a significant impact on the quality of their life and to have prevented them from having crises or deepening need and are grateful for being able to access services within the city. Users are particularly positive about way that advocates work with them holistically, working alongside them to tackle their multiple issues and challenges over time, providing continuity of support in a welfare system that is increasingly fragmented and specialised. This is even though only some advocacy services support people struggling in the benefits system and there is little advocacy available to deal with housing problems. This research suggests that the impact of any reduction in advocacy for people like those interviewed in this research is likely to result in more crisis management and deepening need and therefore be felt in other parts of the local health and social care system.

Stakeholder engagement

The findings of the questionnaire consultation with those who refer into advocacy services indicates that participants felt that they assessed the advocacy needs of their clients and were able to refer clients into advocacy support without any difficulties in a timely manner. Issues identified included the complexity of service provision with each service having its own referral processes. Overall satisfaction with the provision was high.

Findings from the focus groups were affected by the role of the different teams. Teams with more specialist roles such as the Deprivation of Liberty Safeguards (DoLS) and Specialist Older Adults Mental Health Service (SOAMHS) teams had positive experiences of referral. However the more generic needs of clients supported by Adult Social Work teams in particular experienced greater difficulty in accessing advocacy support. Participants from the Adult Social Care Service and to some extent the Learning Disability Service identified the multiple needs of their clients as presenting a gap between client need and current service provision as it was difficult to know which service to refer into with the effect that it deterred referrals. Other issues that negatively affected the uptake of services were the lack of a common access point and waiting times. Comments were also made about the need for advocates to be multi-skilled, probably reflecting the issue identified earlier in respect of the complexity of many client's needs. There was also some concern about the professionalism of some advocacy support with respondents indicating



incidents when they either felt there had been insufficient challenge to decisions or inappropriate challenges that touched on lobbying rather than representation. The need to raise awareness of local advocacy services was also mentioned as was the need for greater integration of service provision.

Providers who took part in the questionnaire indicated that they felt that a gap existed between those who would benefit from accessing support and those who actually made contact with the service. Lack of awareness of existing services was considered the key factor affecting this and this was again referenced when respondents were asked what they would like to see changed. Ambiguity as to understanding what advocacy meant was also cited as a factor. Increased capacity and funding were also cited as elements that the participants would like to see changed.

Findings from the Focus Groups supported the findings identified in the questionnaire for the need to raise awareness, improve promotion of services and the need to aid understanding of what advocacy was. Participants also felt that the more socially isolated a potential service user was, the less likely they were to be in contact with advocacy support. When asked what they would like to see changed providers who took part in the focus groups indicated that they would like to see more partnership working between services. It was also suggested that greater in-reach exist into referring services with for example social care teams having a member of staff with specialist expertise around advocacy: an Advocacy Champion. The value of having advocacy services delivered by services with local knowledge was also identified through the focus groups.

Lack of clarity around the meaning of the word advocacy was identified by service users as an obstacle to access for some clients, as was a perceived lack of awareness amongst staff who may refer to advocacy services. The most common responses from those who deliver services were made in respect of the need to raise awareness of advocacy services. This theme was also the most frequently mentioned at the Focus Groups with 14 participants suggesting the need to raise awareness and increase promotion of services. Examples of ways of doing this that were provided included the use of a directory, and greater outreach into the community. The stakeholder engagement expressed the need for professional high calibre staff with wide ranging knowledge who had the ability to actively listen to a client's wishes. Participants also mentioned the lack of integration between services and that this made access difficult to navigate. It was also recognised that many who access Advocacy support have complex and specialist needs.

Recommendations

Findings from the preceding sections of the report have been synthesised and the following recommendations reached:



1. Commissioners and providers to work to the definition of Advocacy used in the Advocacy Charter (and in this needs assessment)

This definition is already used by the existing advocacy providers and by adopting the meaning already in operation this could aid consensus building and collaboration. It is important for commissioners and providers to identify what isn't advocacy and support this need in other ways e.g. social prescribing, community navigator, mental health support.

2. Commissioners and providers to work to raise the awareness of advocacy and advocacy services through better promotion:

a. Promote awareness of the advocacy services in Brighton & Hove with a clear description of the offer available to: service users; those referring into services; service providers and other Council services (for example by updating the BHCC advocacy webpage, inclusion in the MyLife website)

b. Develop and maintain an accessible directory of advocacy services available in Brighton & Hove

c. Consider the development of 'Advocacy Champions' within teams who refer people for advocacy

3. Ensure that an effective and integrated advocacy service is offered in Brighton & Hove that is tailored to the specific needs of the City

a. Commission an integrated service across the City with a single point of referral reflecting the potentially multiple needs of the user. Ensure that all providers work in partnership, for example by sharing training, information and experiences

b. Commission a responsive service, features of which would include: a common point of access with referrals being responded to within an agreed period; a duty system able to pick up calls/e-mails and respond within an agreed time threshold; referrals allocated across services to aid workflows and reduce waiting times

c. Agree a care pathway with commissioners, providers and referrers that specifies levels of service and expected timescales.

d. Consider co-location of advocates with referrers where appropriate

e. Commissioners and providers to ensure that people with interpreting needs (including British Sign Language) are able to access all advocacy services, and that demand in this group is monitored

f. Commission advocacy services with reference to the Social Care Institute for Health (SCIE) Care Act 2014: commissioning independent advocacy self – assessment tool. Consider co-commissioning and/or co-production of services with



providers and community members where appropriate

4. Ensure that advocacy services in Brighton & Hove can meet current and future demand

a. Consider commissioning different types of advocacy e.g. could consider commissioning group advocacy or self-advocacy training courses, which anyone irrespective of their defined need could access

b. Provide feedback from advocacy services to relevant departments, for example workload requirements to assist with housing and benefits issues that could potentially be avoided if these services were more accessible

c. Further engagement work to be undertaken with older people and BME communities to better understand their needs for advocacy

d. Consider the development of an Advocacy Commissioners Network to aid integration and sharing of best practice between those who commission advocacy services across the City.

