Advocacy Mapping Report

Connected Voice Advocacy

Commissioned by

Cumbria, Northumberland, Tyne and Wear NHS Trust

and Inclusion North

March 2022

Connected Voice
Higham House, Higham Place,
Newcastle upon Tyne NE1 8AF
www.connectedvoice.org.uk
advocacy@connectedvoice.org.uk
0191 235 7013

Contents

A. Introduction

The aim of this report is to create a better understanding of advocacy services across the North East of England and North Cumbria for the benefit of service users, patients and multi-agency working.

Forming part of the National Advocacy Review by NHS England/Improvement, Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Trust and Inclusion North commissioned Connected Voice to complete a mapping exercise of statutory and other representational forms of advocacy available to people across the North East & North Cumbria.

The areas covered by the report are:

County Durham (Durham,
Darlington) North Cumbria
Northumberland
Teesside (Hartlepool, Middlesbrough, Redcar and Cleveland, Stockton)
Tyneside (Gateshead, Newcastle, North Tyneside, South Tyneside)
Wearside (Sunderland)

The geographical boundaries within the North East and Cumbria are complex, with areas sometimes falling within a number of different types of regional boundary e.g. the Borough of Darlington is a Unitary Authority in County Durham and is a member of Tees Valley Combined Authority. Organisations included in the report might cover areas across boundaries and deliver advocacy across multiple areas.

Seventeen organisations provide advocacy services across the region. This report and the Mapping Template provide detailed information about their provision.

B. Methodology

Commissioning for this piece of work was finalised on 25 January 2022 to be completed by the end of February 2022. The process and timescales were as follows:

1. 10/1/22: Virtual scoping meeting between CNTW, Inclusion North and Connected Voice to decide collaboratively on the template criteria for information gathering.
2. 25/1/22 – 31/1/22: Connected Voice gathered the required information, which involved:
   - Reaching out to advocacy organisations across the region and gathering their responses via online survey and focus group
   - Researching advocacy provision across the region to ensure the mapping covers the full extent of provision.
3. 3/2/22: Catch-up meeting between the CNTW and Inclusion North project team and Connected Voice to check on progress and discuss any queries to support the completion of this work.
4. February: Connected Voice continued to reach out to advocacy organisations to encourage them to complete the survey, did further research into those that had not completed it and finalised the Template and wrote the Report.
5. March: Connected Voice present a complete template/document back to project team containing information on advocacy provision across the regions.
6. Report finalised and disseminated by CNTW and Inclusion North.

We received detailed survey responses from all seventeen of the organisations providing advocacy services in the region. We also received responses from organisations outside the CNTW area which have not been included in this report.

In addition to circulating the Survey, we held a series of formal and informal discussions with advocacy providers. During the course of these a number issues and trends came up which do not necessarily fit within the structured questions in the Survey and we have reflected those contributions in Section E.

Where we had incomplete information from an organisation either through the Survey or an interview, we researched on the internet and used intelligence from our networks, adding available data to the template. In some sections there are discrepancies between information given via the survey and information held on organisations' websites e.g. Legal Status and Social Media. We have noted these instances in the report.

We have endeavoured to ensure all information is accurate and current, but welcome any feedback about additions or inaccuracies.

C. Summary of findings

The table below shows which Local Authority areas each service delivers advocacy services into and whether they provide statutory services, non-statutory services, NHS Complaints Advocacy or a combination.

	Local Authority area in which services are delivered											
	County Durham	Cumbria	Darlington	Gateshead	Hartlepool	Middles-brough	Newcastle	North Tyneside	Northum-berland	Redcar & Cleveland	South Tyneside	Stockton	Sunderland
Adapt North East									Stat & Non-Stat & NHS				
Advent Advocacy					Stat & Non-Stat & NHS								
Carers Federation	NHS		NHS	NHS	NHS	NHS	NHS	NHS		NHS	NHS		NHS
Connected Voice Advocacy				Stat & Non-Stat			Non-Stat	Non-Stat	Stat & Non-Stat		Non-Stat		Non-Stat
Darlington Association on Disability	Stat		Stat		Stat	Stat				Stat		Stat	
Hartlepool Citizens Advice					Stat & Non-Stat								
Independent Advocacy North East								Stat & Non-Stat					
Mental Health Matters											Stat & Non-Stat		
Middles-brough Citizens Advice						Stat & NHS				Stat & NHS		Stat & NHS	
Middles-brough & Stockton Mind					Stat [IMHA]	Stat & Non-Stat				Stat & Non-Stat		Stat & Non-Stat	
N-compass		Stat & NHS											
National Youth Advocacy Service	Stat & Non-Stat	Stat & Non-Stat	Stat & Non-Stat		Stat & Non-Stat	Stat & Non-Stat				Stat & Non-Stat		Stat & Non-Stat	
People First		Stat & Non-Stat & NHS				Stat & Non-Stat				Stat & Non-Stat		Stat & Non-Stat	
Rethink	Stat & Non-Stat & NHS												
Skills for People					Stat & Non-Stat	Stat & Non-Stat				Stat & Non-Stat		Stat & Non-Stat	
Voiceability													Stat
Your Voice Counts							Stat				Stat & Non-Stat		

D. Analysis

This section provides analysis of the data received in the Survey responses, together with additional data from research, collated in the accompanying Advocacy Mapping Template. Numbering aligns with the relevant column/s in the Template.

1. Organisations and advocacy hubs

All information is entered against individual organisations. However, some advocacy services are delivered via advocacy hubs in which several organisations provide services across a specific area. In these cases, we show the name of the advocacy hub [Col C] so that organisations can be sorted by hub. This is one aspect of the complexity to the advocacy landscape as some organisations participate in more than one hub and hubs operate with varying remits. The Hartlepool Hub operates with an administrative lead (Incontrol-able) acting solely as a referral pathway, while the Tees Hub has a lead provider (People First) which manages the hub and also delivers advocacy within it.

a. Organisations

All seventeen of the organisations who provide advocacy services within the region submitted responses to the survey, as well as responding to queries by email and telephone. Thank you to all of them for finding the time in amongst busy schedules and for their comprehensive and considered answers which have enabled us to provide the detail in this report. The seventeen provider organisations are:

Adapt North East
Advent Advocacy
Carers Federation
Connected Voice Advocacy (part of Connected Voice) Darlington Association on Disability (DAD)
Hartlepool Citizens Advice
Independent Advocacy North East (IANE) Mental Health Matters
Middlesbrough Citizens Advice (Tees Advocacy Service) Middlesbrough & Stockton MIND
N-compass
National Youth Advocacy Service (NYAS) People First
Rethink
Skills for People
Voiceability
Your Voice Counts

b. Current active advocacy hubs:

Hartlepool Hub: administered by Incontrol-able and includes:
- Advent Advocacy
- Darlington Association on Disability
- Hartlepool Citizens Advice
- Middlesbrough & Stockton MIND
- Skills for People

Tees Hub: led by People First and includes:
- Darlington Association on Disability
- Middlesbrough & Stockton MIND
- People First
- Skills for People

- Middlesbrough Citizens Advice (Tees Advocacy Service)

2. Service delivery areas by Local Authority (in North East and Cumbria region)

The table in Section C shows which Local Authority areas each service delivers advocacy services into and whether they provide statutory services, non-statutory services, NHS Complaints Advocacy or a combination.

The majority of organisations in the region provide a range of advocacy services. Two organisations, both national, have specialisms in one particular area:

Carers Federation which currently delivers NHS Independent Complaints Advocacy across much of the region, although some of the contracts governing this are due to end in March. Local authorities are now consulting Advocacy providers on whether to include NHS complaints into their combined statutory contracts rather than having a separate provider.

National Youth Advocacy Service which delivers advocacy to children and young people across a lot of the region.

3. Organisational information

a. Geographical area in which organisation delivers advocacy

Whilst Section D.2 focusses on provision within the report region, this section provides information about the total area of each organisation's delivery. This varies considerably from localised delivery in one Local Authority area, to national providers delivering advocacy across England and Wales. Some organisations deliver advocacy to several Local Authority areas across the North East and Cumbria.

b. Organisational base

Most of the providers (ten) are based and operate solely in the region with premises in at least one of the Local Authority areas into which they provide services. Two providers are based in the region but deliver services both within the region and further afield, one into Lancashire (People First) and one nationally (Advent Advocacy). Some organisations have multiple premises - three larger national organisations have their headquarters elsewhere but also have physical premises in the region (Carers Federation, Rethink and Voiceability). One organisation (N-compass) is based in Preston, covering the North West region and delivering a service in Cumbria. National Youth Advocacy Service is a national organisation based elsewhere and does not have a physical base in the region.

There are complex resource issues for advocacy organisations about running premises in areas of delivery and decisions about providing office space for advocates and administrative staff. Financial considerations include travel time and costs, which can be particularly high in large authorities such as Northumberland. Some organisations do not provide regional premises for staff who are all home-based (NYAS).

c. Organisational legal status

Sixteen of the provider organisations are registered as charities with the Charity Commission, of which seven are also Companies Limited by Guarantee. One organisation is not registered as a charity and is a Company Limited by Shares.

Some of the local providers are independent charities in their own right but are associated with a national charity e.g. Citizens Advice (Hartlepool and Middlesbrough Citizens Advice) and Mind (Middlesbrough & Stockton Mind). We did not ask about the precise nature of their relationship with the national bodies.

There were some discrepancies between information given via the survey and information held on organisations' websites possibly because people completing the survey were not fully aware of the legal status. For example some respondents said their organisation was only a charity, but the website also gave a company number. In these instances we have favoured the information on websites.

d. Websites

All organisations in the region have a website. On the Mapping Template we have listed their main websites within which some have advocacy-specific pages or, where it is a national charity, pages relating to specific regional services.

e. Social media

All seventeen organisations have a social media presence but use it to a greater of lesser extent. All have Facebook accounts and sixteen have Twitter accounts, although one is rarely used. Research showed that at least four organisations have YouTube accounts in which videos about advocacy are available (Connected Voice Advocacy, N-compass, Skills for People, Voiceability).

There are discrepancies between information given via the survey and information held on organisations' websites. We have researched each organisations' Twitter and Facebook accounts and used this information above.

4. Statutory advocacy services

a. Statutory roles delivered

Statutory Advocacy is Advocacy commissioned and provided as a legal right as defined under legislation (Mental Health, Mental Capacity and Care Acts)

IMHA: Independent Mental Health Advocacy
IMCA: Independent Mental Capacity Advocacy
ICAA: Independent Care Act Advocacy

NHS Complaints Advocacy is Advocacy commissioned to support the right to make a complaint about any aspect of NHS care, treatment or service as written into the NHS Constitution

One organisation provides NHS Complaints Advocacy only (Carers Federation), but most organisations provide multiple advocacy roles:

All roles: 2
NHS Complaints: 1
IMHA/IMCA: 1
IMHA/ICAA/IMCA/RPR: 3
IMHA/ICAA/IMCA/RPR/Rule 1.2 Rep: 1
IMHA/ICAA/IMCA/RPR/Rule 1.2 Rep/NHS Complaints: 1
IMHA/ICAA/IMCA/RPR/Rule 1.2 Rep/Litigation Friend: 4
IMHA/ICAA/IMCA/RPR/Rule 1.2 Rep/NHS Complaints/Litigation Friend: 2
IMHA/ICAA/IMCA/RPR/Rule 1.2 Rep/Litigation Friend/Children & Young People: 1
IMHA/ICAA/IMCA/RPR/NHS Complaints/Litigation Friend/Children & Young People: 1

The number of organisations across the region delivering each statutory role:

IMHA: 16
IMCA: 16
ICAA: 15

RPR: 15
Rule 1.2 Representative: 11
NHS Complaints: 7
Litigation Friend: 10
Children & Young People: 4

We are also aware of a company, Action First, based in London, who provide the RPR role on a spot contracted basis across the country and might therefore sometimes provide the RPR role in this region.

We included Independent Sexual Violence Advocate (ISVA) and Independent Domestic Violence Advocate (IDVA) in the survey but no organisations providing those roles responded to the survey.

b. Commissioning Local Authorities

Organisations vary from being commissioned by one Local Authority only (five) to multiple Local Authorities (eight) in the region. Three further organisations are commissioned by multiple Local Authorities across the country but by only one in the region. One organisation does not identify any commissioning Local Authorities, but mentions CCG commissioning [see Section F.2.c].

c. Hospital and in-patient settings

Organisations primarily work into hospital and in-patient settings relevant to and located within the commissioning Local Authority area.

Some organisations provide advocacy out of area. Several organisations work into specialist units e.g.:

Roselodge specialist learning disability unit in South Tyneside (Your Voice Counts)
Lustrum Vale specialist rehabilitation and recovery mental health unit in Stockton (Darlington Association on Disability, Hartlepool Citizens Advice and Middlesbrough & Stockton MIND)
National Autistic unit at the Mitford Unit in Northgate Hospital, Northumberland (Connected Voice Advocacy)

One organisation states that this is commercially sensitive information, one says 'none' and one did not reply to the question.

"*We do not work directly in settings though we work with all the Hospital Trusts/ Mental Health Trusts in the North East and many beyond to support NHS complaints work. We also work right across all Primary care and with NHSE.*" Carers Federation

[As well as hospitals located within the commissioning Sunderland area] "*all care homes within Sunderland and Supported living settings and also out of area placements funded by Sunderland safeguarding under DOLS.*" Voiceability

The location of hospital and in-patient settings in relation to statutory advocacy contracts and the varying and changing interpretation of legislation has created a considerable degree of inconsistency in advocacy provision.

The larger mental health in-patient settings in the region include:

St Georges Park - Northumberland
St Nicholas – Newcastle

Hopewood Park – Sunderland

The wider provision for NHS inpatient settings includes:

Gateshead:
Queen Elizabeth (older people units) Newcastle:
Campus for Ageing and Vitality Elm House
St Nicholas Hospital
South Tyneside :
Rose Lodge
Sunderland
Hopewood Park
Monkwearmouth
Hospital County Durham:
Brooke House
Cygnet Appletree
Priory Hospital Middleton St George Northumberland:
St Georges Park
Cygnet Hospital
Hexham Cumbria:
West Cumberland Hospital.

Some providers work in areas with large in-patient settings and some work in smaller catchment areas e.g. North Tyneside, Gateshead and Redcar. This has an impact on the number of IMHA referrals they receive as this is based on the location of the hospital the person is sectioned in. This can cause issues for people on discharge as they might not have continuity of advocacy provider when they move to the community.

There is also inconsistency in the criteria for the different statutory advocacy roles:

IMHA and IMCA are based on where the person is.
ICAA and DoLS RPR are based on the responsible Local Authority.

Examples of the impact of this:

A person in hospital has an IMHA from a provider in Newcastle but is discharged to a community setting and receives care planning advocacy from a Gateshead advocacy provider.

A person in a care home receives advocacy from the provider commissioned by their Ordinary Residence but has an advocate for safeguarding from the area they are currently living.

After a significant restructure by CNTW in October 2019, in-patient settings were rationalised to three key locations: St Nicholas Hospital in Newcastle, Hopewood Park Hospital in Sunderland and Northgate Hospital in Northumberland. This had significant impact on advocacy provision for the three advocacy providers in Northumberland, Sunderland and Newcastle.

d. National advocacy provision in the region

Connected Voice Advocacy delivers an IMHA service for national inpatients in Northgate Hospital Morpeth. Connected Voice Advocacy was awarded a contract for IMHA and IMCA

by Northumberland County Council from October 2013 to March 2015 following the closure of Spiral Skills at Learning First. In 2015 the contract was put out to tender and awarded to Adapt North East. Since 2013 CNTW NHS Foundation Trust has commissioned Connected Voice Advocacy to provide IMHA services for both the Forensic and Autistic inpatient wards, now known as the Mitford National Autistic Centre. This contract is for national inpatients in Mitford Unit and falls outside of the local authority statutory duty to provide IMHA service for Northumberland Ordinary Residents. The specialist contract for autistic inpatient IMHA services is a block contract based on patient need rather than delivery hours and is therefore an enhanced IMHA service. The enhanced contract includes:

Daily attendance on ward by IMHA to develop trust/rapport with patients and increase presence and scrutiny on ward

IMHA contribution to Formulation meetings

IMHA contribution at monthly MDT/CPA/CTR meetings

IMHA review of trends and critical feedback to ward

IMHA contribution to service development

Input into service user/carer forum meetings.

5. Out of area protocols

Asked whether they have out-of-area protocols for crossing boundaries with other advocacy providers and/or Local Authorities, 13 organisations said they have out of area protocols in place and four said they do not. Those that do said:

"*We deliver on spot contracts and will always consider working across boundaries where appropriate and assuming funding arrangements are agreed.*" Adapt North East

"*We have informal arrangements though we are commissioned on the postal address of our service user if they access an out of area service we are still able to support. We regularly advocate for these service users in the two areas - Stockton and Northumberland - where we are not commissioned principally as a lot of secondary care does not fit convenient Local Authority boundaries*" Carers Federation

"*Where needed to provide consistent advocacy we are able to get permission off commissioner to support people who are from Darlington but inpatient in Co Durham. As we work across the whole of Tees Valley we are able to support people if they move across different areas. We aim to organise this in a manner which makes it seamless for the person accessing advocacy.*" Darlington Association on Disability

"*Legislation and local informal agreements with providers*" People First

"*Discussed with commissioners*" Rethink

"*If we are understaffed we will seek to spot purchase cases to different advocacy providers. Also have agreements that we will take on cases that are funded by Sunderland across North east region. Currently have cases in Newcastle, Durham, North Tyneside, Darlington and Hartlepool areas.*" Voiceability

"*Not as such, where we have a request for advocacy out of area we would consider if the distance is likely to disadvantage the person and would negotiate with the referrer/head of service approaching a more local service e.g. support for care plans under the care act would work really poorly if we're in the north and the person is in*

Hartlepool - distance would be a barrier to providing the face to face support the person may require." Your Voice Counts

"*We sometimes work out of area if the home local authority of the service user is within our service area but the service user is living out of area*." Middlesbrough & Stockton Mind

It could be beneficial to develop cross boundary/out of area protocols across the CNTW region to provide clarity and consistency [see Section F.2.a].

6. Other contracted delivery

Asked about other contracts, organisations responded as follows:

a. Local Authority contracts: Yes: 16; No: 1; No reply: 0
b. Health Trust contracts: Yes: 7; No: 8; No reply: 2
c. Criminal Justice and Police & Crime Commissioner (PCC) contracts: Yes: 3; No: 14; No reply: 0

The survey did not ask for further details about other contracted delivery. It is therefore not possible to extrapolate anything further from this data [see Section F.2.c].

7. Charitable funding

Asked whether they receive charitable grants for advocacy, organisations responded: Yes: 6; No: 11; No reply: 0.

Given that this mapping exercise aimed to look primarily at statutory and contracted services we did not ask for specific information about the services funded via charitable grants [see Section E.2.c]. Organisations seek to secure charitable funding to provide non-statutory/community advocacy services. These might be generic advocacy services or services aimed to provide advocacy support to a particular client group.

Charitable grants can be crucial in funding community based advocacy provision which ensures continuity of advocate on the advocacy journey after a person is discharged. Organisations often identify gaps in provision and seek funding to meet that demand or alternatively respond to funding calls by charitable funders around a particular area of interest identified by the charity. Charitable funding can also be a source of income to cover organisational core costs. These are increasingly difficult to fund, with contracts frequently awarded according to lowest price, necessitating extremely tight, sometimes inadequate budgets.

It is important for organisations to collate accurate data to analyse the reach and gaps in their services in the community. Advocacy services develop their own referral and monitoring forms and systems for collating and analysing the data. It could be useful to consider developing consistent referral forms in order to collate the same data across the sector [see Section F.2.b]

8. Non-statutory/community advocacy delivery

Asked whether they deliver non-statutory (community) advocacy, organisations responded: Yes: 13; No: 2; No reply: 2.

Non-Statutory or Community Advocacy is Independent Advocacy provided outside any legal right, usually either commissioned or funded via charitable grants.

Details include:

General case/issue-based advocacy (Northumberland, Darlington)

Telephone advocacy (Northumberland)
Spot contracts with Children's services (Northumberland)
Health & Social Care Advocacy (Newcastle and Gateshead, Middlesbrough, Stockton, Redcar & Cleveland, Cumbria, Teesside) including people with mental health needs, physical or learning disabilities, ethnically minoritised people, older people; people from LGBTQ+ communities; refugees and asylum seekers.
Hate Crime Advocacy (Northumbria and Tyne & Wear;
Darlington) Families through Crisis (Newcastle)
Mental Health Advocacy (Darlington, North Tyneside, Hartlepool)
Victims of Crime who have a mental health need (Darlington)
Group and peer advocacy (Darlington)
Learning Disability (North Tyneside, South
Tyneside) Physical Disability (North Tyneside)
Autism (South Tyneside)

9. Advocacy models supported

Asked which advocacy models they support, organisations responded as follows:

a. Self-Advocacy: Yes: 16
b. Peer Advocacy: Yes: 10
c. Group Advocacy: Yes: 13
d. Participatory Evaluations: Yes: 9

We included this question as it is an area which is explored in the Advocacy Quality Performance Mark Assessment [see Section D.12].

Self-Advocacy: Supporting people to self-advocate for themselves is a core element to the advocacy role and the Advocacy Charter [see Appendix 2] to help empower people and work in a person centred way with the person leading the process.
Peer Advocacy: This is where one-to-one support is provided by an advocate with similar lived experience to a person using services, for example they might have a similar disability, have experience of using mental health or other health and social care services, have common identities, etc. Peer advocates can bring a particular level of understanding to their support and are often volunteers.
Group Advocacy: Similarly to Peer Advocacy this can be where a group of people with similar or shared experiences meet to support each other and collectively strengthen their voice. It can also be facilitated by paid advocates with a group who have common experiences or concerns.
Participatory Evaluations: An approach that involves the stakeholders of a service or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis and the reporting of the study.
The research showed that all providers have a commitment to supporting the people they work with to advocate for themselves. Some had strategic approaches to self-advocacy such as workbooks and online tools. Two organisations mention using self-advocacy apps [see Section D.16]:

DIY Advocate®: Connected Voice Advocacy
N-compass Advocacy App: N-compass

10. Non-advocacy services

Asked whether they deliver services in addition to Advocacy, organisations responded: Yes: 14; No: 3; No reply: 0.
These include a wide range of services including:

Carers: support for young carers; National Provider of accredited Carers Standards to UK Colleges/Universities.

VCSE Infrastructure Support and Development; Financial services to the VCSE Support for people to use self-directed support

Independent Living Hub

Counselling, IAPT Helpline

Volunteering Services

Housing, Crisis Accommodation

Employment, job coaching

Criminal Justice System: Court, Prison services

Community based interventions for people with learning disabilities

Children and young people's services; support for care leavers

Family support; Contact

centres Older people

Health: mental health, Healthwatch, GP surgery links; Covid support Education, training, training research

Welfare Benefits and Advice services (debt, energy, consumer, employment) Service user support

11. Service user involvement

Asked about involving people who use their services, organisations responded as follows:

a. Do you have a service user strategy to involve people in advocacy service delivery? Yes: 13; No: 4; No reply: 0.
b. Do people who receive advocacy services engage in project planning or service delivery? Yes: 12; No: 5; No reply: 0.
   Comments from those who answered yes include:
   "Involved through a staged feedback process throughout the advocacy journey to shape any learning and also through a comprehensive exit feedback process at closure." Carers Federation

   "Service user group & focus group evaluations, quality audits, films, blogs, recruitment" Connected Voice Advocacy

   "As a local user led organisation we are governed and controlled by disabled people including those who use advocacy services. This is also reflected in our staff team. The organisation has a Stakeholder forum made up of disabled people and cares who support DAD to identify how it develops, including the business plan. COVID has curtailed some of this work but this is now gathering momentum again." Darlington Association on Disability

   "*We have a citizen involvement board with advocacy service user representation to help shape strategy and delivery*." N-compass

   "*We have a participation manager that engages CYP in recruitment processes, planning NYAS services, supporting them to feedback to LAs etc.*" National Youth Advocacy Service

   "*We have a number of paid and voluntary 'Lived Experience' roles for people with learning disabilities and people with experience of mental health services. These include our Co-Production team who are supporting us to develop our approach to co-producing services with the people who use our services, Experts by Experience who*

are panel members for CTRs, and our team of Quality Checkers who undertake checks of GP practices and other health and social care services." Your Voice Counts

"*We routinely ask for feedback, have people who have used our services on our Board of Trustees and run an annual 360 degree review including all customers*." People First

"*Feedback gathered monthly to measure service delivery and where improvements can be made, implemented*" Mental Health Matters

"*User representatives with the board. Groups are facilitated to ensure they are fully involved with decisions. Co creation and co-production of projects*" Skills for People

"*Our service delivery is led by input from service users on an individual case by case basis and service user feedback is used to inform project planning and service delivery.*" Middlesbrough & Stockton Mind

c. Is your organisation governed by people who receive advocacy services and do they hold decision making positions on your board? Yes: 6; No: 11; No reply: 0. Comments from those who answered yes include:

"*As an organisation we are constituted [so] that 90% or our trustees are disabled people, the majority of which access advocacy services when they require support.*" Darlington Association on Disability

"*This is being developed currently*" National Youth Advocacy Service

"*We have four people with learning disabilities on our Board, one family carer and we are about to recruit someone with lived experience of mental health services.*" Your Voice Count

"*Our Board includes people who have lived experiences of using advocacy. We also run a lead group which includes reps from five self-advocacy groups who act as a conduit to the Board.*" People First

"*This is something that is currently being strengthened by having representatives from all project and areas being brought together to work alongside the board.*" Skills for People

There is a wide range of models of involvement across the responding organisations and this reflects some of the challenges and considerations to having service-users meaningfully engaged in governance and service planning/design.

Thirteen out of the seventeen providers who responded state that they have a service user strategy to engage people who use services in their planning and delivery. Some include roles at board level or in focus groups, one had a Participation Officer post dedicated to involving people and some service users had a scrutiny and quality checking role in the organisation.

Some of the providers in the region are grassroots user-led advocacy organisations which reflect the origins of the Advocacy movement (e.g. People First, Skills for People and Darlington Association on Disability). However the sector has changed and this is

reflected in the make-up of providers today. The changes have come about with the introduction of:

National Advocacy Qualification

Advocacy Charter [see Appendix 2] Advocacy QPM

Independent Advocate role in legislation (Mental Health Act, Mental Capacity Act and Care Act).

Having once been a voluntary user-led movement, Advocacy has evolved. Providers are held to account and audited now and the sector is exploring the advantages to being regulated. To find out more about the history of Independent Advocacy go to page 18 of Connected Voice Magazine Summer 2021.

Some providers have met during the pandemic to share resources and good practice. One area of focus was around service user involvement. Connected Voice and Your Voice Counts are exploring funding opportunities and the demand for a post to support region-wide development for service user involvement.

12. Quality

Asked about quality standards and awards, organisations responded as follows:

a. Do you hold a current Advocacy Quality Performance Mark? Yes: 12; No: 5; No reply: 0.
   At the time of writing this report, of those who answered yes, two appeared to be due for renewal according to the website of Advocacy QPM awarding body, National Development Team for Inclusion (NDTi) and one did not appear.
   https://qualityadvocacy.org.uk/current-qpm-organisations/

The Advocacy Quality Performance Mark (QPM) is the only quality mark for organisations offering independent advocacy and is a requirement for some statutory contracts. It is assessed and awarded by National Development Team for Inclusion (NDTi). It is awarded to organisations who can demonstrate that they provide excellent services in line with QPM standards and the Advocacy Charter [reproduced in Appendix 2].

Organisations are rated against performance in key areas including: Clarity of Purpose, Independence, Confidentiality, Person-led, Empowerment Equality and Diversity, Accessibility, Accountability, Safeguarding, Supporting Advocates. It involves a robust audit of policies and procedures, a sample of casenotes and reports, followed by a site visit which includes interviews by the assessor of key people within the organisation (including Trustees, CEO, Advocacy managers, and advocates), people who use the service and key stakeholders, e.g. commissioners. The assessor produces a detailed report which can include actions for improvement. If the organisation meets the require standards, the QPM is awarded for a three year period.

b. Do you hold any other quality standards? Yes: 10; No: 4; No reply: 3. These include:

Investors in People (IIP)

Investing in Volunteering (IIV)

Contractors Health and Safety Assessment Scheme (CHAS) North East Better Health at Work Gold Award

Real Living Wage Employer

North of Tyne Combined Authority Good Work Pledge Mindful Employer

Disability Confident
Employer ISO 9001

c. Do you hold any advocacy awards? Yes: 3; No: 12; No reply: 2.

In addition to the Advocacy QPM the sector holds annual Advocacy Awards to recognise good practice. Of those who answered yes, two provided no details. Connected Voice Advocacy was awarded Outstanding Service at the National Advocacy Awards 2018, the only North East provider to win this award. After a gap in awards due to the Covid pandemic the sector will celebrate awards again in 2022.

13. Staffing and volunteers

Asked about staffing and volunteering levels, organisations responded as follows:

a. Number of Full Time Equivalent Advocates in your organisation: Of the 16 organisations who provided this information the average was 18.4 (however some organisations might have given data for provision outside the region)
b. Number of paid Advocates: Of the 17 organisations who provided this information the average was 18.4 (however some organisations have given data for provision outside the region and one said “all advocates are paid”.
c. Number of volunteer Advocates: Of the 16 organisations who provided this information, ten have no volunteer advocates and one said not applicable. Five have volunteers and of those, the average was 8 volunteer advocates per organisation.

The majority of organisations use only paid advocates to deliver advocacy. Four organisations also use volunteers (none of the respondents use only volunteers). We did not ask for data about which of those organisations’ services use volunteer Advocates, nor did we ask about the rationale for using/not using volunteers. There are both advantages and disadvantages to using volunteers, for example:

the volunteer model can provide a pathway to paid employment

it is not a cheap option, requiring resources and time to do properly, including training and supervision

14. Training

a. Number of Advocates trained in National City & Guild IAQ Level 3 or 4 or 5?
Fifteen organisations provided this information and two did not. Analysis of the number of advocates training in the IAQ against the number of paid advocates shows that:

in 11 of the organisations 95-100% of paid advocates have achieved, or are working towards, achieving the qualification

in 4 of the organisations 50-68% have achieved, or are working towards, achieving the qualification

b. Areas Advocates are trained in:
All legislation (IMHA, IMCA, ICAA): 17
Instructed advocacy: 14
Non-instructed advocacy: 13
Specialism for advocating for people with a learning disability: 10
Specialism for advocating for people with autism: 8
Specialism for advocating for children and young people: 5

The Independent Advocacy Qualification was launched in 2009 and some would say it marked a professionalisation of the sector and a move to bring about a degree of standardisation in the skills, knowledge, and qualities of advocates.

There is a clear commitment across the sector to ensuring that advocates are trained to an appropriate level and in the relevant roles. It is evident that this is seen as a priority with organisations ensuring either that advocates are IAQ qualified before they start working or new staff are charged with undertaking the qualification.

c. Does your organisation deliver advocacy training to the wider sector? Of the 14 organisations who completed the question: Yes: 6; No: 10; No reply: 1.
Details provided:
"*National Training provider for IAQ to level 5 City and Guilds approved delivered since 2010*" Carers Federation
"*Deliver advocacy awareness training across health and social care and within the community*" N-Compass
"*CYP [Children & Young People] advocacy delivered externally*" National Youth Advocacy Service
"*We provide informal and formal training including the advocacy qualification*" People First

In discussions some providers shared with us reasons for no longer providing training when they also deliver on advocacy contracts as this posed a conflict of interest.
They felt that having advocates qualified by an independent body is a way to safeguard against any conflict and an externally verified qualification system gives more validity to the service.

15. Language and interpreting

Organisations responded as follows:

a. Do you have multi lingual advocates? Yes: 8; No: 8; No reply 1.
b. Do you use interpreting services? Yes: 16; No: 1; No reply:
0 Information given about interpreting services includes:
Provided by CNTW or Local Authority for Statutory services British Sign Language
Big Word
Clear Voice
Language Line
Language Empire
Clear Lingo
Asylum and Refugee Service Newcastle (North of England Refugee Service) Newcastle Interpreting Service
Everyday Language Solutions
Funded by Access to Work for a deaf advocate Local volunteers

Nearly half the respondents have multi-lingual advocates and all bar one use interpreting services.

16. Innovation and technology

Organisations responded as follows:

a. Have you any examples of innovation in advocacy? Yes: 9; No: 4; No reply: 4.

Of those who answered yes, two organisations said this was commercially sensitive and did not provide further information, one said "*most are on the website*" and another gave no examples.
Examples of innovation include:

DIY Advocate self-advocacy app; self-advocacy workbook Connected Voice Advocacy

Range of peer advocacy opportunities. The first of which was our stronger voices project in 2015. Darlington Association in Disability

MSA model; Advocacy App N-Compass

b. Do you use digital technology in advocacy? Yes: 16; No: 0; No reply: 1. Several who answered 'Yes' did not give examples and one said it was commercially sensitive. None gave information about what stops them using digital technology. Examples include:

Meetings conducted using variety of platforms based on the person's preference including Zoom, Teams, WhatsApp.

Apps (Advocacy apps and communication tools0 Tablets, Talking Mats, Say and Speak

Casenotes (secure digital recording and storing)

One Consultation (allows for remote face to face communication) Mobile phone

The pandemic has encouraged progression in digital advocacy. Notwithstanding the concerns over digital exclusion and gaps in privacy and safeguarding disclosures, there has been some positive progress in this area.

One respondent made the point that despite the increase in the use of digital platforms since March 2020 due to the Covid pandemic and the majority of their work now done through electronic communication, some more vulnerable service users still need to be supported through more traditional methods such as telephone, writing and face to face.

Two organisations mention using self-advocacy apps (Connected Voice Advocacy and N-compass). We are aware of two advocacy apps available in the region:

DIY Advocate®: developed by Connected Voice Advocacy

N-compass Advocacy App: developed by N-compass from a white label version of the Connected Voice DIY Advocate® app sold in 2018

Another advocacy app has been developed outside the region:

Advocacy Focus App: developed by Advocacy Focus.

17. Networking and partnerships

a. Do you attend networks at local/ regional or national level? Yes: 17; No: 0; No reply: 0. All of the organisations attend networks. These included:

National Advocacy Leaders Network: 4 organisations attend this Annual Black Belt Advocacy Conference

National Working Group – advocacy

Networks involving collaboration with regional services for the purpose of delivering cross boundary advocacy

Networks specific to NHS Complaints e.g. NHSE - National NHS complaints Managers Network, Patient Experience Committees

regional collaboration,

Kate Mercer Black Belt Training provides links to national developments Local MH Boards

Safeguarding

Boards LD Alliance

Local advocacy providers network

Kate Mercer Black Belt advocacy network Cloverleaf advocacy providers

Examples of barriers to engaging in networks:

Capacity and resources "capacity prevents being part of national networks"

Networks have become complicated due to competitive tendering and concerns about revealing commercially sensitive information to potential competitors. A number of networks have not survived e.g. North East Regional Advocacy Network. The demise of networking and a supportive environment across the sector can only be detrimental to the people we work with.

b. What outcomes do you expect from networking? Responses included:

"*Shared experience and learning, more seamless service delivery across the region, better experience for service users.*" Adapt North East

"*Partnership working and also sharing benefits of service and ensuring service users outcomes are not compromised by not having the correct support. Learning from each other.*" Carers Federation

"*Sharing good practice, collaboration on projects, campaigns, joint consultation responses, peer support, shared resources.*" Connected Voice Advocacy

"*National developments, including good practice, emerging guidance*." Darlington Association on Disability

"*Learn more about the community and other services*" Independent Advocacy NE "*Share best practice and developments*" N-compass

"*greater joint working to benefit the CYP, relationship building*" National Youth Advocacy Service

"*Sharing of experiences*" Rethink

"*Cross communication with other services and with CNTW so that Advocacy is better understood and received at all levels. Being able to engage quicker with those that need our support especially as changes in legislation under MHA mean that soon all patients in hospital will have the right to be referred to advocacy.*" Voiceability

"*Influence of local interpretation of key legislation/guidance. Opportunity to ensure advocacy is considered within local procedures. Raise awareness of the value and impact of advocacy - increase understanding of the duty to refer/eligibility*." Your Voice Counts

"*More support for and from other providers.*" Tees Advocacy Service

"*Build knowledge. Share experience. Build relationships. Drive improvements. Influence policy*." People First

"*Enhancing the advocacy provision and co-productive working*" Advent Advocacy "*Increase in referrals*" Mental Health Matters

"*Improved knowledge, awareness of best practice, training, improved service delivery*" Middlesbrough & Stockton Mind

"Further training and support" Hartlepool Citizens Advice

We have had proven success across the region in joint campaigns, collective responses to consultations and getting heard at parliamentary level.

c. Do you deliver advocacy in a partnership/ consortium? Yes: 6; No: 10; No reply: 1
Details include:

"*We subcontract to other partners in some of our delivery areas."* N-compass

"*Depends on the contract and if adults and children's delivery is required*." National Youth Advocacy Service

Seven of the organisations are members of advocacy hubs [see Section 1.b].

Examples of barriers to partnership working/consortia:
Similarly to the complications of networking above, partnership working can be complex in the competitive tendering climate:

> "*Commissioning arrangements are not conducive to deliver in a partnership. The work we do is a niche service and there has not been sufficient development right across advocacy to educate commissioners that "lumping" all statutory advocacy together and driving down costs is feasible and addresses the needs of the population. Whilst we do engage with other advocacy services we are only able to share our knowledge on health based complaints. We are also not viewed as a parity service by some mental health advocacy providers when actually we are dealing with significant numbers of ongoing complaints in mental health settings. We are currently commissioned on a consortium basis i.e. a consortia of 10 Local authorities though this is due to change from April 2022.*" Carers Federation

One organisation refers to a partner organisation ending their part of the contract. This highlights the potential for partnerships failing. Contracts often require a lead partner which can create inequities in the partnership. Sub-contracting arrangements can also bring difficulties to the relationship between the parties.

In summary, partnerships were discussed and generally considered positively. As partnership approaches are encouraged for funding and contracting it is essential that there are clear and detailed Service Level Agreements and that all parties are clear about their role, remit and responsibilities (including financial arrangements, monitoring and reporting arrangements, data collation and sharing between services). It was acknowledged that additional time and resources are needed for a partnership approach. Some issues were aired around data protection, data sharing, consolidation of information systems and staffing.

E. <u>Other trends and issues</u>

In addition to circulating the Survey, we held formal and informal discussions with advocacy providers. During the course of these a number of issues and trends came up which do not necessarily fit within the structured questions in the Survey. We are keen for these contributions not to be lost so reflect them in this section.

1. Some providers benefit from selling **bespoke contracts** to meet gaps beyond statutory provision e.g. Litigation Friend, community DoLS (Rule 1.2 Representative) and Child Protection hearings.
2. Many providers are now using an **integrated advocacy model** – using multi-qualified advocates to follow the patient journey into the community and stay with them for continuity across advocacy types. This brings more flexibility but can incur higher training costs and more planning for service managers.
3. **Variance in referral forms** was discussed and standardising them was suggested in order to ensure appropriate demographic information is collated and reduce repetition of storytelling for those making referral.
4. Given that there is so much good practice to share in the region, people talked about wanting to **avoid re-inventing wheels**, and wondered how this can be facilitated.

5. Some participants talked about the ‘elephant in the room’ and their belief that the sector would be greatly benefitted if we reduce competition, improve commissioning processes and nurture and encourage collaboration, whilst managing risk.
6. **Inequality of IMHA provision** due to some areas having larger hospitals e.g. Newcastle. Sunderland, Northumberland and Middleborough
7. **Inconsistency around criteria** for advocacy e.g. IMHA and IMCA is based on where the person is. ICAA and DoLS is based on the local authority responsible.
8. **Disjointed** services where health advocacy is commissioned by local authority and Health Trusts are not involved in service planning. This relates particularly for IMHA services in local hospitals or inpatient community settings, or Continuing Health Care assessments which are not joined up with local authority Adult Social Care planning under the Care Act.

F. Conclusions

a. There is a comprehensive mix of statutory, non-statutory/community and NHS Complaints advocacy across the region, with many of the organisations delivering a mixture of statutory and non-statutory services.
b. Providers range from smaller local organisations to larger national organisations, with two areas operating Advocacy Hubs which primarily provide a referral pathway. Some providers deliver only advocacy services and some are part of organisations delivering a range of other services.
c. Services are funded through a mixed economy of commissioned statutory services, contracted non-statutory services and non-statutory services funded via charitable grants.
d. The matrix of which providers deliver which advocacy roles in which areas is complex and is subject to change as contracts are recommissioned. This can lead to confusion for referrers and service users and can sometimes make it impossible to provide the same advocate throughout the advocacy journey.
e. There are high levels of training throughout the sector, with the majority of advocates supported to complete training appropriate to their role/s prior to, or as soon as possible after starting work as an advocate.
f. There are local, regional and national networks in operation as well as localised partnerships/consortia but these have taken their toll due to the economic climate of competitive tendering, reduced availability of charitable funding and lack of resources and capacity.
g. There is a need for joined up planning of advocacy services across the health and adult social care sectors. Integrated Care Systems may result in improved commissioning for advocacy with a holistic person centered approach to follow a person’s journey across services.

Appendix 1: Survey Questions

The order of the questions has been changed in some places in the Advocacy Mapping Template, but the original numbers of the questions in the survey are shown on the Template.

1. Organisation Name

2. Status (all that apply)

- ☐ Registered Charity
- ☐ Charitable Incorporated Organisation (CIO)
- ☐ Company limited by Guarantee (CLG)
- ☐ Community Interest Company (CIC)
- ☐ Company Limited by Shares (CLS)
- ☐ Limited Liability Partnership
- ☐ Unincorporated Association
- ☐ Trust
- ☐ Partnership
- ☐ Sole Trader

3. What is your website address?

4. Do you use Social Media? (please share contact details)

5. Name of your main contact/ CEO or Advocacy Manager

6. Email of main contact

7. What geographical area do you deliver Advocacy?

8. Do you receive charitable grants for advocacy?

9. Do you deliver local authority advocacy contracts?

10. Do you deliver health trust advocacy contracts?

11. Do you deliver Criminal Justice/ Police & Crime Commissioner advocacy contracts?

12. Does your organisation deliver services in addition to Advocacy?

13. Do you have a service user strategy to involve people in advocacy service delivery?

14. Do people who receive advocacy services engage in project planning or service delivery?

15. Is your organisation governed by people who receive advocacy services and do they hold decision making positions on your board?

16. Do you hold a current Advocacy Quality Performance Mark?

17. Do you hold any other quality standards?

18. Do you hold any advocacy awards?

19. Number of Full Time Equivalent Advocates in your organisation

20. Number of paid Advocates

21. Number of volunteer Advocates

22. Do you have multi lingual advocates?

23. Do you use interpreting services?

24. Have you any examples of innovation in advocacy?

25. Do you use digital technology in advocacy?

26. Does your organisation support (tick all that apply)

- ☐ self advocacy
- ☐ peer advocacy
- ☐ group advocacy
- ☐ participatory evaluations

27. What statutory advocacy services do you deliver (tick all that apply)

- ☐ Independent Mental Health Advocacy (IMHA)
- ☐ Independent Mental Capacity Advocacy (IMCA)
- ☐ Independent Care Act Advocacy (ICAA)
- ☐ Relevant Person's Representative (RPR)
- ☐ Rule 1.2 Representative
- ☐ NHS Complaints Advocacy
- ☐ Litigation Friend
- ☐ Statutory advocacy to children and young people
- ☐ Independent Sexual Violence Advocate (ISVA)
- ☐ Independent Domestic Violence Advocate (IDVA)

28. Which local authorities commission your statutory Advocacy services?

29. Which in-patient settings and hospitals do you work in?

30. Do you have out-of-area protocols for crossing boundaries with other advocacy providers/ Local Authorities?

31. Do you deliver non-statutory (community) advocacy?

32. Number of Advocates trained in National City & Guild IAQ Level 3 or 4 or 5?

33. Are your advocates trained in (tick all that apply)

- ☐ all legislation (IMHA, IMCA, ICAA)
- ☐ instructed advocacy
- ☐ non-instructed advocacy
- ☐ specialism for advocating for people with a learning disability
- ☐ specialism for advocating for people with autism specialism
- ☐ for advocating for children and young people

34. Does your organisation deliver advocacy training to the wider sector?

35. Do you attend networks at local/ regional or national level?

36. What outcomes do you expect from networking?

37. Do you deliver advocacy in a partnership/ consortium?

Appendix 2: The Advocacy Charter

Appendix 3: Graphics Presentation

Attached separately.