



Sheffield Advocacy Hub

Advocacy under the Care Act 2014

What we have found so far and emerging best practice

June 2019

Contents

Executive Summary	5
Introduction	6
Methodology	6
Findings	8
1. Referrals	8
2. Casework Process Issues	12
3. Concerns, Challenges and Complaints	18
4. Closing Casework	20
5. Common recording requirements for all cases	23
Conclusion	24

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Citizens Advice Sheffield - Our values

The Advocacy Charter, together with its associated Code of Practice, guides all our advocacy services and governs our work.

It embeds a set of core principles, policies and practices into our work and our organisation which ensures we provide a high quality, independent, accountable and confidential service to all those people who need to use our services.

In 2017-18 we participated in a review of the Charter, and the associated Quality and Performance Mark (QPM) which is used to benchmark the quality of advocacy services. We currently hold the QPM for our service.

The Charter ensures we maintain the key principles which the sector agrees are essential to ensuring high quality advocacy services.

You can find out more about the Advocacy Charter and QPM by visiting <https://qualityadvocacy.org.uk/>

We are also a key part of the services offered by Citizens Advice Sheffield and the core values of advocacy as expressed in the Charter are shared by the whole organisation in its principle function of providing Advice services to the people of the city.

Advisers work to the same principles of confidentiality and independence and also insure their advice is impartial. Advisers provide options to people needing help, and support them to make decisions. We may be separate services, but our work has a very similar focus. There is also significant cross over in that many advice clients with mental health issues also access advocacy support. We work closely with the Mental Health Unit in particular and are co-located to facilitate this.

You can find out more about our wider organisation here: <https://citizensadvicesheffield.org.uk/get-involved/>

Executive Summary

Four years since the implementation of the Care Act 2014 including its Advocacy provisions, it is timely to consider our evolving practice in this area. This report seeks to set out the position in Sheffield, identify emerging best practice and agree common approaches with all involved including commissioners.

There is a need for **Awareness raising of the duty to refer**, and when this arises is an important function of the advocacy service to support and offer guidance. Without this, progress is unlikely to be made. This appears to be particularly crucial for those in **Transition** and **Young Carers** where few referrals are being made locally and perhaps more widely.

Referral categories that are too rigid are likely to exclude individuals with a statutory entitlement to advocacy support and lead to delay and inadvertent breach of the law. **An inclusive approach to initial referrals** is recommended.

Advocacy under the Care Act is subject to the limitations of Adult Social Care and related services themselves. It can hinder the effectiveness of all if different services - eg adult social care and local health and social care trusts – adopt different approaches to the same duties. Budget cuts for adult social care can increase the advocacy time/cost across cases.

The lack of **parity for mental health** is clear in social care issues as it is in health issues, with people falling through the gaps between services.

Work under the Care Act is both complicated and complex – local policies and procedures mix with the law, and people with substantial difficulty in navigating these – even before considering practice issues. It is necessarily time consuming in many cases, and this is largely unavoidable.

There are real problems around the practical use and value of **Care Act reports** and these are only as good as local escalation procedures in the absence of a formal appeal mechanism. **Social Care complaints** are an area of contention and need.

There are many areas that require further work – the boundaries of the role, the relationship with financial assessments and direct payments, the relationship with education and similar areas. These require further conversation and development.

Introduction

Sheffield Advocacy Hub is a partnership between Citizens Advice Sheffield, Cloverleaf Advocacy and Disability Sheffield. Together we provide statutory advocacy services for adults in Sheffield, alongside other advocacy services for adults and children.

This project arose out of a need to address new questions arising from the development of independent advocacy under the Care Act 2014. We felt it was timely to review the local implementation of the new provision from an advocate's point of view.

The aims of the project were:

- To examine the role as it has developed in Sheffield;
- To examine the nature of relationships between advocates, our clients, and professionals;
- To identify the boundaries of the role;
- To make recommendations for practice guidance for advocacy under the Care Act and more widely.

Methodology

In order to do this, we set up a working party with participants from each partner organisation with experience in a range of types of advocacy, as well as work carried out under the Care Act role.

Eight advocates participated, meeting monthly between November 2018 and February 2019 and focusing on a number of areas through the project drawing on case stories and experiences of the work to identify issues arising. Meetings focused on:

In 2017-18, we supported 221 people in relation to social care processes. In 2018-19, we supported 294 people – however 98 of these were in the final quarter, and the rate of referral is increasing.

This type of advocacy accounted for 14% of our total referrals in 2018-19, but 27% of our advocates' casework time.

The average time for cases in both 2017-18 and 2018-19 is consistent at 31 hours, higher than any other type of advocacy. Some cases are very brief, but the most complex can continue for months and even years.

- Case examples – identifying themes of what goes well, what goes less well;
- Where does casework begin and end, including a timeline, recording requirements and exceptions?
- How far to go within casework, including boundaries of the role, working with professionals, what client support looks like and exceptions?
- Can we identify standard factors for all cases, what should they look like and are any additional resources required?

Findings

1. Referrals – how do people access advocacy support?

Awareness of the duty to refer

We have been concerned about the low levels of referrals under the Care Act and advocates discussed ways of increasing these to ensure that professionals are considering advocacy support at first contact with the local authority, as is required by the Care Act. We have discussed this with the Commissioner on an ongoing basis.

Actions Taken:

This has been discussed with Adult Social Care and a briefing session arranged with the First Contact team. Further sessions will be arranged with Locality teams to ensure wider awareness of when a referral is required under the Care Act and other types of advocacy support which may be required or appropriate.

We are seeing increasing levels of referrals in response to this ongoing work.

Adequate information

Referrals often lack enough information to enable effective triage. Sometimes key information such as communication needs is not included. In addition, professionals are often unsure of what type of advocacy is required in a given situation, and as such what information is relevant to the referral.

Actions Taken:

We have combined our referral forms for professionals into one form, to gather all of the relevant information to enable our staff to ascertain eligibility and urgency. We have also devised call handling forms to prompt staff taking telephone referrals to ask relevant questions to gather all of the required information.

Referral categories

The Care Act 2014 details 9 social care processes where an advocate would be required if the person meets the substantial difficulty criteria and there is no one appropriate to support the person to be fully involved. These are:

- Care Needs Assessment
- Care & Support Planning

Care Review
Child's Needs Assessment
Carer's Assessment
Young Carer's Assessment
Child's Carer's Assessment
Safeguarding Enquiry
Safeguarding Adult Review

Retrospective referrals

A significant number of referrals have been made retrospectively, for example when a needs assessment has already been carried out. In some cases, this reflects a lack of understanding of referral criteria and in others it is only becoming clear that an advocate is required a significant way into the process.

Question

Should an advocate request that a meeting or process be repeated under these circumstances to allow the person to participate with advocacy support, or should this be done simply using the paperwork produced?

Suggestion

This to be considered on a case by case basis, particularly taking into account the client's views where these can be known.

Action taken

A pilot period has been agreed with adult social care to enable referrals to be made much earlier in the process, alongside training as detailed below. This should reduce the number of occasions where this occurs.

Multiple Areas

Advocates noted that in practice, one referral can cover several of these areas with a single referral commencing as a needs assessment but also including safeguarding, care and support planning and the financial assessment. This means that referral data does not accurately capture the range of work being carried out. It can also then be challenging to maintain appropriate boundaries around the work and explain these clearly to the client which impacts on the client's understanding of the role and their ability to instruct the advocate.

Proposals:

- Separate referrals to be logged when new issues arise. As it would seem unnecessarily bureaucratic to require new referral forms from professionals, the proposal is that advocates would log a new referral when a new issue (eg safeguarding enquiry) arises
- Alternatively, a broad approach to work under the Care Act could be taken which encompasses advocacy support to address any arising social care issues within an 'episode' of support. The disadvantage of this route is that an 'episode' (ie one case) may last for many months, and other issues are likely to arise over this time

Action to be taken:

To be discussed with the Commissioner; current practice is the second of the two options above, however this does not capture the breadth and complexity of the work in a way which can be easily reported in monitoring processes.

Referrals and allocation of care manager/social worker

In some cases, referrals have been made before a worker has been allocated to a case.

Agreed:

Such referrals should be accepted, not least because it is not always possible to allocate an advocate to a new referral immediately. To do otherwise would leave the person with no support to follow up any delays in allocating a care manager or social worker.

Action taken:

These referrals are accepted.

Difficulties Accessing Adult Social Care

We have come across a number of clients in other areas of advocacy or who contact us directly who are having difficulty in accessing Adult Social Care to obtain an assessment of their needs. There is no formal referral under the Care Act for these clients at this stage.

Action taken:

We are discussing this with our Commissioner, and accepting these informal referrals to provide advocacy support in accessing Adult Social Care. Once accepted by Adult Social Care, a formal referral is requested.

Transition work and work with young carers

Very few referrals have been received for under 18s and it is clear further work is required to ensure that services are referring for advocacy support in these cases.

Action taken:

We are discussing this with the Commissioner, and also participating in the new National advocacy standards - Expert Advisory Group coordinated by [Article 39](#).

2. Casework Process Issues

Understanding of the role

Professionals do not appear to understand the role of the advocate, and ask advocates to complete tasks that are outside of the role.

On some occasions, referrers have made it clear that they have made the referral because they have been told to do so, and that they do not understand why an advocate is required or do not want an advocate to be involved. This can make it very difficult for the advocate to establish a constructive working relationship with the professional on behalf of the client and lead to delays in progress as the professional does not respond to contacts from the advocate.

Suggestion:

- Awareness sessions for professionals to include information on what to expect working with an advocate and what is included in the role.
- The advocate discusses and agrees the expectations and boundaries of the role clearly with the referrer before work commences.
- Where appropriate or if there is any dispute between the advocate and the client, or the advocate/client and the professional, a formal action plan could be agreed in writing (in an accessible format for the client).

Action Taken:

The Advocacy Hub will provide further training to Locality teams within adult social care to ensure a wider understanding of the role. This is to take place in 2019.

Advocates will attempt to set out clear expectations not just with people they are supporting, but also with professionals involved early in the casework.

Changes to practice

There was evidence that some advocates were not aware of changes to safeguarding practice under the Care Act and Making Safeguarding Personal. Professionals have asked advocates what outcomes clients are seeking in particular cases, and concern was expressed that the advocate was being put in the role of a decision maker.

Action taken:

All advocates have now received updated Safeguarding training including the centrality of the client's desired outcomes and the advocate's potential key role in identifying these.

Differences of approach

We found that practice within the city varied considerably between different organisations such as Sheffield City Council and Sheffield Health and Social Care Trust (SHSCT), and also between different roles for example care managers vs social workers.

It was noted that staff from SHSCT appear to have less knowledge of their duties under the Care Act in relation to advocacy and also that advocates spend more time chasing up actions and progress on behalf of clients in these cases. Advocates often find themselves having to explain the duty to refer to staff from SHSCT when this arises in existing casework such as mental health advocacy.

Suggestions

- Joint work between adult social care and SHSCT could begin to address some of the differences of approach
- Training on advocacy under the Care Act can be provided to SHSCT staff. This has been planned since late 2017 but has yet to take place.

Action taken:

The Hub is following up with the organiser of the training for SHSCT staff.

Falling through the gaps

Advocates noted particular difficulties in cases where the client has both social care or physical health and mental health needs. One example was given where a client's mental health declined during the course of the casework, and the local authority social worker made a referral to SHSCT and then closed the case.

However the mental health social worker declined to accept the referral, as it was deemed that the needs were primarily related to physical health. The advocate was left in the position of supporting the client through a process that had come to an abrupt halt. This left two choices – to cease involvement on the basis that there

was no social care process underway (technically, this was correct under the Care Act) or continue to support the client to seek access to the care and support that was required (which was very time consuming and related more to a dispute between services than the client's needs).

Action Taken:

Advocates will continue to support clients who find themselves in this situation, as it is clear the person would continue to appear to have eligible needs under the Care Act. The role would be to advocate for re-engagement from the local authority and relevant others to properly assess and meet the client's eligible needs.

Complexity and complication

Advocates noted that initial training had portrayed the role as very boundaried, for example support before a meeting, attending the meeting and a debrief afterwards. In practice, this is rarely the reality as the work can be both complex and complicated. Complexities arise from the nature of supporting people who, by definition, have substantial difficulty in being fully involved in the processes involved and from those processes themselves. Complications arise as casework inevitably takes time and new circumstances emerge such as a change in the care needs or health of the person, or a change of personnel such as the social worker or care manager involved.

This is reflected in our records which show that on average, Care Act casework lasts around 32 hours per client. This includes some very brief work and a small number of cases which can take several hundred hours of work and last for over a year.

Family Involvement

Advocates reported that cases where there are family involved can be extremely complex and time consuming. Where the person has declined family to act as an appropriate person, or family members themselves have declined, an advocate can find themselves being pressured by vocal family members who may agree or disagree with what the client wants, but who expect the advocate to put forward their views. This can be very difficult for advocates to manage not least in terms of how time consuming it can be, and especially so in cases where the person themselves is unable to express a view or is being influenced by family views.

Recommendation

It was noted that in some areas there is a separate advocacy role to support families in these situations, outside of formal support for Carers, which can enable both the person and family to be supported and represented in social care processes. The Commissioner to be asked to consider this.

Practical actions

Advocates gave examples of situations where an apparently simple issue could be followed up by the advocate taking a practical action to resolve it. One example given was of a mistake in the delivery of a wheelchair which the advocate could follow up on behalf of the client.

Recommendation

It was agreed that it was not appropriate for advocates to become involved in practical actions as these are outside of the advocacy role. The advocate's role in general, would be to assist the client (if this is required) to raise the issue with the care manager/social worker.

Although it may be more time consuming, not less, to raise such issues with care managers, it was clear it would confuse the advocacy role if advocates took on such practical actions directly. In addition, it may mask gaps in services if advocates take on these tasks.

It was also noted that in some cases, such practical action might fall within the remit of the organisation – for example, Disability Sheffield has volunteers who can assist with some practical matters. This does not mean actions can be carried out by advocates.

Direct Payments – gap in services

A further gap was identified around Direct Payments. An advocate supported a client through the social care process and the financial assessment which lead to direct payments being agreed. However the social worker involved was clear that direct payments were outside of their role. As this clearly falls outside of the advocacy role, there is a clear gap in this area for support for clients who are unable to manage direct payments without assistance. We have seen some care packages break down in this scenario. This has then required additional input such as early reviews with further advocacy support.

Recommendation

The Commissioner to consider appropriate support for people requiring it to manage direct payments.

Delays and Escalation

Advocates noted that there were often delays in care planning or plans being put into place, that when these were followed up care managers would offer reassurance however the delays continued. Advocates were unsure of when and how to escalate concerns, whether those of the client or the advocate

Action taken

The Hub now has a clear route for escalating concerns

Boundaries of work with under 18s – interaction with the Children Act 2004

Difficult issues arise for under 18s around the boundaries of the role. Some advocates have attended Section 17 Child in Need meetings and noted that whilst some of the content is not relevant, much of it directly relates to social care needs. It is not clear whether attending such meetings – which may well involve the child and their social worker – fall under the remit of the role.

Recommendation

To discuss with the Commissioner and agree a way forward

Education issues

Issues can arise in relation to education, and Education Health and Care Plans for our clients. It is not clear to what degree an advocate under the Care Act can support the person in pursuing issues or making complaints in these areas. There is no clear separation in practice as a particular issue which is being addressed under the Care Act may also relate directly to education.

In general, advocates felt it was the role of the care manager or social worker to resolve issues in relation to education and not that of the advocate.

Recommendation

To discuss with the Commissioner and agree a way forward

3. Concerns, Challenges and Complaints

Advocates use informal means of addressing issues, such as raising concerns on behalf of the person or requesting work be carried out again, for example where a person believes a needs assessment did not properly take into account all of their eligible needs.

Formally, Care Act reports and complaints are used, and advocates use the Look Again process where a client wishes to pursue this option. An advocate may properly support a client with these processes under the Care Act 2014. However it is less clear whether or not an advocate acting in this role can support a client to take a complaint beyond local resolution to the Local Government Ombudsman. [A report from the LGO in July 2017](#) recommended that access to independent advocacy for support with social care complaints be provided equivalent to the existing NHS Complaints Advocacy services. This does not answer the question as the latter is not restricted to those who would have 'substantial difficulty' and no appropriate person.

Recommendation

That the Commissioner consider whether or not Advocacy under the Care Act 2014 should include support to complain to the Local Government Ombudsman. We believe that it should.

Care Act Reports

7.50 There will be times when an advocate will have concerns about how the local authority has acted or what decision has been made or what outcome is proposed. The advocate must write a report outlining their concerns for the local authority. The local authority should convene a meeting with the advocate to consider the concerns and provide a written response to the advocate following the meeting.

Care Act 2014

Where a client can instruct the advocate, and the client is dissatisfied with 'how the local authority has acted', the Care Act requires that a report should be submitted to the local authority, and a meeting then convened. However advocates have found that it is unclear when such a report should be written (the client may raise numerous concerns during the process including for instance when first contacting

adult social care, during or at the end of a care assessment and planning process) and clients and advocates do not often receive responses to reports.

7.51 Where the individual does not have capacity, or is not otherwise able, to challenge a decision, the advocate must challenge any decision where they believe the decision is inconsistent with the local authority's duty to promote the individual's wellbeing.

In our non-instructed work the advocate works to gather as much information as possible about the client's wishes and feelings, beliefs and values, past and present in order to inform the process. The Care Act also requires the advocate to make a judgement about whether the local authority is promoting the individual's wellbeing. This can be a very difficult judgement to make, and it is once again unclear when this judgement should be applied. Advocates only do so after careful consideration, and usually after consultation with colleagues. We have found that advocates are often challenged for taking such action on behalf of clients unable to instruct.

Actions taken

We have discussed the lack of responses with a senior manager of adult social care, and agreed clear escalation routes in this situation. However further work is also needed on a national basis to provide more guidance about when to write a report, what should be included, and what response should be expected.

4. Closing Casework

When does the role end?

Advocates felt it was often very unclear when work on a case should end, particularly where the client was not happy with the outcome.

How far should an advocate pursue issues on behalf of a client? What about when a care manager has considered all of the available options, put in place care as deemed appropriate, but the person is not happy with this? Or when the response is that there is no suitable care available which can meet the client's needs? Or when a care package which would meet the need is seen as unaffordable by the client leaving them at risk?

Advocates agreed that where care and support arrangements have been made and put into operation, cases should be kept open for six weeks during which time the advocate would not actively carry out casework. At the end of the six weeks the advocate would contact the client to find out whether the client is happy with the arrangements and if so, close the case. If not, then the advocate would support the client to raise any concerns or issues.

In some cases, a '12 week review' is now being put in place. In these cases the advocate would need to hold the case in order to effectively support the client to participate in the review.

Advocates agreed that a final debriefing session with the client is important, to ensure the client understands that the role is coming to an end, and what to do if further issues arise which may require advocacy support. This would also include signposting to other appropriate services if not already done. It should also include informing the client on how to provide feedback about the advocacy provided. Where a client was not able to instruct or comment on the process the advocate's questions would be more general.

Advocates agreed that it was important to reflect on casework as part of the closing process, to identify learning and lessons for use in other cases and to share with colleagues. This could be documented on the advocate's profile on the case recording system, and discussed in supervision sessions.

Recommendation

Clear case closing procedure for casework to be provided for advocates, for use in Care Act and other types of advocacy.

Outcome Measurements

Outcomes are a longstanding question in advocacy work, as not only is the bulk of such information entirely qualitative and subjective, it is also very difficult to ascertain the cause of any change. Advocates are by definition assisting people in their journey through the health and social care system, so it becomes very difficult to ascertain whether any changes – positive or negative – are a result of advocacy input, or a result of input from health and social care colleagues or indeed unrelated to either.

Work has been carried out to ascertain best practice in reports such as that of the [National Development Trust for Inclusion](#) (2016). In the longer term, using the toolkit provided by NDTi and applying it to this work would appear to be the most appropriate option. This framework includes four areas, outcomes for the individual, changes to the health and social care sector, changes for the wider community and changes to the advocacy service.

Colleagues from Cloverleaf Advocacy focus on one key area central to the advocacy role which cuts through some of this – asking the client ‘how included do you feel in decision making?’ This is an example of how to record some of the information relating to individuals and could be used as part of a wider strategy.

Citizens Advice Sheffield is also more widely exploring the use of storytelling in gathering information from clients, volunteers and staff. The richness of these methods is beginning to be more widely recognised and integrated into approaches such as Ux design (User experience) processes. We believe there is much to be learned from these approaches when considering the approach to outcomes in general. We are also fortunate to have significant local initiatives including [Storying Sheffield](#).

Recommendation

Sheffield Advocacy Hub to develop a full model for measuring outcomes and to consider using the NDTi framework. This is a significant piece of work which will pull together

information already collected routinely, alongside changes to procedures and to practice itself. This is wider than our Care Act related work in itself.

5. Common recording requirements for all Casework

1. Clear and full information at the time of referral, including:
 - the reasons for the referral
 - the client's communication needs
 - any accessibility issues for the client and for advocates
 - any risk issues relevant to the advocate's work with the client
 - clear information on any urgent issues for accurate triage
2. A record that the Sheffield Advocacy Hub Privacy Policy has been explained to the client at the start of the work, or that the client lacks the capacity to understand the policy.
3. An advocacy agreement, including where relevant consent to share information with third parties in the course of advocacy work. Consent to be specific in line with the requirements of the Data Protection Act 2018.
4. An invitation to the client to provide feedback on the advocacy provided, at any point during the process via our partners Care Opinion (or directly to the advocate).
5. Information on how to make a complaint about the service.
6. Case notes in accordance with good practice in case recording and compliant with the Data Protection Act 2018.
7. A case summary to be maintained with a brief outline of the case and next actions to enable other staff to take over the case in the event that the advocate is absent from work.
8. Relevant documents obtained on behalf of or from the client to be attached to the client record.
9. Outcomes to be recorded as part of the case record, and in other ways once this has been developed.
10. A case closure note to include a reflection on the case and any learning gained.

Conclusions

Any new area of advocacy will also raise new challenges, particularly about how the role is carried out on the ground, and how it relates to health and social care organisations and systems.

This is particularly so when the whole area of law is also new, as in the case of the Care Act 2014. In the context of the financial constraints faced by local authorities with reduced budgets at a time of increasing demand, the difficulties are greater still.

This report has highlighted that there is a great deal that has already been achieved locally and that there is more work to do in liaison with both the people we support and with health and social care providers.

Although this report is based on our experience in Sheffield, we also recognise that the same kinds of issues will be arising across the country, and with that in mind our next step will be to share our work with other advocacy providers in similar cities with a view to developing best practice.

Tell us what you think of our service

***and* what you think of the health or care
services supporting you**



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Citizens Advice Sheffield is a charity.

We provide free, confidential, independent and impartial advice and advocacy.

Our service is provided digitally, by phone and in person.

As this report shows, many of the people we help are among the most vulnerable and disadvantaged in Sheffield.

We are supported by over 40 funders.

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Would you be willing to support us?

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Citizens Advice Sheffield is the operating name of Sheffield Citizens Advice and Law Centre