Older People's Advocacy Alliance (OPAAL) UK

Making a Real Difference

A full report of the national development project

October 2003 to September 2006

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Project funded by the Department of Health

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Contents

Page

Section Five:

Section Six:

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Printed by Prontaprint, Hanley

Section One:

The development of the OPAAL Section 64 national development project

1. Introduction

In 2003 Section 64 funding was awarded by the Department of Health to carry out a 3-year development plan to implement OPAAL's stated aims, and a development officer was appointed in October 2003. Although OPAAL itself aims to work across the United Kingdom, the nature of the funding means that the development project addresses England specifically.

The role of the national development officer was to ensure a firm connection between the core activities of providing a strategic lead on good practice and supporting and servicing the needs of its membership. Advocacy providers were to be confident of a supportive strategic body. OPAAL was to contribute to significant changes in the public and policy perception of advocacy with older people. It was intended that services would be more effective and accountable and their practice better understood. More organisations were to be hosting or supporting independent advocacy providers, who were to be directly responsible for their own management arrangements. There was to be progress towards advocacy being established as a human right for older people.

The immediate aims of the development project, therefore, were to:

> Promote independent advocacy with older people
> Contribute to the development of standards
> Improve access to advocacy for older people
> Develop better practice in the field
> Build the involvement of older people in the organisation
> Develop links with minority ethnic communities

This report will consider the project aims and examine the work that was carried out to address them.

2. How the project operated: recruitment and home-working

From the outset OPAAL management committee members have demonstrated strong equal opportunity values in the way that the project has been managed. This has been demonstrated as follows:

> National advertising for recruitment
> A commitment to supporting home-working for the paid officer
> A strong commitment to accepting staff from within or outside London, and from rural areas
> Apportioning time and costs for travel and distance working
> A robust system of information technology which facilitated the application of distance-working

Taking each point at a time, there are advantages and disadvantages to this approach.

2.1 National advertising for recruitment

Advantages:

This is now a largely standard procedure within the voluntary sector, ensuring a fair selection of candidate and the most appropriate selection.

Disadvantages:

The administration required to apply national recruitment procedures within a small charity can be daunting. The process relies on a voluntary management committee, and a small selection team. There is likely to be a large number of applicants, and a tight time-scale for processing applications.

However, it is obviously preferable to encourage a wide circle of applicants, and to demonstrate good practice and a commitment to equal opportunity based on suitability for the post.

2.2 A commitment to supporting home-working for the paid officer

Advantages:

There are advantages to working from home.

> The post-holder is able to organise their time more effectively without the additional demand of travel to work.
> Home-working fits around domestic requirements, and can adapt to special needs which are likely to be in place already.
> The effectiveness of electronic working is an added bonus.
> It can be easier to focus on work without the added distraction of colleagues, noise or office bustle, etc.
> Office costs are kept to a minimum with no office rental costs, although this is offset to an extent by greater travel and subsistence expenses.

On the whole, working from home is a more relaxed way of working, particularly during peak times in the job, when pressure is building. The availability of excellent administrative and financial system back-up, in OPAAL's case, from the Beth Johnson Foundation has been a genuine asset to the way home-working has been able to operate.

Disadvantages:

> Home working requires a big commitment from the post-holder, and an ability to be self-motivated to a greater degree than would probably be required in an office environment.
> It can be difficult to apply oneself, and a good deal of motivation is needed to ensure there is no procrastination.
> On the other hand, it is equally difficult to switch off from work, without the boundary that occurs naturally in the transition from office to home and home to office.
> Telephone calls can be out of hours, the work computer is always available, and it requires a good deal of self-discipline not to deal with an enquiry or complete a report during a weekend, for example.
> Dedicated workspace is needed if work is not to encroach on home life, which might not be suitable for anyone with a busy family life.
> There is a danger that visitors or family assume you are available because you are always at home, and there have been many occasions when firmness has been required to make the point that office hours do not clash with visiting times.
> At times it would be helpful to have a colleague with whom to mull over an idea or check out progress on an issue, but when working from home this is not an option. Fortunately in this Section 64 project, the post-holder has had the availability of a supportive management committee, but there have been occasions when time has been wasted simply by starting down a wrong track, or misunderstanding a requirement.

In summary, on balance home-working is to be recommended because it offers more flexibility, but it does require greater self-motivation than might otherwise be expected. Care must be taken to monitor and control the workflow, and regular good supervision sessions are an absolute necessity to check out the work direction.

Thanks must be extended to the Beth Johnson Foundation for their excellent and efficient assistance throughout the life of the project, without which home-working could have met problems, in administration, electronic systems, financial management and mentoring support. Recognition should also be given to the OPAAL management committee for their ongoing support to the development officer, without which the project could have had a very different outcome.

2.3 A strong commitment to accepting staff from within or outside London, and from rural areas

The post was advertised in a national newspaper and candidates were short-listed from all over England. This offered the opportunity from suitably experienced and/or qualified individuals to contribute to the national advocacy scene from anywhere in the country, which is unusual for this type of national post. The opportunity to work from home, together with an acceptance that the development officer might be a long distance from the national 'policy-making' centre, demonstrates a diversity of thought on the part of the management committee, and in practical terms, a recognition within the budget that high travel costs would need to be allowed for.

Advantages:

> A ready acceptance from advocacy scheme managers who work in a rural setting, that not all development work depends on a central city base
> A greater understanding of the problems that arise from distance-working and rurality
> A good example of the practicality of electronic working and good communications, without the need to meet face to face

Disadvantages:

> The frustration of not being at the centre of policy development
> The need to make greater effort to ensure that communication is maintained
> Very high travel and subsistence costs to the organisation
> Much time is spent in travel rather than working from the home office

Considerable support was offered by advocacy schemes in parts of England other than London, simply because OPAAL is not based in London. There is a common conception that people working in a London environment do not appreciate the challenges particular to the rest of England, such as rurality, distance, and isolation. It was certainly the case that advocacy managers considered that OPAAL could relate to their difficulties because of being based in a rural area and outside London.

In conclusion, the willingness of schemes both inside and outside London to accept the development officer is an indication that both settings found it easy to work in this way. In some cases, it was the first link to have been established with advocacy schemes that are rural-based, and this was much appreciated by them.

2.4 Apportioning time and costs for travel and distance working

This way of distance and home-working is only possible if there is sufficient money in the budget to cover the additional costs. Extensive travel is very time-consuming, requiring good planning and prioritising to balance office and home, and it is difficult to amend a budget appropriately once the project has started.

Advantages:

> Travel offers a good insight into why advocacy schemes work in the way that they do, and to see what sort of facilities are available in the different regions
> Travel offers the opportunity to meet people who otherwise would not leave their own region or town, often applicable to older people themselves
> Travel offers an additional dimension to the job, and a good opportunity to compare and contrast

Disadvantages:

> If the budget is too small, restriction on travel requires extensive prioritisation and restrictions on the work that can be carried out
> There is a heavy reliance on public transport, whether air or rail travel, which can lead to delays and time-wasting
> Travel is tiring, and this needs to be taken into account at all times. Too much travel can lead to inefficiency and a lack of concentration

However large or small the budget, travel within the post needs careful planning and organisation. Whilst it adds to the dimension of the job, it is also tiring and can be monotonous. In summary, therefore, it is essential that there is enough in the budget to sustain ongoing travel, but this should also be balanced with a good electronic communication system, and the use of new methods like tele-conferencing. Any travel needs to be justified as appropriate to the post in question.

2.5 A robust system of information technology which facilitated the application of distance-working

Electronic communication (e-mail) was without doubt the mainstay of the development officer's post. It was noticeable that in 2003 when the post started, many advocacy schemes did not have e-mail, or if they did, many were reluctant to use it on a regular basis. Many managers saw e-mail as a 'frivolous' way of working. This changed throughout the course of the 3-year post. By the end of the project, nearly all advocacy schemes had become used to working electronically, and much more communication was done in this way. It had become more normal to suggest that face-to-face meetings were not necessary, and that group e-mails would suffice. In addition, more and more older people were also becoming used to the use of information technology, but it has to be borne in mind that there needs to be ongoing provision for older people who are not used to computers, particularly if OPAAL is to progress in its efforts to include as many older people as possible in future development work.

The website offers a good opportunity to showcase the organisation, but will only be as good as the information that is put into it.

Advantages:

> Electronic messaging offers instant communication which can be picked up wherever needed, and to suit the recipient
> Websites offer a good opportunity to advertise current and future activity
> Group e-mails can be as effective as face-to-face meetings, thus saving much travel time
> E-mails are cheap, quick and reliable, and keep a permanent record of conversations, which is not possible by telephone. Storage is easier to manage without many volumes of paper to store
> The internet offers an opportunity to interlink with other appropriate and relevant organisations, thus spreading knowledge to interested parties

Disadvantages:

> Not everyone is computer literate and important links could be left out of regular communication and planning
> Website development is time-consuming and requires specialist expertise. If a website is out-of-date, it is unlikely it will be revisited.
> Information technology can, and does, break down, which can lead to loss of stored documents and records.
> People who might need advocacy services can also be housebound, which makes access to any information technology impossible
> There is often a misconception that everyone is kept informed, whilst it is very easy to omit important contacts

In conclusion, information technology is a huge advance in the way communication is possible. The development officer's job would not be possible without the use of internet and e-mail, for example, and communications would be slower, more expensive and less reliable. However, there needs to be constant awareness that not everyone has internet access, and that some people can feel excluded because they are not in the loop of electronic mailing, through no fault of their own. As long as a perspective is maintained, the use of information technology is a great advance on the way organisations used to work, with improved communication, and cheaper, quicker links to anywhere in the UK or worldwide.

3. How the project operated: governance

The OPAAL members elect a management committee on an annual basis. The committee meets four or five times a year, and during the lifetime of this programme held one away-day. A business sub-committee has met consistently but infrequently. The organisation's business plan, although in draft form, has twice been revised, and is currently undergoing further review.

The development officer had input from an on-line development support group in 2004/2005. Operational management fell to the Chair, who provided supervision on a quarterly basis, contributing full appraisals at six months, one year, and two years. This co-development model can be judged to have been relatively successful but it has been a logistical challenge to keep all trustees fully informed and engaged with strategic development. As a result OPAAL has now given more management responsibilities to the new national project manager and is currently reviewing its governance.

4. Regional development programme and subsequent aims:

As part of the national development programme, a series of meetings took place throughout England in 2004 to hold discussion groups with advocacy schemes and older individuals. The aim of the meetings was to determine the availability of advocacy services for older people and to assess the current training and standards systems in use, in line with the aims of the OPAAL national programme.

Over 100 advocacy schemes and older individuals participated in the meetings, which included both generic and specialist advocacy providers. There were four topics for discussion, which were:

> Guidance on good practice and examples of quality frameworks
> Evidence basis for advocacy
> Case for independent advocacy for older people as a right and examples of older people's involvement in the promotion of independent advocacy
> Funding sources

A summary of the meetings are attached in Appendix 1 of this report.

The final recommendations to the whole report considered the need for more effective partnership working, within the advocacy field and with external organisations. There were 6 major recommendations:

a) Development of better working standards to a national identification

b) Development of common statistical recording methods, which ultimately could be collated by one national organisation and used to the benefit of all schemes

c) Common policies and procedures within all schemes, without diminishing the independence of each individual scheme

d) A greater involvement at local, regional and national levels in decision-making boards, to raise the awareness of advocacy and its effectiveness

e) National evidence of Best Value

f) More effective partnership working, both internally and externally

The full version of the report 'Advocacy: who cares for older people' can be found on the OPAAL website www.opaal.org.uk

4.1 Responding to the recommendations

It was decided in the early spring of 2005 to proceed with the following responses:

a) Develop OPAAL recommendations for policy and procedures for advocacy schemes

b) Develop a project to consider the views of older users' of advocacy

c) Develop more advocacy provision in the south-west of England, which had shown up as the region least served for advocacy

d) Continue with networking

e) Carry out a benchmarking exercise to ascertain exactly what advocacy schemes offer and how this might be developed

4.2 Input from the OPAAL evaluation

OPAAL asked the Older People's Programme at Help and Care to evaluate the national development programme. An evaluation sub-committee has met regularly with the evaluators, Meena Patel, and Helen Bowers.

OPAAL has given a high priority to the evaluation, which will be published in the late autumn of 2006. There have been three reports so far, all developed around direct contact with the organisation's membership. First came a baseline survey, reporting in April 2005, followed by two small regional studies, and an exit survey asking members what they had gained.

The evaluation has particularly influenced the Big Lottery funded programme with its emphasis on working with commissioners. However, the baseline survey was influential in three ways. It helped focus the benchmarking programme around the social policy contribution of independent advocacy. It prompted OPAAL to consult its membership with respect to a standard for independence. It contributed to the decision to focus a part of the development programme on the involvement of older advocacy users.

4.3 How these programmes worked out in practice: brief overview

These five programmes were a very big commitment for one person to undertake, particularly given the time restraints on the development project as a whole. As an overview, the development officer was barely able to scratch the surface of the work that was needed. Any one of these five programmes had the potential to become projects in their own right, for a much longer term development than was available.

However, having said that, it was certainly possible to establish a starting point for each programme, and a base-line from which to develop further work.

This is further explained for each programme as follows:

One: Develop OPAAL recommendations for policy and procedures for advocacy schemes

It was established that nationally there was much work going on around this, and there was a danger that additional work could duplicate existing developments, leading to confusion.

OPAAL took a view that it was better to link in to existing development work, through the networking process, to contribute where possible, and to gain an overview of how work was progressing. This was particularly relevant for the Age Concern Quality Framework development, in which OPAAL took an active role, with the development officer and three management committee members taking the lead and attending steering group sessions.

At the 2005 AGM, OPAAL made a commitment to develop a policy on independence, and a questionnaire was included in the December 2005 newsletter. The response was poor (see results included in this report). But a draft independence policy was written on the basis of the responses, and related to the published Age Concern Quality Framework, for discussion and approval or amendment at the 2006 AGM.

> ***Recommendation One:***
> Further research and work could be done to develop advocacy standards which are particularly relevant to older people, care home application and dementia advocacy**.**

Two: Develop a project to consider the views of older users of advocacy

The inclusion of older people is key to all OPAAL work and development, so this programme had particular relevance. OPAAL had previously been asked by funders and commissioners, for example, ‘How do we know that advocacy makes a difference?’, so this particular programme set out to gather evidence around the question.

Because this was specific work, OPAAL felt that it would benefit from working within a defined region rather than England-wide. For this reason, an independent consultant was appointed with experience and strong connections throughout London. London was selected because it was possible to identify older people from

various advocacy centres who would not otherwise have met each other, and who thus were independent of each other.

The results of this work are documented in 'A Voice That Wasn't Speaking' (Chapter 9). As a result of time and budget constraints, the programme was not able to do more than a small initial survey. Older people felt valued in being consulted, and agreed that, in specific circumstances, a network of older users of advocacy could be beneficial.

> ***Recommendation Two:***
> OPAAL has agreed that this work is taken forward, and that additional development work is progressed to include the formation of a users' network in London. It is recommended that OPAAL use the existing format to pilot the work in regions other than London, so that eventually there is a comprehensive documentation about the value of independent advocacy and how advocacy intervention might have made a difference to older peoples' lives.

Three: Develop more advocacy provision in the South West of England, which had shown up as the region least served for advocacy

This work was initiated at a late stage of the development project. It was therefore not possible, given the other time demands on the development officer, to attempt more than an almost cursory look at how advocacy could be developed in the south-west, which is a vast region and an ambitious undertaking. For example, letters were written to relevant contacts throughout Devon, but when no replies were received, no follow up work was carried out, simply because of a lack of time. This is clearly not a satisfactory way to attempt advocacy development. Cornwall, on the other hand, offered a good response and enthusiasm to develop advocacy into care homes. However, the problem here was one of funding, which again takes time to achieve.

The two responses were interesting, however, in their differences, even if the ultimate result was not so positive. Devon and Cornwall gave a good indication of differing interests and priorities, and lessons can be learnt from these initial approaches. In development work, there is a need to present the reticent local authorities with conclusive evidence that older people's advocacy can, and does, make a difference, both to build enthusiasm, and to gain momentum. Cornwall was more successful because managers within Cornwall Care were prepared to promote both the involvement of older people and independent advocacy.

Further work is needed in the south-west, and OPAAL is committed to development of advocacy in the region. It is such a large region, only one County or part of a

County should be the focus of any development. Devon, for example, is much too large to attempt one development throughout the whole County, and barriers to travel in rural areas could be one reason for the negative response so far.

Recommendation 3:
Future work should focus on the development of a strong steering group which has commitment and drive to push the project forward even if there is a negative response. It needs to be owned by the relevant steering group, who should be responsible for funding applications, and all development planning. OPAAL does not have the resources to do more than offer expertise and networking links. Unless such a steering group is established, OPAAL feels it is unlikely that future advocacy development will succeed.

Four: Continue with networking

Networking has been the mainstay of the whole of the development project. (See Chapter 6) The outcome of networking is that OPAAL has been able to:

> keep abreast of existing and planned developments in other areas of place and interest
> encourage relevant individuals to join the OPAAL management committee and/or sub-committees
> maintain a good knowledge of the political environment
> promote advocacy
> promote the inclusion of older people in policy developments

With only one full-time paid officer, OPAAL could not possibly gain this knowledge without active networking. The planned development of a national working group is now the key outcome of the last three years' work.

Recommendation 4:
OPAAL should continue to network as much as possible, but should ensure that all meetings, conferences, seminars and training are specific to the aims of the OPAAL business plan and funding requirement. This will mean ongoing prioritising of workload, which is inevitable for any national officer.

Five: Carry out a benchmarking exercise to ascertain exactly what advocacy schemes offer and how this might be developed

This is another example of the shortage of resources, which meant that the benchmarking exercise was only able to establish a small survey within a national setting. Whilst invitations to participate were sent to a wide selection of advocacy scheme managers, only eleven volunteered to take part. Because of the shortage of resources, this was not followed up to encourage more participation, and it was accepted that OPAAL should continue with a small sample. During the course of the work, several schemes dropped out, with valid reasons, and fewer baseline examples were submitted.

However, the results that eventually emerged are a valuable contribution to the question 'What do advocacy schemes actually do?' and are documented in this report in Chapter 10 and Appendix 10. This programme offers an excellent baseline from which to develop further work. It demonstrates a variety of work and validates the need for advocacy intervention. It also demonstrates to some extent the length of time each case can take and the complexity of the work.

Recommendation 5:
OPAAL should establish a benchmarking steering group to take this work forward, which could easily operate on a 'virtual' electronic basis for ease of involvement. The work carried out so far is no more than a starting point but it could lead the way to extensive future policy development, particularly as it uses real examples to justify advocacy schemes' involvement.

Section Two:

Promoting independent advocacy and building the involvement of older people

5. Newsletters, the OPAAL membership, and the 2006 conference

5.1. The newsletter

At the start of the development project, OPAAL undertook to issue a regular newsletter. It has striven to issue one copy each quarter, circulated to all OPAAL members, highlighting any specific areas of interest, current events in the older people's advocacy field, and informing members about OPAAL's progress. Newsletters appeared twice in 2004, three times in 2005, and twice so far in 2006, an average of 3 rather than 4 a year. Feedback has been positive, and OPAAL members have reported that they have found the newsletters helpful and informative. Members were invited to submit material to the newsletter, and some issues were used to ask for members' views on relevant topics.

During the course of the development project, it has been reported on many occasions, by advocacy scheme managers, that they feel isolated, and are rarely able to meet colleagues in a similar situation on a regular basis. They are therefore not informed about developments in advocacy, and are often forced to make assumptions about developments, or to survive in isolation. OPAAL has tried to address this through the newsletters, which also aim to encourage membership of the organisation. There is a particular need to circulate information about funding issues, or statutory developments such as the independent mental capacity advocacy development. The newsletter is also a good opportunity to collect evidence about any particular issue, and OPAAL has done this by asking about advocacy scheme closures, and about the independence policy development. It also reported on the Office of Fair Trading market study into care homes, and on OPAAL's own involvements in policy developments.

> ***Recommendation 6:***
> The positive feedback received from OPAAL members indicates that the newsletter should continue to be issued on a regular basis, and to provide an arena to circulate national developments, internally within OPAAL and government policy developments.

5.2 Involving the membership

Like many similar organisations, OPAAL confronts difficulties in defining, and sustaining, the role of its membership. Members (i.e. advocacy schemes) have difficulty committing time and energy to the work of a secondary support group, even where it has a campaigning and lobbying function as OPAAL does. For this reason the most successful collaborations, as with the programme of regional meetings in

2004, and the London users' network initiative in 2005, have been where OPAAL has been able to commit resources to work directly alongside its members. OPAAL has also to reflect the interests of non-members operating in the field, affiliates, and, increasingly, of users and potential users. All this may call for a more demanding, strategic, approach to be adopted in the future.

It is a sad reflection of the times that in 2006 there have been more advocacy closures than during the whole of the previous period of the project. These appear mostly to be due to local government funding cutbacks, perhaps prompted by the NHS budget situation. They arise at a time when there are stated government intentions to ensure that advocacy services are available (see Chapter 14). As a result of these cutbacks, or, in some cases, redirections of funding, whole counties are now without advocacy provision (see appendix 7).

Recommendation 7:
OPAAL should:
> work with its membership to monitor changes in the level of provision, and publicise them appropriately
> review its capability to develop a toolkit for advocacy users, promoters and providers to lobby in favour of advocacy at local level
> review the terms of reference of the national programme (Appendix 11) to ensure that both the national working group, and the commissioner training programme, respond to these issues
> endeavour to broaden the debate about how advocacy is funded.

5.3 Age, Advocacy and Citizenship Conference, 19 July 2006

This conference focused on the link between human rights, citizenship, older people and the role that advocacy can play within this. There is a full report on the conference in Appendix 10.

The guest speaker was Katie Ghose, Executive Director of the British Institute of Human Rights, who acknowledged the importance of advocacy in upholding one's entitlement to basic human rights. She offered a link between the importance of advocacy and making a challenge in line with the Human Rights Act.

The conference also centred around workshops which offered those present, a mixture of older people, statutory bodies and advocacy schemes, the opportunity to put their views on how advocacy should be developed in the future. The workshop titles were:

> Involving older users of advocacy
> Advocacy developments in dementia and mental incapacity
> Mapping advocacy for older people
> OPAAL Evaluation Programme
> What does advocacy mean in practice?
> Advocacy and citizenship
> The development of adult protection procedures
> Older people and learning disability
> Promoting care home advocacy
> The development of support systems for older people

The conference also saw the launch of two important publications, reported within this document under the appropriate headings, which are:

Mapping advocacy in the English regions – Gary Kitchen, Get Heard and OPAAL, funded by the Tudor Trust (July 2006)

A Voice that Wasn't Speaking – Mel Wright and OPAAL (July 2006)

Both reports are available in full on the OPAAL website www.opaal.org.uk

Recommendation 8:
OPAAL should:

> establish a working link with the British Institute of Human Rights, aiming to improve the understanding of human rights among advocates and improve the use of the Act by advocacy schemes
> continue to represent advocacy with older people within the Age Reference Group of the Commission for Equality and Human Rights

6. Networking

Networking has made a major contribution to what the project has achieved. In order to develop any services, it is essential to know what already exists, and what needs to be done. Lack of networking, therefore, could lead to duplication of effort or irrelevant development.

The development officer was involved in extensive networking from the start of the project. This was further augmented after the conclusion of the regional visits, when new contacts were established and there was greater awareness of the needs of advocacy schemes nationally, and regular links maintained with various advocacy managers and advocates. It was also important to keep abreast of developments within government and in the statutory sector in general. Wherever possible, the development officer tried to connect with older people themselves, and to this end, contact was made with Better Government for Older People and the Older People's Advisory Group, as well as with individuals.

There were various methods of networking:
> in person
> at meetings and seminars
> at conferences
> electronically
> by telephone
> through the management committee

Using modern practices, working relationships could now be formed with organisations and individuals without actually meeting anyone face to face.

6.1 Organisational links:

The following links were important to the development of older people's advocacy and support for OPAAL (in alphabetical order):

Access to Justice (Justice in your Job)
This is a European multi-faceted initiative hosted in England by Help the Aged. The Development Officer was present at early meetings, and argued the case that all older people should have access to advocacy. This includes working older people. The project was mostly concerned with the development of information packs specifically for people who are experiencing discrimination at work on the grounds of age. It was important to recognise the importance of advocacy and the fact that an information pack may not be sufficient to encourage older people to pursue their rights. People in such situations might also need the services of an advocate.

Action for Advocacy

In the course of the development project, Action for Advocacy widened its remit from a London-only support service, to a national perspective. OPAAL worked alongside Action for Advocacy in the early development stages of introducing voluntary advocacy standards and training development. Subsequently there was ongoing networking to monitor progress. OPAAL submitted articles for the Planet Advocacy magazine, and liaised throughout the life of the project. Action for Advocacy was a member of The Advocacy Federation whilst it was in existence, at which time there was a sharing of ideas and developments. The Advocacy Finder database was particularly useful for OPAAL when receiving enquiries and for referring individuals to their nearest advocacy scheme.

Action on Elder Abuse

There were strong links with Action on Elder Abuse. Although older people's advocacy is not exclusively directed around adult protection, this is an important factor for older people who are, or might be, suffering abuse. Action on Elder Abuse appointed their own advocacy national training officer at the same time as OPAAL's development officer, and the two postholders linked up, particularly in the early days of the project, to ensure good liaison. In the latter stages of the project, some key multi-agency developments were in preparation to deliver some pilot project work around adult protection.

The Advocacy Federation

The Advocacy Federation (TAF) was a network of regional and national second-tier organisations. The intention was to develop peer support networks, working links and liaison, share new ideas, and establish how organisations might be able to link together for maximum effectiveness. Unfortunately this was not a success. The need for such a network was recognised, but there were problems with the organisational arrangements, and a degree of struggle for power and recognition.

Advocacy Resource Exchange (formerly CAIT)

There was a good liaison between the Advocacy Resource Exchange and OPAAL, particularly in the early stages of The Advocacy Federation and the development project. It was particularly useful to refer to the national database of advocacy providers and the training programme, in response to telephone enquiries to OPAAL. The Advocacy Resource Exchange was able to provide a comprehensive background to the history of advocacy development in the UK in the early stages of the project.

Age Concern England

OPAAL enjoyed excellent communication and links with the Age Concern England Research and Development team. There was a good sharing of ideas and developments, and the development officer was very pleased to contribute to the development of the Age Concern advocacy standards publication which was

circulated in 2006. This is a partnership which has been very useful throughout the life of the project, and the readiness of the officers to work alongside OPAAL has been highly appreciated and valued.

Better Government for Older People (BGOP)
OPAAL's principles of empowerment, independence and inclusion related well to the work carried out by BGOP, and the development officer felt that it was important to create a strong link with this organisation. Several meetings were held, and personal links developed. In the later months of the development project, an important multi-agency development around adult protection was in the planning stages, which will be followed up after the end of the development project. OPAAL wrote an article for the Stratagem magazine about advocacy, what it is and how it can help the older individual. The involvement of older people in both BGOP and OPAAL was another common link.

City Councils
Throughout the life of the project, there was minimal opportunity to be involved in advocacy development with statutory authorities. However, from time to time OPAAL was consulted about new initiatives and local authorities wanting more information about the nature of advocacy and what advocacy could offer. Following the publication of the Social Exclusion Unit's report 'A Sure Start to Later Life: ending inequalities for older people', OPAAL made contact with the local authorities responsible for developing pilot projects for the Link-Age Plus initiatives. This was to try to ensure that advocacy was included at the planning stages, as recommended in the Social Exclusion Unit's report.

The development officer was also invited to give presentations to 2 City Councils who were looking at positive ways to develop advocacy services, and subsequently consulted at later stages. Unfortunately with minimal resources available, the OPAAL contribution was relatively small, but nevertheless, it was felt that this was a step forward.

One City Council was keen to include OPAAL in the development of their POPPS scheme, but due to a lack of availability and scarce resources within the organisation, it was not possible to follow this up.

Commission for Equality and Human Rights Age Reference Group
The development officer was delighted to be invited to join this group of largely national officers, chaired by Help the Aged, and with Gordon Lishman, Executive Director of Age Concern England present as liaison officer for the Commission. A presentation was given by OPAAL on the Unheard Voices of Older People, and there was a regular opportunity to promote the need for advocacy when addressing human rights abuses. Meetings were held quarterly when feedback was given by Gordon Lishman on the progress of the Commission development. There were guest speakers

from the Department for Work and Pensions, Department of Trade and Industry, human rights specialists, Disability Rights Commission, and the Office of Fair Trading, to name but a few. A paper was published on multiple discrimination and older people.

Commission for Social Care Inspection (CSCI)
OPAAL was invited to participate in several CSCI consultation programmes, some on-line and some in person. OPAAL was able to stress the need for advocacy provision in a care home setting, and also highlighted the need for more resources for advocacy to fulfil the need for a comprehensive service nationally. At the meetings, the need for advocacy was always acknowledged by the Commission. OPAAL's Chair addressed a final meeting of the Commission's lay inspectors.

Counsel and Care
The development officer established contact with Counsel and Care at a fairly late stage of the project, but to good effect. Regular meetings have been held with Counsel and Care to discuss collaborative working around the directory, and how the two organisations (OPAAL and Counsel and Care) might link up for future work. The Chief Executive joined the OPAAL management committee as a co-opted member and has made valued contributions to partnership working. It is certainly hoped that this work will continue into the next phase of OPAAL work.

Dementia Networks
The national Dementia Advocacy Network (DAN) is based in the Westminster Advocacy Service for Senior Residents (WASSR). OPAAL's development officer gave presentations to the network, and met on a regular basis with the co-ordinator, in person or electronically.

A recent development is the Northern Advocacy Dementia Network which meets in various locations in the north of England. It liaises with the Dementia Advocacy Network. OPAAL was present at an early meeting, and was pleased to offer support.

There was also close liaison with Dementia North, based at Northumbria University, particularly following publication of the report 'Hear What I Say'.

Durham University
Durham University was instrumental in the development of advocacy standards relating to the Independent Mental Capacity Advocacy service and the Independent Mental Health Advocacy Act. When the latter was withdrawn, the university's role became less clear. The development officer attended consultations around this, however, as well as responding electronically to questionnaires and databases.

Government departments (see Chapter 14)

Help the Aged

Help the Aged has been a valued partner throughout the development project, and the development officer has liaised on a regular basis with several officers within the organisation. The development officer was consulted on several occasions by Tessa Harding, former senior policy officer, and the development officer was an active member of the Access to Justice programme and the Age Reference Group of the Commission for Equality and Human Rights, chaired by Help the Aged. Support was offered and advocacy regularly promoted by Paul Cann, Chief Executive. All OPAAL management committee meetings have been held at the Help the Aged offices with full co-operation throughout the life of the project. There was regular consultation with officers within the organisation, and assistance was offered with the preparation of the conference 'Age, Advocacy and Diversity' which was later cancelled through lack of support. The development officer is very grateful for the amount of assistance available, which has been a historical partnership with OPAAL since its inception.

Individual advocacy schemes

The development officer was particularly pleased to be consulted by many individual advocacy schemes, and also to receive information about successful initiatives. This came about mainly as a result of the regional visits. Another useful outcome was the ability to put one advocacy scheme in touch with another when any development of new services was considered. Much of this work was done by telephone or electronically, with occasional visits where possible.

National Advocacy Co-ordinators' Network

This network consisted largely, but not exclusively, of Age Concern schemes. It met usually on a quarterly basis and was organised by Age Concern England and chaired by Age Concern Coventry. It was a very important network which enabled those involved in the delivery of advocacy to older people to meet up and share ideas and developments. The development officer was very pleased to be invited to join the planning group, although was not able to attend as many meetings as she would have liked due to other work commitments. Nevertheless, it was an important link and an excellent opportunity to meet with groups of people who deliver advocacy. Guest speakers included specialist dementia advocates, solicitors presenting on power of attorney, and adult protection officers, and OPAAL itself was also invited to present the findings of the regional development programme.

National Coalition of Citizens Advocacy

There was a close working relationship between OPAAL and the only other national development officer who worked within this organisation. OPAAL attended regional meetings, and the Coalition was represented on the OPAAL management committee. Many ideas were shared and developed electronically, and the OPAAL development

officer was particularly impressed at the effectiveness of this informal approach in relation to older people. Both officers benefited from mutual and peer support and liaised whenever possible to ensure any duplication of effort was kept to a minimum.

Older individuals (see also Chapter 9)
From time to time the development officer has been fortunate in working directly alongside older people who have been willing to contribute and offer new ideas and suggestions for advocacy development. This was particularly relevant during the regional visits, but also contact through conferences, meetings, focus groups, and by e-mail and telephone. These contributions have been invaluable to strategy development, have offered a fresh and relevant perspective, and have been highly appreciated.

Older People's Advisory Group (OPAG)
Members of the Older People's Advisory Group were regularly in attendance at meetings attended by the Development Officer, and over a period of time, there was a greater awareness of OPAAL's work. There were no official links except that the OPAAL Vice-Chair was herself involved in OPAG. However, OPAG was linked with Better Government for Older People and through these links, advocacy was able to sustain a greater profile through OPAAL's involvement.

Polari
The development officer attended seminars which considered the difficulties of older gay men, lesbians and transsexuals as they grow older, and particularly in a care home setting. Articles from Polari were included in the OPAAL newsletter, and there was regular liaison with the Polari staff. Representatives were often present at meetings and conferences also attended by OPAAL, when current developments were discussed and noted. Like many organisations, staff at Polari were very supportive of OPAAL's work, but as advocacy was not their major focus, were not able to offer a more active role.

Regional networks
The regional programme was instrumental in making links with advocacy schemes across England, and the importance of these cannot be overstated. Regional work has been successful in gaining support for OPAAL as well as recognition for individual schemes which might otherwise not be acknowledged. The high level of expertise and development ideas which have been shared with the development officer have been encouraging, but unless there is regular contact, much of this valuable work would not have come to her attention. Regional meetings of advocacy managers do more than share ideas. They also offer a flavour of the local political scene and why difficulties arise in certain areas, but not in others. The National Coalition of Citizens Advocacy has long held regular meetings throughout the regions on a quarterly basis. OPAAL should link in to these meetings, and encourage the attendance of local and regional older people's advocacy schemes.

Particular mention should be made to the second-tier regional support schemes, in particular Hampshire Advocacy Reference Group (HARG), Gloucestershire Advocacy Support Services (GASS), and Advocacy Network Leeds, each of whom have contributed to OPAAL development.

Recommendation 9:
OPAAL supports the regional model of support, where an umbrella organisation maintains an overview of all advocacy within a particular region, offering opportunities for joint training, recruitment, funding and development. One of the difficulties reported to the development officer throughout the project has been that of isolation. Second-tier support offers a method of bringing advocacy schemes together in a local area, with excellent knowledge of local requirements and local policy. This support enables the advocacy scheme managers to run a service, leaving the second-tier organisation to provide additional support networks.

7. Talks, presentations, publicity, consultations

7.1 Publicity material:

Several reports have now been written and circulated, some of which are related to the work of the development officer, and some from earlier years.

These publications are available on the OPAAL website, and are:

Advocacy – who cares for older people? A report on the results of a series of workshops held in the English regions with groups of advocacy providers and older people between June and December 2004.

Mapping Advocacy in the English Regions: A directory of older people's advocacy services throughout England, compiled and with a report by Dr Gary Kitchen, Get Heard, and funded by The Tudor Trust.

A Voice That Wasn't Speaking – older people using advocacy and shaping its development: A report written by independent consultant Mel Wright, to consider how older people who have used advocacy services felt about its effectiveness and usefulness.

Age, Advocacy and Citizenship – a national conference hosted by OPAAL in July 2006: A summary of the conference, the workshops, and delegates' recommendations for the future.

Dignity on the Ward – advocacy with older people in hospital: A report written in 2000 by Andrew Dunning, in partnership with Help the Aged, which still holds relevance today. This report has been reformatted and updated.

Independent Advocacy with Older People – a national conference hosted by OPAAL and sponsored by Help the Aged in July 2002: This conference prepared the way for the OPAAL development project which began in October 2003. The report summarises the workshops and recommendations.

7.2 Presentation material: (Appendix 2)

The development officer has prepared some presentation material which is available to management committee members who wish to make presentations in their locality or within their own area of expertise. There would need to be a short training before any external presentations were given, to ensure that a consistent message is given, and that everyone understands exactly what might be required of them. The presentation covers basic information about older people's advocacy, what it is and what it is not, advocacy principles, information about OPAAL, the benefits of independent advocacy, and recommendations in government reports to include advocacy provision.

In addition to this, the development officer herself has given presentations at several conferences, including Action on Elder Abuse (2 presentations), National Pensioners' Convention Ethnic Minority Group, Age Reference Group for the Commission for Equality and Human Rights (The Unheard Voices of Older People), Older Citizens' Advocacy York (OCAY) AGM, National Age Concern Advocacy Network, National Dementia Advocacy Network and Liverpool City Council. Whenever possible, the development officer, the chair, the vice-chair and other trustees have taken advantage of attendance at relevant meetings to raise the profile of older people's advocacy and the need to develop services further and to support existing services. This ongoing presence has, without doubt, helped to raise the profile of older people's advocacy in the last 3 years and has contributed to a greater awareness of advocacy.

Articles and letters about older people's advocacy and the work of OPAAL have been published in Community Care, The Guardian and The Observer newspapers, Planet Advocacy, Stratagem (Better Government for Older People) and OPAAL is featured in A Sure Start to Later Life: Ending Inequalities for Older People (ODPM 2006, page 50) published by the Social Exclusion Unit.

It is important to maintain a high profile whenever possible with organisations which may not be aware of the effectiveness of advocacy for older people. However, it is also recognised that one person cannot be in all places, and that presentation material takes time to prepare. A consistent message, however, is effective in its delivery.

Recommendations 10:
OPAAL should train its management committee members and other supporters in the use of the presentation material. Those who are prepared to do so should make use of this to promote the organisation in their locality or field of interest and report back to feed into future development plans.

8. Working with the general public and campaigning groups

8.1 Statement of Intent (Appendix 3)

OPAAL's statement of intent was adopted in 1999 after consultation with over 200 advocacy groups and affiliates. It provided the basis for an Early Day Motion supported by 175 MPs in the House of Commons in 1999. It was slightly revised in 2001 and the Annual General Meeting of 2003 agreed that the organisation should take steps to promote it. The Statement is available on the OPAAL website and an extract from it incorporated into the organisational leaflet in 2003.

8.2 Conference stands

With limited, largely voluntary, resources OPAAL has concentrated its conference work on events that attract the older public rather than professionals. We had a stand at the Pensioners' Parliament in Blackpool in 2003, 2005, and 2006; at the Multiple Sclerosis Society's MS Life at Manchester's G-Mex Centre in April 2006; and at the Capital Age Festival on London's South Bank in August 2006. These are large events and we have probably dealt with around 300 enquiries overall.

Over a four-year period at Blackpool it is evident that popular understanding of the term 'advocacy' has increased significantly. There is also more identification with the term among older activists, and a lessening of the perception that advocacy is a distraction from 'campaigning'. Indeed, the 2006 Parliament saw a growing number of people enquiring about training as advocates, or about establishing schemes.

At the G-Mex event, Manchester, OPAAL was the only stall holder linked explicitly to older people. The interests of older people with MS was identified as an issue. Many disabled people in mid-life raised concerns about their parents.

8.3 The Pensioners Manifesto and the Pensioners Charter

Changed expectations among delegates to the Pensioners Parliament may be linked to two recent initiatives by the National Pensioners Convention (NPC): the Pensioners Manifesto (2004) and the Pensioners Charter (2005). Both make references to advocacy. OPAAL has represented the issue in debates at the Parliament in 2004, 2005, and 2006. In 2004 the Chair proposed an amendment which led to a demand for advocacy being included in the final version of the Manifesto. In 2005 the vice-chair moved an amendment which means that a right to advocacy is included in the 10th demand of the Pensioners Charter. During 2005 the Charter was widely discussed at local level among NPC affiliates, and this may have stimulated some of the increased interest in advocacy.

8.4 Advocacy, carers and Disablement Bill

In an enterprising move the National Pensioners Convention tabled a mock private members bill at the 2006 Parliament. This asserted that:

> *"Free and independent advocacy services shall be available to individuals via;*
> *(a) a friend or relative chosen by the individual, or*
> *(b) a representative from a suitable organisation undertaking advocacy work chosen by the individual."*

This is the first proposal of its kind since the Statement of Intent. Although OPAAL was not consulted by the NPC at the draft stage, we offered it general support in discussion at Blackpool. The Chair indicated some of the contradictions with respect to independence that arise from clause (a). Nevertheless, there is common ground here with the ideas being circulated in relation to 'A Sure Start to Later Life' (see page 77). These need not be incompatible with the social goals of independent advocacy.

Recommendation 11:
OPAAL should work with its membership to examine both the possibilities and the pitfalls of supporting 'informal' advocacy in the future.

8.5 Lord Ashley's Independent Living Bill

In April OPAAL briefly discussed with the Disability Rights Commission the work they had done with the Multiple Sclerosis Society to support Lord Ashley in presenting a bill which would give a right to independent living in the House of Lords. We have been unable to contribute to formal consultation on this measure, but have done our best to let members know that it offers an unequivocal endorsement of a right to independent advocacy.

> *'We want to enshrine in the Bill 'rights to advocacy and supported decision-making including support for self-advocacy'*
> Para 4.11 Briefing on Lord Ashley's Independent Living Bill (DRC Feb 2006)
>
> *'Each individual who makes a complaint in relation to a local authority in respect of its function under the Act has the right to independent advocacy ...'*
> Section 27. Disabled Person's Independent Living Bill,
> (House of Lords, 2006)

This may be important in the future in building political support for advocacy. Overall, the intention is to shift the local authority obligations in social care away from duties to provide certain types of response to a duty to meet the user's requirements.

9. The views of older users of advocacy

9.1 Background to the initiative

One of the priorities for OPAAL has always been the inclusion of older people when developing services. However, it has, at times, proved difficult to identify groups of older people who knew enough about advocacy to contribute to its development.

The development officer wanted to carry out a consultation exercise to see what older people who have used advocacy felt about its effectiveness. OPAAL also wanted to explore the feasibility of a users' network. To do this, OPAAL engaged the services of Mel Wright, an independent consultant, who has extensive experience of user involvement throughout the London area. London was selected in this instance as the most accessible region. Starting in London meant that Mel Wright was able to contact older people from each section of the city, and to hold a final meeting for all the older people who had participated. He did this by contacting London advocacy services, and asking scheme managers to recommend older contacts. He then held individual meetings with older people who had used advocacy services to ascertain how they felt about the services they had received.

The final report gives a details breakdown of the outcome. It is available on-line on the OPAAL website www.opaal.org.uk. Extracted below are the introduction, summary and conclusion.

9.2 A Voice That Wasn't Speaking – Older People Using Advocacy and Shaping Its Development

This report presents a summary of the main findings of a consultation with older people who have had contact with and/or received advocacy services. The consultation was undertaken on behalf of the Older Peoples Advocacy Alliance (OPAAL) UK as part of a project with the following aims:

> To contribute to an evidence base for the effectiveness and impact of advocacy which can be reported to stakeholders, including policy-makers, commissioners and funders.

> To engage older people with an interest in the development of advocacy services.

> To explore the potential for a network of older people who have used advocacy services.

More specifically, the consultation focused on the following key considerations:

Experience and impact of advocacy on older people:
a) whether or not they have used advocacy services
b) if they have used advocacy services, what motivated them to do so
c) whether they found the advocacy assistance helpful to their situation at the time
d) whether advocacy met their expectations, and what these had been
e) whether they felt supported throughout the process
f) whether they would change anything about the advocacy process

Interest in seeing advocacy develop:
g) what their interest is, or has been, in advocacy
h) what they would see as the benefits to themselves, and to others, of older users involvement with independent advocacy
i) whether they would be prepared to communicate with other older advocacy users, or meet others at a facilitated meeting
j) whether their would be obstacles to their participation, and how these might be overcome

The findings presented in this report are intended to be of interest to older people, advocacy organisations, policy makers, commissioners and funders, as well as to inform the future work of OPAAL.

Summary and Conclusion:
The key considerations of the consultation were the experience and impact of advocacy on older people and the engagement of older people in future development, including the potential for the creation of an advocacy service user network of older people.

The main findings to emerge from the consultation as highlighted in the report can be summarised as follows:

1. Older people generally unfamiliar with term advocacy at the outset and remarked on its problematic and contested nature. Most had subsequently seen advocacy in terms of style or approach they received, which the advocate provided. They then became keen to encourage the promotion and development of advocacy more widely.

2. The motivation or need for advocacy was broadly related to protection from abuse; combating discrimination; obtaining and changing services; securing and exercising rights – as well as being involved in decision making and being heard. Participants presented a range of experiences of varying degrees of complexity and concern.

3. Participants generally felt supported and emphasised the significance of the advocacy process. They valued both the instrumental and the expressive roles of advocates and highlighted the skills and attributes required.

4. Participants identified two sets of successful outcomes – those relating to tangible or material gains eg. obtaining a service and those bound up with feelings of greater confidence and self-esteem, and of being better equipped to deal with life situations themselves.

5. The consultation confirmed the view that service users' active involvement is of great value in shaping and sharing in the future of advocacy. There was real interest and potential for taking forward OPAAL's proposal of an older people's advocacy service user network.

9.3 Next steps in developing a user network

Further work is now required to develop the aims, membership, organisational structure and support requirements of participants as well as the type of network model to be taken forward – by OPAAL, advocacy services and older people themselves. OPAAL has been discussing these issues with the Greater London Authority.

Section Three:

Contributing to the development of standards, and developing better practice

10. Benchmarking Project

'The need for coherence and unity in the advocacy movement has never been stronger; the opportunity to achieve them may not come again'
A Right Result? Advocacy, justice and empowerment – Rick Henderson and Mike Pochin 2001

"Joined up policies and planning are required for more joined up delivery on the ground. Furthermore, this integration needs to be 'vertical' (between different tiers) as well as 'horizontal' (between different services and stakeholders). It is an easy assumption that the more an advocacy scheme can offer, the better it will be considered. In reality, the opposite could be assumed, that there are other agencies which offer similar services, such as Citizens Advice or government advice agencies. The advocacy scheme is unique, but it will become increasingly essential that it finds ways to demonstrate its effectiveness, not as an information and advice agency, but as a support and channel towards independence, empowerment and inclusion for its user group"
Better Government for Older People (2000) Making a Difference: programme evaluation report

10.1 What did we want to address?

One of OPAAL's objectives is to explore the use of quality frameworks, both to help look at the outcomes of advocacy and at the processes whereby it is delivered. We were conscious that work being undertaken on standards tended to focus on broad-based issues (cf. pages 41 and 42) and to have little to offer on many of the questions asked by the general public and referrers. We thought it would be important to focus on the process of delivering advocacy, the content of what advocates actually do.

Following the regional visits to advocacy schemes in 2004, it became clear that advocacy schemes were working in different ways, addressing different problems, and administering cases (or partnerships) in very varied ways. Whilst it was to be expected that advocacy would privilege self-determination and creative variety, it did become a matter of concern that there was no standardisation about the work carried out, nor was there any **regular communication** between different advocacy schemes as a matter of routine.

At the same time, advocacy was attracting attention from policy-makers and funding bodies, being mentioned in many government reports, and developing its own lobbies (eg. Independent Advocacy Campaign, 2004). OPAAL was concerned that the variety of approaches on the ground might contribute to confusion and a lack of understanding, and that a lack of consistent reporting might weaken advocacy's impact, hindering its future development.

Age Concern England Advocacy Guiding Principles (2006):
The following are taken from the Age Concern England 'Framework for Advocacy' (2006). They are adapted from the Advocacy Charter, first drawn up by advocacy services in London, and published by Advocacy Across London, (now Action for Advocacy) in 2002. The development officer was present at consultation meetings in the initial stages of the 'Framework for Advocacy' and worked with Age Concern England to develop the recommendations. The benchmarking project makes use of the principles when relevant.

Clarity of Purpose:
It is essential that all people involved in the advocacy process know what to expect and how it will work. This includes being clear of the role of an advocate and about what they can and can't do. It also involves avoiding doing work that is more appropriately undertaken by others.

Putting People First:
Advocacy starts from the individual's viewpoint, ensuring that the client's/ partner's voice is heard and that their wishes and rights are respected. People coming to advocacy services will be in control of the advocacy process. Advocacy works in the way that partners want and at the pace that they want and it is never judgemental.

Empowerment:
A principle of advocacy is to enable people to have and/or keep as much control as possible over their own lives. The advocacy process aims to empower people, to enable them to advocate for themselves as much as is possible.

Accessibility:
Advocacy services should be free of charge and inclusive. They have a duty to recognise and try to remove barriers that may stop people being able to access advocacy.

Equal opportunity:
Advocacy strives to redress inequality and to tackle prejudice. It is essential that advocacy services are aware of possible discrimination in their own practice and of the need to develop robust approaches to deal with it.

Supporting advocates:
Advocates need to be given adequate support and training to enable them to support their partners to the best of their abilities. This includes clearly defining roles and providing ongoing support and/or supervision. In addition, the contribution of all advocates is to be valued and acknowledged.

Confidentiality:
People are not able to explore options and speak freely unless they know that they can do this in confidence. However, there will be times when confidentiality might have to be broken. This is always treated with caution and there will be safeguards to make sure that it is necessary and appropriately managed. It is essential that everyone, but particularly partners, know when and how this would happen.

Independence:
Independence relates to organisational structure, funding sources and psychological independence – the advocate's belief in their ability to challenge institutions. The independence of the advocacy service from other services that partners need and/or receive, is vital. The first responsibility/loyalty of an advocate is to the person they are working with. Being able to demonstrate independence increases both the likelihood that a person will come to an advocacy service and that others will respect the advocate's role. Partners need to know that an advocate will always aim to understand, respond to and represent their interests with the same commitment as if they were the advocate's own.

Safety:
Advocacy services will be able to assure clients/partners that they have taken all reasonable steps to ensure that the service is safe. This safety relates not only to health and safety issues, but also to ensuring that services do not put partners at increased risk of abuse, that people who work within advocacy organisations are safe and that advocates are not operating beyond their level of knowledge or ability. Advocates need to know that they may check all aspects of their work in the safety of confidential supervision.

Accountability:
Advocacy can be difficult to measure. Simply measuring outcomes or time input per case (for example) does not give a true reflection of advocacy's effectiveness. However, services require ways of checking that they are working effectively. Partners should be able to find out if advocacy services are doing what they are supposed to. The same applies to those who support and fund the work, and will probably be a condition of the funding. Each case will be recorded, monitored and evaluated for the benefit of partners and the service. Regular reports will be available for funders, for the Trustees and for other relevant agencies.

Complaints:
There will be times when partners are not satisfied with an advocate or the advocacy serviced. A clear policy that sets down an efficient complaints process makes it easier for everyone involved. Some partners might want and/or need the support of another person or external agency in making a complaint.

10.2 Why benchmark?

Several issues had given cause for concern while implementing the initial regional programme. These included participants representing as advocacy what appeared to be advice, information, or befriending, or pursuing approaches which obstructed the recording of essential information. Later, OPAAL received case studies written up in ways that reinforced the dependency of the partner, rather than addressing their empowerment. These issues had proved difficult to address in conference workshops or regional meetings and could often lead to frustration among more experienced and confident practitioners.

OPAAL has no management remit within advocacy, and its members are not contracted to collaborate with the organisation. Processes of change need therefore to be as democratic, collaborative and interactive as possible. We decided to try and address these issues by carrying out a benchmarking exercise. Advocacy schemes would then be exploring such concerns for themselves. (Initiatives along these lines have been developed within some specialisms, and at regional level, although there was very little published material to which we could turn. Also, much development work in our field appears to go on between advocates rather than between schemes.)

A benchmarking programme would involve schemes working together to help build up a picture of their practice, and could then go on to encourage comparative learning, the exchange of constructive criticism (see box below), and perhaps the setting of standards (or 'benchmarks') to which participants could aspire, and measure the quality of their services.

The UK government highlights seven ways in which it believes benchmarking delivers wider benefits to public sector organisations. As these may also have an application to the voluntary sector we have summarised them here:

> learning from those who have achieved excellence

> sharing knowledge and insight between organisations about overcoming common problems

> setting appropriate performance measures, and developing realistic targets for improvement

> encouraging the involvement of staff in making changes happen

> introducing collaborative approaches that give rise to better outcomes

> developing a culture of continuous improvement and a willingness to learn from outside our own organisation

> introducing new ways of working, and innovative solutions

www.benchmarking.gov.uk

10.3 Priorities for the benchmarking programme

Ultimately, we wanted to focus the work around:

> the development and use of consistent tools for recording activity
> working towards a consensus about what it is that advocacy schemes are trying to achieve with older people
> working towards meeting robust criteria around the 3 major principles of **empowerment, inclusion and independence.**

The first step would be to establish more clearly what advocates actually offer older people, and how schemes operated. A number of advocacy schemes were approached to participate by working with OPAAL to provide examples of the range of work covered. OPAAL would then work with its partners to analyse the results and develop recommended standards accordingly.

Due to a lack of OPAAL resources, it was necessary to keep the benchmarking exercise to a manageable proportion, and decided to work on line. At this stage, therefore, nothing has been discussed about how participating schemes might make use of comparative methods to achieve, or reinforce, standards. We note with interest the decision made by Age Concern England to incorporate a peer review model, and look forward to tracking its progress.

10.4 The Benchmarking Participants

In order to be effective, it was important to select schemes of varying sizes and in rural and city locations, which were either generic or specialist, multi-service and stand-alone advocacy.

Initially, 6 Age Concern schemes were approached, one run by MIND, and 11 independent organisations. Most expressed considerable interest and support, but not everyone had the time or resources to participate. Others did not feel it would fit into their work patterns or funding criteria.

Out of those invited, the following agreed to participate in the benchmarking project (in alphabetical order):

> Age Concern Buckinghamshire
> Age Concern Richmond-upon-Thames
> The Beth Johnson Foundation Dementia Advocacy Project
> Derbyshire MIND
> Hampshire Advocacy Regional Group (HARG)
> Norfolk Elders' Advocacy Alliance
> Sefton Pensioners' Advocacy Centre (SPAC)
> Westminster Advocacy Service for Senior Residents (WASSR)
> Wyre Forest Advocacy for Older People

The range of schemes was therefore very diverse:
> one umbrella 'second-tier' organisation not directly providing advocacy
> three rural schemes
> three urban or city-based schemes
> one specialist dementia project
> two of the largest older peoples' advocacy schemes
> three multi-service organisations which operated advocacy within them
> a mixture of schemes employing volunteers, paid advocates or both
> one very small generic advocacy scheme, with a specialist older people's project working within it.

Although only 9 schemes were signed up to the benchmarking, it was felt that this was a fair representation.

10.5 Structure and method for the OPAAL benchmarking

The structure for the benchmarking programme is currently under review, but, ideally, the model would have the following staged components:
> schemes sign up to the programme
> schemes provide a wide range of basic data
> OPAAL and schemes agree priorities for performance measurement
> schemes measure their performance
> schemes exchange data about performance: mediated discussion
> schemes agree whether they want to set a performance standard
> schemes agree whether they want to identify 'excellent' performers
> learning is exchanged on a continual basis
> new partners come on board

10.6 Baseline stage: mapping the content of older peoples' advocacy

It was decided to use a questionnaire to map the content rather than trying to carry out site interviews or, at this stage, to ask schemes to maintain work-place diaries. The questionnaire model seemed to offer greater flexibility all round, and to fit with working on-line.

We developed a comprehensive questionnaire. Seven sets of questions were sent out to each scheme, one section at a time. These are included in the results section of this report, together with the examples provided, an analysis of the evidence, and recommendations for standards. Each section consisted of between five and seven questions around a particular aspect of the work. Examples were invited in the following categories:

> Information
> Access – instrumental help
> Choice
> Decision making
> Complaints and legal rights
> Empowerment
> Self-advocacy, group advocacy

The questions were designed to invite responses from practising advocates, rather than scheme managers. In some instances, managers also advocate, and in other instances, the practising advocate admitted to finding it difficult to allocate sufficient time to find examples. The aim was to tease out evidence from each scheme about the sort of query referred to the advocate, and how this was addressed.

> *Good practice point.* One scheme successfully used the request for examples as a training aid within staff meetings

Baseline Category 1: Information

> *'Information is what you need or want to know; advice is being guided as to how to go about things; advocacy is a way of acting on that information and advice to get your due'*
> Older participant, Manchester (Dunning 2005)

OPAAL was helping advocacy schemes find evidence to show how they were differentiating advocacy, information and advice. OPAAL wanted to know how schemes dealt with information enquiries, whether they referred to other agencies such as Citizens Advice, or whether they put every enquiry under one umbrella of advocacy. Some schemes, for example, offered advocacy but had developed specialist information services to work alongside this. Other schemes, such as Age Concerns, had specialist advocacy units within one larger multi-service umbrella. All Age Concerns offer information and advice services, but not necessarily advocacy.

> *'Information and advice services can be described as empowering in that they may provide an older person with greater awareness and understanding in order to direct their own actions and make decisions. Yet …the role of advocacy as a process of empowerment is more strongly stated. Indeed, for some within the field of advocacy, this is a defining quality.'*
> (Dunning 2005)

The information section, therefore, was seeking to establish the extent to which schemes were focusing on information, and the relationship between that and the provision of advocacy. Any information will empower the recipient to take action from a position of knowledge, although advocacy assistance might be needed to achieve this.

Category 1 Information examples:

> An example where you provided information
> An example where you researched information
> An example where you supported someone to identify and make use of information resources themselves
> An example where you helped someone assert their right to information
> An example where you advocated to get a professional service to research and provide information

Commentary on information

The examples suggested that schemes use information where it is crucial and relevant to the advocacy provided. Some of the examples demonstrated that minor interventions can have positive and sometimes dramatic effects to the lives of the advocacy user, and are often empowering. Soft outcomes, such as increased confidence or well-being, can be evidenced through the provision of relevant information and/or advocacy intervention.

As Andrew Dunning states in his book 'Information, Advice and Advocacy for older people', older people saw the relationship between information, advice and advocacy as points or tiers along the same continuum. The link is described as 'inter-related circles' in which each links to the other, otherwise described as 'circles of support'. However, caution should be exercised within advocacy schemes not to become too specialised in information-giving to the detriment of pure advocacy.

Baseline Category 2: Access – Instrumental help

Advocacy schemes are often, but not always, working with vulnerable members of society, some of whom will require special support to communicate. This requires a high level of specialism and skill, which might need to be developed with minimal resources, a volunteer workforce, and within a multi-lingual and multi-faceted society.

The examples given demonstrated a high level of initiative and persistence on the part of the advocate. No two examples provided were the same, and all required adaptations to be developed at short notice. Examples included adaptations for deaf and blind needs, language needs, negotiating with authorities to produce alternative means of communication, finding accessible meeting venues, etc.

Category 2 Access examples:

> An example where you yourself adapted information to make it accessible
> An example where you researched the means to make information accessible
> An example where you helped someone assert their right to receive information in an accessible format
> An example where you advocated to get a professional or commercial service to provide information in an accessible format
> An example where the need to work in an accessible way altered the shape and style of your practice

Commentary on instrumental help

This section aimed to look at how advocacy schemes make use of additional resources in order to assist the client. It is linked to the application of equal opportunity and how advocacy can ensure people do not suffer a lack of opportunity because they are unable to express themselves or access help.

Advocates work with a variety of partners and situations, some of which do not fit into the model 'pattern' of advocacy. There is a need to adapt work and communication methods to suit the partner at the time. The examples offered demonstrated a skilful adaptability on the part of the advocate to improvise, research and request adapted texts etc to empower the partner and improve independence and social inclusion. It is clear from the examples given that advocates have the skills to be able to tune in to a user's needs and can recognise the need to improvise. In all the examples offered, the user would have been worse off without the intervention and assistance of the advocate.

These adaptations take time and resources, and largely pass unnoticed. OPAAL recommends that the development and introduction of a central recording system might ensure that there is every opportunity to promote active local social policy work. This could also contribute to cost-benefit analyses which aim to show how advocacy offers value for money.

Baseline Category 3: Choice

> *'The greatest strength of advocacy is in promoting the choices of partners who would otherwise not be heard.'*
> A Right Result – Rick Henderson and Mike Pochin 2001

'There is growing evidence that where people are actively involved in choosing services and making decisions… the results are better.'
Our Health, Our Care, Our Say – 2006

'It's like going into a restaurant without a menu. How do I know what I want if I don't know what is available?'
Quinn et al. – JRF 2003

We live in a society where choices have never been more prolific, but only if one is in a position to choose, or has the knowledge needed or the means to make an informed choice. In reality, there is a danger that the most vulnerable and excluded members of society, particularly amongst older people, become further excluded if they are not aware that a choice exists, or if they have no assistance to follow their chosen option. This section, therefore, was looking for examples where advocates helped someone to understand choices, identify choices, and follow a choice through.

It is important to recognise that in making a choice, all individuals from time to time in life can follow the wrong path. The important thing for an advocate is to ensure that their partner made an informed choice, and received assistance to follow that choice through as far as they wanted. It is not about advising the partner to make the 'right choice', which would be dis-empowering and demonstrate a lack of control. Sometimes this presents a dilemma for the advocate, but it is a good indicator of independence and empowerment.

*"I got a lot of my self confidence back. I don't take any nonsense now!"***..**
Advocacy user, (OPAAL, 2006)

Category 3 Choice examples:

1. An example where you supported someone to identify the choices available to them
2. An example where you helped someone understand the choices that a professional service said it could make available to them
3. An example where you advocated to get a professional service to explain that there were choices available to your partner
4. An example where you supported your partner in making and pursuing a choice which others opposed
5. An example where you supported your partner in realising and pursuing a choice which they subsequently changed their mind about
6. An example where you supported your partner in making and pursuing a choice which they subsequently regretted and which brought about a change in circumstances they were unhappy about

Commentary on Choice

The majority of the subject material, although not all, revolved around housing choices, in connection with hospital discharge, residential care, respite care or domiciliary care. Advocacy clearly has an important role to play in this respect, being able to ascertain exactly what the partner wants, and able to negotiate and put the case to care staff. One of the biggest problems reported to OPAAL is that such decisions are frequently left to the last minute, giving the advocate minimal time to consult with or get to know the partner. Obviously advocates cannot represent their partner's best interests unless they have a good knowledge of the situation. It is important that all care staff are informed about the nature and effectiveness of advocacy, and liaise with local advocacy staff from the outset of a situation.

Many of the choices illustrated will have had a life-changing influence on the partner, so there is a great importance for both external information to carers and others, and on internal training for the advocate to gain the knowledge and skill to assist. Sometimes making choices takes time, and the advocate needs to work with the partner for as long as it takes to ensure that the situation is fully understood. The need for time, however, is not always understood by care staff.

Baseline Category 4: Decision-making

> *'We have been involved in discussion and processes to remodel services; these have transformed what happens. A new strategy has been produced, and the benefits are seen in better informed services, in which patients are treated as individuals, not stereotypes.'*
> Living Well in Later Life. – DoH. 2006b
>
> *'Systematically and rigorously finding out what people want and need from their services is a fundamental duty of both the commissioners and providers of services. It is particularly important to reach out to those whose needs are greatest but whose voices are often least heard.'*
> Our Health, Our Care, Our Say – DoH 2006a

This section was looking for examples where the older person had been assisted through advocacy to have an involvement in, and make decisions about, the development of services, or about their future care or treatment.

Decisions can present themselves at times in an older person's life when they are at their most vulnerable. OPAAL wanted to see how a partner was supported to understand that a decision was needed. It was also looking for examples where an advocate was able to get a professional service to explain that a decision was about to be made. It could also be where an advocate was working within a professional

service system to influence a decision about care or treatment, or enabling a partner to control or influence decision-making. OPAAL wanted to ascertain the level of involvement of the advocate, and what, if any, difficulties had been experienced.

Category 4 Decision-making examples:

1. An example where you supported your partner to understand that a decision needed to be made
2. An example where you advocated to get a professional service to explain that a decision was about to be made
3. An example when you supported your partner to make a decision about their care or treatment
4. An example where you supported your partner within a professional service system to fully understand that a decision about their care or treatment was being made
5. An example where you advocated within a professional service system to influence a decision about their partner's care or treatment
6. An example where you advocated within a professional service system so that your partner was able to control decision-making about their care or treatment
7. An example where you advocated with a professional service system where your partner was unsuccessful in influencing a decision about their care or treatment

Commentary on Decision-making

All the examples offered in this section demonstrated important stages in a partner's life. Many involved decisions about housing and care, mental health hospital care, medical treatment and financial affairs. Without the intervention of an advocate, the outcomes could have been very different for the partner. Independence and empowerment are both prevalent outcomes when it comes to decision-making, with advocacy helping the partner to take control of their own lives.

In some cases, there was a degree of mediation involved in making decisions, but the important factor is that the partner is helped to understand and carry through their own choices and decisions, even if these might not be the most appropriate. The advocate will carry out the partner's wishes as far as they are able, and will not make judgements about the wisdom of a decision. This has been known to cause friction with other parties, whether family or statutory authority, and this demonstrates the importance of empowerment. Without advocacy, the partner would be in a more vulnerable position and at the mercy of others to make decisions for him/her.

Baseline Category 5: Complaints and Legal Rights

> *"They have been a great help to me. I'm learning a lot about what's going on and keeping abreast with things. They made a real difference – when I complained about a service they helped me."*
> Advocacy user (OPAAL, 2006)

There are times in everyone's life when we need to make a complaint (see also Chapter 14.2, page 71). For the socially excluded or disempowered individual, this is a daunting prospect, and for an older person, the process can be even more threatening than the cause of the complaint. Advocacy assistance empowers the individual, whether the advocate acts on behalf of the partner, or whether they are supported to act for themselves.

In this section, therefore, OPAAL was looking for the range of issues meriting a complaint, and to what extent advocacy intervention was helpful. The questions followed the process of identifying a complaint through to ensuring that the person's concerns were acted upon and dealt with. OPAAL also wanted examples of where the advocate acted to ensure that the partner was fully engaged in the resolution of a complaint.

In addition, OPAAL was looking in this section for examples of where knowledge of legislation or guidance altered service outcomes, procedures or attitudes.

Category 5 Complaints and legal rights examples:

- An example where you helped someone identify that they wished to make a complaint
- An example where you helped someone ensure that a complaint was recognised and dealt with
- An example where you advocated to ensure that your partner was fully engaged in the resolution of a complex complaint about care or treatment within the agreed procedures
- An example where you have advised someone of their position with respect to legislation and guidance
- An example where you have advocated using your knowledge of legislation or guidance to alter service outcomes
- An example where you have advocated using your knowledge of legislation or guidance to alter procedures or attitudes

Commentary on complaints and legal rights

A variety of examples of complaints were offered in this section. It can be daunting for anybody of any age or situation to face a complaint situation and challenge an authority, particularly if this means challenging a family member or carer. The situation becomes more difficult when you are in a vulnerable situation, possibly facing age discrimination, and unsure about your rights. Making a complaint can become more problematic than suffering the cause of the complaint. In such situations, the existence of advocacy representation is a clear example of empowerment, independence and making one's voice heard. Advocates have supported their partners with all levels of complaint, from consumer complaints to disputes about care with the Healthcare Commission. Advocates have also worked with care homes after the resolution of a complaint to rewrite policies.

All the examples given demonstrate the effectiveness of advocacy intervention, where a situation could otherwise have serious repercussions. The outcome of a successful complaint increases confidence and self-respect.

The examples also demonstrate, however, the need for relevant training and the need for advocacy managers to ensure there is a clear policy on independence in existence. Advocates have used case law, knowledge of consumer law, guardianship law, and benefit knowledge. They have also liaised with Citizens Advice, demonstrating the value of partnership working. The latter addresses the point that it is not necessary for advocates to spend resources keeping information up-to-date when they could be more usefully employed in the provision of pure advocacy and representation.

Baseline Category 6: Empowerment

> *'Some organisations in the NHS, local government and the voluntary, community and private sectors have engaged users and citizens in a systematic and robust way. However, these are not the norm. We want to see all parts of health and social care open and responsive to what people feel and prefer. People's voices will be most effective if they directly affect how resources are used.'*
> Our Health, Our Care, Our Say – DoH 2006a
>
> *'Acknowledge that no one has control over everything, but how a person responds to situations may be within one's control'*
> Older People Doing It. For Themselves – Laurie Kerr and Vivien Kerr 2003

This section of examples is powerful in its subject matter. It covers situations, among others, around adult protection and abuse, ending harassment and taking control of financial affairs. OPAAL was looking to see to what extent, if any, the advocate was

able to empower individuals to act for themselves, and also to what extent the advocate was able to get involved and work with statutory authorities as needed.

Category 6 examples:

1. An example where you have enabled your partner to end harassment
2. An example where you have ensured someone can get control of their financial affairs
3. An example where you have supported someone to end an episode of abuse
4. An example where you have advocated about an adult protection procedure
5. An example where you have advocated for someone accused of abuse
6. An example where you have advocated to ensure that an adult protection procedure is instigated
7. An example where you have advocated to ensure that institutional neglect is acknowledged and acted upon

Commentary on empowerment

The results in this category do, indeed, demonstrate the seriousness of the situation, and the life-changing result of advocacy intervention, without which the outcomes for the client could have been very different. It is interesting to note the effectiveness of partnership working and the successful outcome for the client when the statutory authorities agree to involve the advocate, and listen to what the advocate has to say.

There were few replies in this category, however. This arose partly because of the administrative pressure at this stage of the project. These are now issues now intends to make a major priority, and OPAAL will now invite the group to consider whether the shortfall reflects a lack of referrals, the limits to what their scheme can attempt, or a lack of confidence among their users.

Baseline Category 7:. Self-advocacy and group advocacy

> *'Advocacy organisations need to be appropriately funded in order to serve their community. They also need to train older members of the community to become effective advocates for their peers and themselves'*
> Older People Doing It. For Themselves: Laurie Kerr and Vivien Kerr 2003

In this final section, OPAAL was looking for examples of anyone who had previously used advocacy, who either:

> went on to represent themselves, without support, or with continuing support
> had gone on to become a practising advocate
> now contributed directly to the development or management of advocacy

Good practice point. It is known that some MIND organisations include an invitation to participate in the organisation within their welcome pack.

Category 7 examples:

1. An example where someone has gone on to represent themselves, without support, or with continuing support
2. An example of a partner who has gone on to become a practising advocate
3. An example of a partner who now contributes directly to the development or management of advocacy

Commentary on self advocacy and group advocacy

There were very few examples given in this category. However, there are show that schemes who have been successful in involving clients in advocacy have been very pleased with the outcome and the ability of their partners to contribute. This is a further area which OPAAL intends to prioritise in the next stage of its national programme.

10.7 How the baseline mapping developed:

Advocacy schemes were approached to join the group in May 2005, with the initial set of questions sent out in August 2005, beginning a monthly schedule, which was brought to an end in May 2006.

The process was in-depth and time-consuming. Several schemes stopped participating in the course of the project and the development officer had to work hard to maintain the engagement of some participants, and to recover some of the completed data records. The mapping work on Sections 6 and 7 sections remains incomplete, either because the schemes had not encountered these situations, or because of pressure of work as this section was circulated at the end of the financial year when reporting and funding were uppermost in scheme managers' minds.

Initially, nine schemes agreed to participate but at the point where work had to stop there were only four. Schemes did not seem to opt out from a lack of capacity. Of the

four remaining at the end, for example, one was about to close with 8 staff redundancies, another had only 2 staff, one was a specialist dementia advocacy project with only 1 staff, while another was a larger national mental health advocacy scheme. By contrast, another scheme withdrew when it was decided that participation would involve too great a workload for an incoming manager.

Despite these shortfalls, OPAAL has decided that sufficient good practice points have emerged for us to make a number of recommendations. These are summarised below, and are also included in the complete returns summarised in Appendix 4 at the end of this report. They also formed the basis for a workshop presentation at the OPAAL Conference in Birmingham in July.

We would like to thank all who took part in the baseline mapping exercise. We recognises that building up these records and extracting examples from a large case-load takes a great deal of work. Schemes operate under pressure to offer a good service, and any additional work demonstrates a big commitment to improving advocacy services. Collating and analysing the data and preparing for its inclusion in this report, made substantial demands on the development officers time.

10.8 Next steps for the benchmarking programme

In effect, since the conference workshop, we have suspended the benchmarking programme. We must now share with the existing programme members the. recorded outputs, and review the progress made. At this stage, therefore, nothing has been discussed about how participating schemes might make use of comparative methods to achieve, or reinforce, good practice.

Its evident that OPAAL now needs to proceed carefully to re-establish the programme. On reflection it was probably an error to try and complete the whole of the baseline mapping without engaging participants in the more reflective aspects of the programme, and establishing the mechanisms for them to participate collectively and control the schedule more directly.

OPAAL's own limited resources contributed to this programme being partially completed. To some degree the multi-faceted role required of the development officer, replicated some of the challenges facing advocacy scheme managers and co-ordinators, and made servicing the programme extremely challenging. Future commitments will need to be manageable and may require additional resources.

However, it seems evident from the data already gathered that this initiative offers a way forward for advocacy. We note with interest, for example, the decision made by Age Concern England to incorporate a peer review model, into the implementation of

their framework (ACE 2006). We look forward to tracking its progress, and learning from such initiative, and from that proposed by Counsel and Care in establishing a supporting hub through their Care-link scheme. There may be opportunities to benchmark the benchmarkers!

Recommended good practice points from the baseline mapping. (see also Appendix 4)

Information:

> Advocacy schemes should include in their training procedures a system of exploration of the differences between information, advice and advocacy and how these might inter-relate

> Monitoring procedures in place to ensure work relates to advocacy provision, or how work relates to advocacy

> Clear protocols in place for referral to external information and advice agencies and/or departments within the same organisation

Access: Instrumental Help

> Advocacy managers should record specialist staff skills within their scheme, demonstrated by a written or electronic record

> Advocacy schemes should maintain a local reference file which will enable staff to signpost or liaise directly

> Advocacy should have a system in place to update local reference files as appropriate, including websites

> Advocacy schemes should be able to demonstrate an annual system of updating reference information

> Advocacy schemes should keep a central record of situations which benefited from specialist intervention, to demonstrate evidence of active social policy work

> Advocacy schemes should maintain a coded system to protect confidentiality when maintaining social policy records

> Advocacy schemes should keep a central record of work which has addressed local equal opportunity and diversity failures. This can be used to demonstrate the benefits of advocacy to funders and commissioners

> Advocacy managers should record instances where usual practice has been varied, and why

Advocacy managers should submit an annual statement of intention to their local authority or overall manager, to raise awareness of need and for future target setting.

Choices

> Schemes should have written guidelines about the nature and scope of advocacy

> Schemes should have adequate publicity material for external agencies which explains the role of the advocate

> Schemes should have training procedures in place to prepare advocates for such procedures

> Schemes should have systems in place to ensure advocates undertake regular refresher training courses

> Schemes should have adequate training courses in place to ensure staff have the necessary skills to help client make choices

> Schemes should have training updating procedures in place

> Schemes must ensure they have insurance protection in case of legal action

> Schemes should have a clear policy on independence to ensure no conflict of interest

> Schemes should have clear policy on independence

> Independence policy should be available to all clients and/or external agencies at start of a case or referral

> Schemes should have a method of feedback from external agencies as a means of quality control

Decision-making

> Scheme needs to demonstrate independence by means of an independence policy

> Schemes should have a process in place to deal with conflicts of interest

> Scheme must be able to demonstrate how advocates enable clients to understand that advocate's first responsibility is to the client

> Schemes should have procedures to train advocates in empowerment principles

> Schemes should have training procedures in negotiation skills and in putting people first

> Schemes should aim to work in clear language avoiding jargon which might further confuse

> Schemes should have procedures to train advocates in empowerment principles

> Schemes should have training procedures in negotiation skills and in putting people first

> Schemes should aim to work in clear language avoiding jargon which might further confuse

> Schemes should have policies in place which support advocates in cases which do not have the outcome desired by the partner

Complaints and legal rights

> Advocacy schemes should have in place a policy to ensure that support is appropriate to the user

> Advocates should ensure that the user knows how to contact them and the limitations on this

> Advocates should ensure that the needs of the partner are acknowledged and acted upon regardless of the nature of the complaint

Empowerment

> Sensitive issues require adequate staff support and schemes should ensure these are in place at all times

> Advocacy schemes should primarily ensure that the wishes of the partner are taken into account at all times

> Schemes should ensure that advocacy partners are empowered whenever possible, and given the opportunity to demonstrate this

Self-advocacy, group advocacy

> Schemes should have procedures in place which encourage and make possible the inclusion of older people in the shaping of policies and practices

11. Standard on independence

There has been much development work in the last 12 months to write standards for advocacy schemes and advocates. Action for Advocacy, Age Concern England and the National Coalition of Citizens Advocacy have written national standards, and regional and local networks have focused their attention on developing their own standards.

OPAAL has completed this benchmarking exercise using actual examples of advocacy in action, from which they are developing recommended standards. This work is still in progress, and it is intended to expand the benchmarking work in the next 3 years. However, at this stage, recommended standards have been included in the last column of the tables at the end of this report, which also list the examples given in each category.

11.1 OPAAL's recommended policy on independence

This was an additional part of the benchmarking programme, but with input requested from all OPAAL member advocacy schemes.

At the AGM in July 2005 it was agreed that OPAAL would develop a policy on independence, and would seek the input of members to assist with the process. OPAAL has developed a policy on independence. This was developed from responses to a questionnaire circulated to all members, the results of which formulated a policy will be recommended to its member organisations.

The aim of the policy is to ensure that older people are guaranteed as far as possible to receive impartial, independent assistance which is not prejudiced by any of the external or internal factors of the schemes which are offering advocacy.

A questionnaire was circulated to all OPAAL members in January 2006, attached to the newsletter. In addition to this, OPAAL consulted with advocacy networks about their own independence policy, and, for ease of application, aimed to link with existing guidelines rather than introduce alternatives.

Approximately 200 newsletters, and therefore questionnaires, were sent out, from which there were 9 replies. This is less than 5 per cent, so a low response. This could be:

a) Because recipients of the newsletter did not read it
b) Because recipients of the newsletter were not the appropriate people to reply
c) Because recipients of the newsletter did not have time/want to reply
d) Because there is no system to address independence within the organisation

A sample independence policy was sent from the National Coalition of Citizens Advocacy, and a draft independence policy was received from Action for Advocacy

The Range of Advocacy Provision:

The size and range of participating schemes is often commented on and highlights the difficulty in introducing standards to such a mixed service. Advocacy ranges from the more informal, longer-term volunteer citizen advocacy, to the formal independent mental capacity advocate (IMCA) which is about to be introduced as a statutory requirement across England.

Advocacy is a term with several meanings, giving rise to some confusion even in the field of health and social care. In the list below, we have highlighted those which most obviously connect with the kinds of independent advocacy provided by OPAAL's members.

Self-advocacy	Speaking up for oneself to represent your own needs, wishes and interests
Peer advocacy	One person advocates for another who shares a common experience, difficulty or discrimination
Citizen advocacy	Informal, volunteer, one-to-one long-term partnership between an independent unpaid person and a partner
Volunteer advocacy	Independent and unpaid, usually short-term issues or a casework basis
Paid advocacy	Advocacy workers who share the characteristics of the volunteer advocates but are paid for the task
Professional advocacy	Sometimes referring to the partial advocacy role of staff in health, social care and other settings
IMCAs	Independent Mental Capacity Advocates will be the first statutory advocates to be introduced in the near future, but with a limited remit

Age Concern England also replied to the questionnaire by giving an overall view of the situation within Age Concern schemes throughout England.

A blank questionnaire is attached to this report.

The results were as follows:

> 6 advocacy schemes indicated that the advocacy scheme is structurally independent from local care providers.

> 3 replies indicated that the advocacy scheme (within a larger organisation) is protected from internal conflicts of interest through its operational management arrangements.

> No replies indicated that there is no independence policy in place in their organisation.

> **What kinds of evidence would you provide to demonstrate that you meet the standard on independence?** (7 replies)

Replies were as follows:

a) The organisation included issues of independence in relation to its fundraising strategy from the beginning of the organisation.
b) The organisation has policies on conflict of interest, and confidentiality, with a County-wide interagency agreement, policy, procedures and standards for advocacy.
c) The evidence is in the staff/volunteer recruitment process and advocacy training information, agreement forms, and volunteers' handbook and policy. Also the Trustee minutes, funding agreements, engagement protocol and reviews with staff of the stated aims and principles.
d) The organisation has their own statement on independence which is included in their own 'Principles of advocacy' policy document.
e) The organisation has independence written into the constitution, highlighted in all the literature and taught to volunteers as part of the induction process.
f) The organisation addresses this through its constitution.
g) The organisation includes independence in the contract and service specification with funder information and policy document, and includes service users on the management committee.
h) Organisations produce minutes of their steering groups and policies for referrals, and procedures for independent supervision and evaluation.

> **The organisation receives funding from more than one source**
Yes 8 organisations No 1 organisation

> **What processes are in place to ensure that funding bodies do not restrict independence in the organisation?** (8 replies)

a) Contract and service specification, policies including confidentiality and reviews. No funding representatives on the management committee.
b) Funding is not accepted where the donor organisation wishes to control the operation of the charity.

c) It is in the organisation's constitution and policies and procedures, and they would not sign a contract with a funder that contradicted this.
d) Funders are made aware that they are not allowed to formulate or influence operational policies or practice.
e) It is made clear that eligibility and prioritising decisions/other operational decisions must be that of the advocacy organisation, not the funders. All potential contracts are vetted to ensure that they do not contradict the organisation's principles.
f) Through service level agreements.
g) A percentage of the funding outcomes are agreed with statutory funders. The Director vets reports to funders on spot purchasing clients, to ensure that no confidential detail is enclosed.
h) Funders will be made aware of policies and procedures designed to safeguard the independence of the service and its policy towards referrals when it is not appropriate for the service and/or the advocate to advocate for the person.

> **Representatives of funding bodies and/or care providers should not comprise more that 20% of the management committee. Do you agree with this statement?**

Yes 7 No 1

One scheme would not allow any funders on the management committee

> **The advocacy scheme's Trustees are representative of the local community in terms of age, gender, ethnicity and disability.**

Yes 7 No 2

From the No replies, one scheme states that the management committee are all users of health and social services and over 18. One scheme states that there is likely to be a bias towards older people, and in seeking service group members.

> **The management committee receives training in advocacy and understands why there is a need to preserve independence.**

Yes 9 No 0

> **The scheme has in place procedures for addressing and minimising conflicts of interest.**

Yes 8 No 1 (stating nothing formal)

> **Please give details of any additional factors used in your organisation to demonstrate independence.** (4 replies)

a) Scheme is managed by County Users' Network
b) Constitution and internal policies are determined by the trustees who are independent persons
c) Signed up to the Action for Advocacy Charter

d) The key feature is that a service has clear referral procedures and provides evidence of cases having to be passed to another agency when there has been a conflict of interest or some other likely compromise of independence.

11.2 Conclusion

The small number of replies to the questionnaire would appear to indicate that the majority of organisations have considered and addressed the issue of independence.

However, an OPAAL recommended policy on independence would hopefully address the situation for advocacy schemes that currently have no policy, and encourage more organisations to take an active stance.

11.3 OPAAL policy on independence:

An individual who is receiving advocacy support, has the right to expect that the service, and the individual working as an advocate with them, will be free to act in accordance with their wishes and aspirations, without any compromise, ambiguity, contradiction or conflicting loyalties.

Recommendations:

1. That advocacy schemes should seek at all times to ensure that individual advocates are fully supported in acting in an independent manner and in identifying and addressing any real or perceived conflicts of interest.

2. That should the situation and/or topic being addressed result in the individual advocate being unable to operate in such an open and uninhibited way on behalf of the person, for whatever reason, then they will declare this to be the case. The service will offer to make arrangements to forward the case to another available advocacy service, or individual advocate, to deal with appropriately.

3. That advocacy provision should be independent of the delivery of other health and community care services.

4. That advocacy organisations/departments should not agree to funding criteria, service agreements or performance measures that compromise the independence of their advocacy support.

5. That, advocacy organisations/departments secure independence by having an autonomous steering/ reference/management group/committee which oversees its operational and policy development, in addition to monitoring the quality of the service. A key function of this group would be to ensure that the service does not adopt policies and procedures that might compromise its ability to provide independent advocacy support.

12. Advocacy, adult protection and elder abuse

One of the four benefits of advocacy put forward by Dunning (CPA, 1995) is the protection it provides from abuse. In February 2004, Age Concern England and Action on Elder Abuse held a conference on the subject, at which a draft 'protocol for advocacy services on dealing with allegations of abuse' was adopted. (It has now been published by Age Concern England as an appendix to their document on advocacy standards, 'A Framework for Advocacy', ACE, 2006). In April 2004, the House of Commons Health Select Committee published its report on Elder Abuse, and called for independent advocacy to be widely available. In the same month OPAAL was asked to make a presentation under the heading 'Thinking Outside the Box' at the All Wales Vulnerable Adults Conference in Llandudno.

Our subsequent approach can be described under two headings. On the one hand we have outlined the prevention role, talked in more detail to advocates about it, encouraged the sharing of case studies on the subject. Jackie Robinson's workshop presentation at the Help the Aged conference in November 2005 (see appendix 5), adopted this approach. We see this as important preliminary work to the commissioning of practice research, which at present is completely lacking. Before making the Llandudno presentation, for example, the Chair read twenty-four advocacy publications (annual reports, project summaries, and advocate personal accounts) going back 20 years. Although case studies do from time to time appear, advocacy schemes do not appear to have had any tradition of representing work to counter abuse in their own reports, or to reporting on their work under such a category.

We have also tried to examine the scope for referral (including self-referral) to advocacy, as an alternative to the investigation model which established through adult protection services in response to 'No Secrets' (Department of Health, 2000). This would involve promoting empowerment in work with victims of abuse, using a rights-based approach. There is positive evidence (Cripps, 2000) from Australia that this can sometimes be effective. [F] Following the Chair's presentation on this subject at the British Society of Gerontology conference in July 2005 a workshop meeting between advocates, adult protection officers, and representatives of PAVA and Action on Elder Abuse, was organised by Better Government for Older People (BGOP), with representation from their Older Peoples Advisory Group. BGOP were interested because the work chimed with their own concern to see abuse tackled from a perspective which privileged the full citizenship of older people.

A subsequent workshop at the Action on Elder Abuse conference in March 2006 aroused considerable interest. Some adult protection officers have become concerned about the victim's experience of investigations, and Action on Elder Abuse have reported on the

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See also the web site of ARAS, the South Australian component of the Australia National Aged Care Advocacy Programme. www.so.agedrights.asn.au

current lack of evidence for the outcomes of adult protection. Adult protection officers have recently identified a keen interest in advocacy. Some wanted the boundaries of the Independent Mental Capacity Advocacy Service to be extended to provide more support to victims. Subsequently, with positive encouragement from Action on Elder Abuse and Help the Aged in particular, an informal partnership with OPAAL as the lead agency, was agreed with the aim of seeking funding for development work. This initiative, which has suffered from a lack of financial resources, forms a key plank of OPAAL's work 'to enhance advocacy's capability in response to issues of abuse and neglect'.

12.1 Partnership Proposal (June 2006, edited September 2006)

Older Peoples Advocacy Alliance (OPAAL) UK and Better Government for Older People (BGOP) are proposing to establish a formal partnership to seek funds and take forward an action research project, with independent academic evaluation, to explore the role independent advocacy with older people could play alongside professional. responses to elder abuse.

There is clearly interest among some adult protection officers in the role advocacy could play to enhance older peoples involvement in the design and delivery of adult protection. There is less confidence that advocacy can shift the balance away from professional investigation to the direct empowerment of people experiencing abuse. The project would aim to explore both.

It is proposed that the scheme would involve the following as partners:

Better Government for Older People [BGOP]
BGOP's Older Peoples Advisory Group [OPAG]
Older Peoples Advocacy Alliance [OPAAL] UK
Action on Elder Abuse [AEA]
Help the Aged [HtA]
Beth Johnson Foundation [BJF]
Professionals Against the Abuse of Vulnerable Adults [PAVA]
Association of Directors of Social Services [ADSS]

Three groupings – the Age Concern Advocacy Coordinators Network, the Dementia Advocacy Network, and Hampshire Advocacy Resource Group – have been identified who may wish to work closely with OPAAL through a practitioners network.

In practice OPAAL will seek to appoint a project coordinator in England, reporting to the new National Project Manager, who will oversee and support a small number of local initiatives, based with existing advocacy schemes, and established with the cooperation of local adult protection committees.

The partnership would have a high profile and call for robust governance. Terms of reference would be locally negotiated within broad guidelines established by the partnership. Considerable funds would be needed for at least two years. An academically-based independent evaluation will be established. In developing services there will be an emphasis on older people's human rights to encourage self-referral, and bypass the stigma associated with terms like 'vulnerable' and 'victim', which many among the older public are known to dislike.

Strategically, there would be constructive links with, for example, domestic violence self-help groups, the Disability Rights Commission's initiative around Lord Ashley's Independent Living Bill, and the British Institute of Human Rights.

Section Four:

Improving access and developing links with minority ethnic communities

13. Introduction

OPAAL believes that access to independent advocacy is determined a combination of factors: principally, the legal and constitutional framework, the commitments made to at a policy level, the resources available, the degree of public understanding, the organisation of schemes and their supporters, and the concerns and interests of service-users who need support.

In this section we consider the dialogue OPAAL has tried to maintain with government, the distribution of services across England, our efforts to influence provision in one region, and the position with respect to minority communities for whom services are clearly under-provided.

14. Working with government and the commissions

During the last three years we have, either at our initiative, or by invitation, liaised with government and its proxies around a number of policy developments. We are mindful of one member's statement: *"as a busy advocate I want OPAAL to be knocking on the doors of powerful people that I can't get to see".*

14.1 Existing guidance for advocacy with older people

With no legislation currently indicating a general right to advocacy for older people, interest has had to focus on guidance. The ongoing development of the Independent Mental Capacity Advocacy Service (Chapter 17 and Appendix 9) is consistent with earlier government encouragement for advocacy to have a very restricted focus: ie.

> *'those users who, because of their disability are unable to express their views and/or who wish or need to have independent representatives to act on their behalf. This will include those suffering from dementia or severe learning disability.'* (HMSO, 1991)

In our dealings with government over the last three years we have tried to face in two directions. We want to ensure that advocacy is available to those people who are self-evidently most in need of it. We also want to reflect the working experience of our members and the demands the public currently makes of them.

14.2 Learning from complaints

In 2003 the Department of Health asked us to be involved in its review of Social Services complaints procedures. As a result the Chair served on the working group during 2003 and 2004. Both the civil servants and representatives of supporting agencies (like the ADSS) were encouraging of improved access to advocacy. It was evident that government was currently under no political pressure to implement improvements, or to resource them. The contrast with the situation regarding 'looked-after children' – who have a statutory right to advocacy (DfES 'Get it Sorted', 2002) – was repeatedly drawn in relation to this shortfall.

Despite the sympathetic approach there was no reference to advocacy services in the regulations, and very little in the draft guidance under 'advocacy and support'. In January 2004 OPAAL proposed that a regulation should be amended so that the local authority was required to:

> "*make arrangements for conciliation, mediation or other assistance,* including independent advocacy*, for the purposes of resolving a complaint"*

and we made proposals at two points under the guidance:

> *"Independent advocacy is important in empowering service-users, and enabling them to make their voices heard, so they can better contribute to decision-making, and in exposing discrimination and prejudice.".*
>
> *"The role of an advocate should also be understood in a wider context. An independent advocate may be effective in enabling a service user to review their wishes and preferences in such a way as to require decision-making or service-planning beyond the scope of the immediate complaint. Steps should then be taken to ensure continuity in the advocacy partnership."*

Staffing changes at the Department of Health meant the suspension of the working party in March 2004. When the consultation was published in October 2004, much of the proposed guidance on 'conflict resolution' had been removed, while the key paragraph under providing advocacy and support now read:

> *"3.5.1 The authority will need to consider where appropriate, what type of support and encouragement it can offer to service users, both to make use of the system and to pursue their complaint through the procedure. Some complainants will need advice and confidential support to make their complaint, to pursue it, to understand the process and to cope with the outcome. Authorities may wish to consider whether the provision of an advocate might facilitate a resolution during local resolution."*

This paragraph attracted widespread critical comment during the subsequent consultation. As now published, (DoH website, August 2006), there is a strikingly unequivocal endorsement of advocacy in a new paragraph:

> *"3.4.1. During the course of making a complaint, a service user may request assistance from an advocate. The local authority should support this request by facilitating independent and confidential advocacy and actively providing information and advice."*

This represents a departure from previous guidance which has tended to direct the local authority's attention towards vulnerability, a lack of capacity, or the risk of abuse. Although complaints work can be viewed as a specialist area this may indicate a relaxation in concern about resourcing advocacy at the Department of Health.

Contributing to a process of this kind, whether in attending meetings or in scrutinising documents, proved very demanding for a small organisation. Although our inputs were intermittent, the opportunity for working contact with the CSCI, Association of Directors of Social Services representative, and the National Complaints Officers

Group, was important. In future, though, OPAAL would welcome the opportunity to brief more substantial organisations who are in a position to resource their contributions properly.

14.3 Office of Fair Trading (OFT) and care-home advocacy

OPAAL is not a member of the Social Policy and Ageing Information Network (SPAIN) but was aware of their super-complaint to the OFT in 2004 about residential care. Only a few elements of their original complaint were upheld, but the OFT set up a Care Homes Market Study Team which carried out substantial research on the issues which it judged to require investigation. Part of their concern was to examine residents' experience of making complaints and achieving redress, and the Department of Health had asked them to contact us. OPAAL met representatives of the team (who subsequently made a presentation to our AGM in 2005) on four occasions. We were particularly impressed that they intended to carry our market research directly with care home residents, and agreed to do some work with our members on the availability, and cost of, advocacy.

At very short notice we asked a small group of members to give us two types of information; the kind of support they offer to care home residents by advocates, and the costs of running their service. Six organisations worked on this project, supplying data and talking over the issues: Sefton Pensioners' Advocacy Centre represented OPAAL at one of the OFT's regional consultations. There was little expectation of reward: one member commented*: "everyone's interested in advocacy but nobody wants to pay for it!"*

In our report to the OFT we noted that, although, since 2003, Standard 17 of the National Minimum Standards has stated: *"where service users lack capacity, the registered person facilitates access to available advocacy services,"* it has not been accompanied by any commitment of funds, or of directives regarding finance, the scope of advocacy services, or the level of availability that might arise. Coverage was therefore inconsistent – and limited. Of the two schemes most involved with care homes residents that we spoke to, one worked within 40 homes in a catchment area with 140, and the other with 15-20 homes in an area with 174.

We noted also that there may be little alternative provision, and that some advocacy schemes carry a considerable responsibility for providing advice and information in homes as a result. One scheme had dealt with 540 of these 'low level' cases alongside 100 'high level' cases (which may be taken as situations where a full partnership must be developed). There is a danger that this kind of 'low-level' work may be increasingly identified as 'advocacy' by funders and the public. The range of work undertaken was of great variety, with one scheme identifying as issues:

> fee paying – concerns by relatives and residents regarding lack of information regarding details of fees and top up fees.
> financial arrangements, some residents on SS funding are confused about their weekly entitlement.
> issues around lack of activities in homes, and a demand for befriending services so residents could get out
> staff shortages.
> medical enquires.
> residents requiring support with family related issues.
> residents requiring support with issues within the home
> calls from relatives in panic as they have been told by a hospital to find a residential place for a relative.

Some of this work could also be intensive. Another scheme had worked closely with the Commission for Social Care Inspection (CSCI) over poor care provision. Fourteen cases had been taken up covering: financial complaints (particularly, in relation to top-up fees), the standard of service delivery, adult protection matters, and assisting people to make alternative choices.

A good practice example from another source impressed the OFT. Here, the advocate's validation of a mentally distressed care-home resident had made it possible to: gain insight into her concerns and assist in communicating them; improve the basic standard of care she received; alter staff interpretations of her behaviour, and mediate a number of professional encounters as a result.

We also tried to do some work on costs. For example, we tried crudely measuring the cost using a 'case' as a unit. This suggested a range of between £400 and £1000 per 'case'. However, this approach threw up two major problems. Firstly, it risked misrepresenting the work of citizen advocacy schemes which work solely around long-term partnerships. Secondly, it risked suggesting a homogeneity both to the design of schemes and to their approach which does not appear to exist.

The variables we judged relevant to calculating costs would include:
> the amount of small-scale information work undertaken
> the amount of development or outreach work undertaken
> the amount of social policy work undertaken
> the depth and capability of the service
> the degree of specialisation in the case-work
> the level of indirect (shared, or management) costs
> the diversity of funding sources
> the size of the neighbourhood affected
> regional or local pricing factors

The cost relationship between paid and voluntary advocacy is also an issue, while larger-scale schemes may be more expensive, with economies of scale cancelled out by the scope and diversity of representative responsibilities. It was also possible that more secure income sources for advocacy would have an impact on the unit costs of some schemes. The support costs of schemes managed by a host organisation (a common arrangement in advocacy with older people) might also prove anomalous.

One organisation provided an estimate that it would cost approximately £200 a day to keep an advocate in the field. They estimated they would need two full-time advocates to match the demand anticipated from 350 residential home residents. That suggests a project running cost approaching £75,000 a year. If across the UK the older population in 'communal establishments' totals around 400,000 that implies a total expenditure of around £85 million.

It was around this time that WASSR published 'Advocacy. Who Benefits? Who Pays?'. This report documented extensively the social benefits of advocacy and identified the advantages to a local authority of resourcing a scheme properly, but it did not carry out a cost-benefit analysis. It was clear that OPAAL, too, lacked either the expertise, or the resources, to carry out such an exercise. Our inability to contribute a 'regulatory impact assessment' (of the kind the Department of Health carried out before it consulted on the IMCAS) brought this project to an end. Lacking substantiated information on the cost benefits of advocacy the OFT limited itself to recommending that the Department of Health establish:

> *"pilot projects to measure the benefits to older people, care homes and authorities, of advocacy services being provided to older people entering or living in care homes, as well as the costs of providing such services."*

Coming, as it did, from within a government department OPAAL regarded, and still regards, this recommendation as an extremely positive development. However, it attracted very little attention in the media (unlike the report as a whole, which was widely reported), nor, apparently, from other stakeholders. In its response the Department of Health stated first that:

> *"it is committed to a number of relevant pilots, and we will share the learning from them."*

and went on to describe the individualised budget pilots and the independent mental capacity advocate initiative. OPAAL has written to the Department on a number of occasions questioning the direct relevance of these initiatives to the concerns identified by the OFT. Our disappointment has been acknowledged, but there has been no further discussion.

We are inclined to agree with the view put forward by Peter Scourfield 2006 that the Office of Fair Trading, a consumer affairs body, has shown a more positive commitment to the needs of older people in care than some professional groups with a more direct responsibility. We were particularly impressed with the extent of their consultation with older residents whose views and concerns are therefore at the centre of the report. We were further impressed with the robust survey technique they used to examine the care industry's view that a low rate of formal complaints indicates a high level of satisfaction among residents. OPAAL has decided to initiate a campaign to ensure that the OFT recommendations on advocacy receive direct attention.

14.4 Independence, Well-being and Choice

Although Department of Health (DoH) officials have sometimes urged the contrary, this key strategic document is not encouraging for the development of independent advocacy. A range of proposals were consulted on to improve assessment, care-planning, and user satisfaction with care services. Following advice from a number of sources the DoH consulted on 'service brokerage', an approach which attempts to empower users within care management decision-making. A crucial difference from advocacy is identified – the service broker is located within the commissioning system.

In its response to these proposals OPAAL was concerned that no role had been identified for independent advocacy in care-planning. We also discussed the issues with our member groups in Camden and Gateshead. The former were concerned at the overlap that would arise, and the confusion that would arise for the public. Their citizen advocacy coordinator said that ' there's not the respect for advocacy that there should be'. The latter, whose colleagues had already raised objections to service brokerage in the formal consultation, identified duplication (advocates needing to be involved to assist users work with a service broker) and were concerned at the limitations arising from brokerage's lack of independence.

OPAAL, through the Chair, contributed to two events which considered this issue, both involving presentations from the learning disability group 'In Control'. At the first, in January 2005, we went as guests of the OFT and joined a broad spectrum of care and policy representatives at an event convened by the CSCI. Puzzlingly, we were not recorded as present in the official report. Neither the extensive discussion, nor the support for, independent advocacy which took place is reflected in the text.

The second event, in London in May 2006, organised by Action for Advocacy, included a presentation from the Department of Health alongside 'In Control'. On this occasion there was enthusiasm from one or two advocacy schemes who were already practising 'service brokerage' in support of people with learning disabilities. One described, how after years of frustration with needs successfully articulated not being met, they had decided to extend advocacy to encompass the implementation

of care-plans. The DoH official was very focused on outcomes – "*Advocacy? Brokerage? I don't really care what you call it"* he said at one point, articulating a view that would no doubt command a good deal of public sympathy. It is interesting that in a recent debate with the Association of Directors of Social Services, the English Community Care Association (a body strongly supportive of advocacy) has pressed for independent 'service brokerage' to begin to replace statutory care management.

Recommendation 12: OPAAL will need to consider a number of factors in engaging further within these developments. These concern: the status of advocacy within policy developments; the applicability of different approaches across care-groups; the interface between advocacy and other social care practices; the feasibility of schemes offering multiple options to users.

Firstly, we need to be saying that it is unacceptable that policy developments (as outlined in documents like 'Independence Well-Being and Choice') pay so little attention to the actual working practice of advocates in care-planning. Secondly, we should point out that comparative studies might reveal significant differences in the scenarios faced by learning disability advocates and advocates working with older people. Thirdly, we need to be open-minded and encourage greater dialogue with others working in the field – service-brokers, mediators, lawyers, counsellors, and befrienders, for example. Lastly, we need to consider the feasibility of schemes' offering different options: a 'centre for older people's rights' might provide independent advocacy, service brokerage, and a public law service, for example.

14.5 The Social Exclusion Unit and 'A Sure Start for Later Life'

Early in the development project, members of the OPAAL management committee, the development officer and Andrew Dunning met with members of the Social Exclusion Unit to consider the appropriateness of advocacy for the well-being of excluded older people. The main points made were that:

> Advocacy ensures that older people are listened to and that their wishes are acted upon
> Advocacy gives older people the opportunity to become involved, in their own lives, in their medical treatment, in society and in decision-making in general (see the OPAAL report: A Voice That Wasn't Speaking (2006))
> Advocacy can help people through periods of major transition in their lives
> Advocacy can ensure that human rights are acknowledged
> Advocacy can contribute to early recognition of cases of elder abuse

The report 'A Sure Start to Later Life – ending inequalities for older people'. was published early in 2006 by the Social Exclusion Unit following further consultation

with OPAAL through the national development officer. There were two agreed government actions in relation to advocacy, namely:

> *The Department of Work and Pensions and the Department of Health will ensure that advocacy services are included in the piloting of the Sure Start to Later Life approach through the Link Age Plus programme, and as part of the Individual Budgets pilots.*
>
> *The Social Exclusion Unit will examine the role of advocacy in delivery of services to socially excluded people*

Following publication of the report, the development officer and the Chair contacted the Department of Work and Pensions and the appropriate leads in the Link Age Plus pilot schemes to ascertain how these agreed government actions were to be addressed. No replies were received from the pilot schemes, but the Department of Work and Pensions offered a commitment that tenders received from the pilot schemes would need to state how they would address the government actions in respect of advocacy. There has been no direct consultation with OPAAL about this, nor about individual budgets. This has been a disappointment, but OPAAL will continue to work towards ensuring that the agreed government actions are instigated.

14.6 Individualised budgets

In 'Independence, Well-Being and Choice' the government also announced that it proposed to extend the direct payments scheme through an individualised budget programme. This would enable service-users to access such support through an agent rather than managing the funds themselves. The thirteen pilot areas were announced in November 2005. Each was to have a budget of £200,000. Significant overlap was. emerging between government departments, and information on this initiative can be found on both the Department for Work and Pensions, and Social Exclusion Unit web-sites. The SEU's report 'A Sure Start for Life' states (ODPM, 2006. p 50) that:

> *"the Department for Work and Pensions (DWP) and the Department of Health (DH) will ensure that advocacy services are included ... as part of the Individual Budgets pilots"*

In the New Year, OPAAL was asked to join a panel discussion at the Counsel and Care Annual Conference 'Power to Older People' on February 21st, 2006. The session referred to 'Joining up Advocacy and Individual Budgets', and to consider how to link up services effectively. It seemed useful to find out what was going on in the 13 pilot areas. Accordingly, the Chair wrote to over 30 OPAAL member groups in advance of the session, asking whether they had heard about the initiative, whether they had

been contacted by commissioners, and how they had responded, or how they might respond if contacted.

This was the least successful of all the consultations we have carried out, with only four members – three of them advocacy providers, or advocacy support groups – covering three of the areas (West Sussex, Gateshead (2), and Manchester) providing information. Within those three areas it seemed evident that the initiative had at that stage prompted little publicity. The preferred mode of operation, in West Sussex, and Gateshead, appeared to be to extend the agenda of the existing direct payments working groups. There had been no contact at all at that stage in Manchester. Since then we have seen and heard little to question the perception that it will be difficult for most advocacy schemes working with older people to engage directly with this kind of networked approach to local development.

One of the ideas being discussed within the Department of Work and Pensions as part of the Sure Start in Later Life initiative is that of 'trusted third parties' (BGOP, 2006). This is a much broader concept than advocacy which, rather like the procedure that enables an individual to appoint a financial agent, aims to ensure that older people can identify proxies to operate on their behalf. One view within the advocacy movement may well be to reject any developments in this area, as neither reflecting advocacy's commitment to independence, and potentially undermining the development of standards.

We would recommend OPAAL try to engage in further dialogue. There could be a useful link with Laurie and Vivien Kerr's promotion of self-advocacy in 'Older People Doing it for Themselves' (JRF, 2004). OPAAL has suggested to BGOP that trusted third parties may benefit from support, and back-up resources. A significant number of our enquirers are providing voluntary support of this kind. Andrew Dunning estimates that as much as 10% of the work undertaken by Birmingham Citizen Advocacy in the 1980s involved support and advice to individuals in this position. A scheme which enabled advocacy projects working with older people to employ a 'casual advocacy support worker' could help address a number of objectives, to:

> link advocacy to people who prefer the support of someone already known to them
> address the divide between 'accredited' advocacy and casual support
> contribute to a citizenship-based approach
> improve links between advocacy and community development, neighbourhood renewal, and social cohesion programmes.

OPAAL will be approaching both the Department for Work and Pensions and the Social Exclusion Unit to make a formal presentation about these issues.

15. The OPAAL directory and database

In organising the programme of regional visits in the autumn of 2004 the development officer was forced to confront just how to difficult it is to identify where and by whom advocacy is provided and to whom it is available. Academic researchers have also commented on this problem in recent years, while, most recently, Counsel and Care, have identified a similar mapping initiative, around which they hope to build a development programme.

From OPAAL's point of view there were three problems. The existing databases at Action for Advocacy and Advocacy Resource Exchange were incomplete with regard to older people's services and also tended to include a sizeable number of contacts who were not independent advocacy providers. We were therefore delighted to be contacted by Dr Gary Kitchen proposed the idea of a mapping exercise to ascertain the exact situation in England with regard to older people's advocacy. Dr Kitchen, who has an independent consultancy, 'Get Heard', in Southport, was a founder management committee member of OPAAL, and has continued his association with older people's advocacy through links with Sefton Pensioners Advocacy Centre.

It was quickly agreed that this would be an important exercise. A successful funding bid was made to the Tudor Trust, and the final directory and accompanying report was launched at the OPAAL conference, Age, Advocacy and Citizenship on 19 July 2006.

15.1 'Mapping advocacy in the English regions'

Dr Kitchen's report is reproduced below at Appendix 7. The full database and report can be found on the OPAAL website, www.opaal.org.uk.

Dr Kitchen raises a number of important issues in his report, which was featured in both 'The Guardian' newspaper and on the Community Care website following its launch in July. OPAAL accepts the challenge set both to promote advocacy, to develop our membership, and to help tackle the serious service shortfalls which arise in some parts of the country (see Chapter 5.2).

15.2 The OPAAL database

OPAAL does not intend to maintain the directory as a publication, though, with its extensive space for annotation, we hope it will provide a valuable working reference book for regional and national referrers. At present there are significant gaps in the information provided on the database and we hope that its prominence will drive up providers' interest in sharing accurate and up to date information about their services. In partnership with the Beth Johnson Foundation OPAAL is now committed to maintaining and extending this database and will need to seek further funding to do so in the medium-term.

OPAAL will promote awareness of the directory at national and regional level and liaise both through our newsletter and our electronic mailing systems to encourage members and providers to keep their entries up-to-date.

16. South West Area Project

Following the regional visits to advocacy schemes throughout England, it appeared that the South-West was the least served for advocacy with older people, and it was selected as the region for more focused development.

Gary Kitchen's mapping exercise has subsequently revealed that this is not the worst served area overall, but the case for development remains strong and has been retained. The south west is a very large region, which stretches from Dorset in its south-east, and to Gloucestershire and Bristol in the north, It incorporates Cornwall, Devon, Somerset, Dorset, Wiltshire, Gloucestershire and Bristol or Avon.

This is too large to become a focus project for one officer, so the decision was taken to focus on Devon and Cornwall. With such limited resources the exact location of a development programme would also depend on local interest (see below). When, in July 2005, the Office of Fair Trading highlighted the lack of advocacy provision in residential care homes, it was just such a response that gave the project its overall focus.

16.1 Preparatory work

Initially letters were sent to:.

> Adult Care Services Managers in Devon and Cornwall
> the relevant County Councillors.
> a national freelance consultant working from Devon
> an older person who lives in Devon
> Plymouth University to try to generate interest in the project
> the services manager at Cornwall Care
> Age Concern Cornwall
> Age Concern Devon
> Help the Aged South West regional office
> Cornwall Community Foundation

16.2 Devon:

No reply was received from the Devon Care Services Manager or County Councillor, nor from the University. The freelance consultant arranged to meet for a discussion and passed on the details of the older person who was not able to assist directly, but who sent contact details for Age Concerns Exeter and Devon. Age Concern Exeter reported that they were awaiting the decision on a funding bid and would be in contact when this was known. However, by the time the outcome of the funding bid was known, there was no time for OPAAL to become involved in the project.

Overall, this was a rather discouraging response from Devon. It highlighted the difficulties of setting up a new development. Time constraints prevented further work, but if it had been possible, face-to-face meetings would have been arranged rather than rely on letter contact.

The lack of response may also reflect a difficulty for local authorities in offering support to an initiative which is not a statutory requirement, even though Government reports are recommending greater advocacy provision. It is a response that has been reported to OPAAL on a regular basis by advocacy scheme managers attempting to develop new services.

16.3 Cornwall

There was a much more positive approach from Cornwall.

The Cornwall Care Manager arranged a meeting within one of their residential care homes. Their current services were discussed, when it was established that they had completed joint projects with Help the Aged and Counsel and Care among others. There was very positive interest in providing advocacy services within the care homes, and within their community care services at a later date. It was agreed that the OPAAL development officer would put together a project and start to fund-raise for the work.

In the meantime, Age Concern Cornwall made contact and were enthusiastic to be part of the development, to extend their services into care homes.

Support was offered from Cornwall Community Foundation to assist financially if necessary, but only small amounts of money were available.

The Adult Care Services Manager within Cornwall County Council arranged a meeting and, although not wanting direct contact, was supportive and interested in receiving information about any future development of advocacy.

A funding bid was prepared for a short-term pilot project to extend advocacy into Cornwall Care residential homes, to develop a template which could be used for development nationally following the end of the Cornwall project. It had been decided to focus on just 5 care homes which was thought to be the smallest practicable number for one project worker. The work was to be peripatetic, with a suggested one day a week in each care home. It had been intended to develop a steering group consisting of older residents, an approach which was commonly applied in Cornwall Care homes. The project would be overseen by the OPAAL development officer, managed by Age Concern Cornwall, and operated within Cornwall Care Homes.

Unfortunately the funding bid was not successful, and the project was not able to progress further than the planning stages. However, the whole exercise was a good example of partnership working, and by no means a wasted effort. The parties concerned were keen to work together in the future, and would welcome the opportunity to resurrect the project at a later stage.

Due to the timing restrictions, there was no time to look for alternative funding and complete the project, before the end of the OPAAL national development project. A summary of the proposed project is detailed in Appendix. 11.

16.4 Future Development:

Contact with Cornwall Care and Age Concern Cornwall has been maintained. Two representatives from Cornwall Care agreed to attend the OPAAL Conference Age, Advocacy and Citizenship, to present a workshop on advocacy development in care homes. They presented details and evidence about their new initiative Care Aware and how this related to the provision of advocacy in Care Homes and in community work.

17 Independent Mental Capacity Advocacy Service

During the course of the project, the first statutory advocacy development was initiated under the governance of the Department of Health. National consultation meetings with the Department of Health took place across England. OPAAL was responsible for hosting a consultation in the South West, when the views of generic and specialist advocacy providers from all fields of work were collated into a report by OPAAL.

In addition to this, OPAAL submitted its own consultation exercise, a copy of which is in Appendix 9.

The views of all the regions were taken into account, and as a result changes were made to the introduction of the scheme. It was inevitable that not every contribution was addressed. Whilst the Department of Health now realise that 4 hours per case is not enough, it has not changed the criteria which states that an independent mental health advocate can only be offered to those without family or friends, for example.

18 Older People's Advocacy within Black, Ethnic and Other Minority Groups

While OPAAL is committed to the development of links with organisations working with minority groups throughout the UK, this is the project objective where we have accomplished least.

18.1 The Aston Conference, 2004

At the start of the project, arrangements were made to hold a diversity conference at Aston University, Birmingham in April 2004. This event was to be supported by Help the Aged, and was aimed at advocacy schemes, commissioners, older people and researchers.

Key considerations of the conference included:

> Why is there still a need for specialist advocacy provision with a particular focus on older people?
> How do we ensure that diversity is dovetailed into the development of independent advocacy with older people?
> How can the principles of independence and diversity be reconciled by advocacy providers in practice?
> What can advocacy schemes working with older people learn from and contribute to advocacy with other social groups and other social movements?
> Where does advocacy with older people stand within wider debates and developments in diversity, inclusion, equality and human rights?

Unfortunately, the uptake of attendance at the conference was very low, with only 45 of 120 places booked six weeks before the event. OPAAL felt there was no option other than to cancel. Although this was costly it was judged preferable to carrying on with something which had aroused little interest.

The committee have considered the reasons for the low uptake, but there is no definitive explanation. It is possible that the timing of the event was wrong, coming at the start of the development project, when fewer organisations were aware of OPAAL. It may also be that independent advocacy for individuals was not viewed as high, or as relevant, a priority as collective initiatives. There had been a lack of interest among possible workshop presenters and it was evident that OPAAL's networks were underdeveloped.

Whatever the reason, the lack of support was regretted. It had seemed evident that such an event would help raise awareness of older people's advocacy within minority communities, and this would have been an excellent opportunity to bring ethnic minority, disability, mental health, and lesbian and gay organisations together to build working links. By virtue of being in a minority, certain older individuals face an isolated, oppressive, future, which could be alleviated through the use of independent advocacy.

18.2 Ongoing work

Since the cancellation of the conference, there has been little opportunity for the development officer to prioritise direct development work, so the development of network contacts has been the priority.

With only one full-time person employed by OPAAL, there was simply not enough time or resources to do much more than pay lip service to the need for work in this direction. This does not intend to minimise its importance. Quite the reverse. It is an acknowledgement that this is such an important field of work that it requires a dedicated focus and funding to develop a paid post specifically to develop older people's advocacy within black, ethnic and minority groups.

Jackie Robinson has attended meetings and conferences held by black and ethnic minority groups. She was a guest speaker on behalf of OPAAL in Manchester, at the black and ethnic minority section of the National Pensioners Convention in 2006. She has also been a regular attender at the Age Reference Group for the Commission of Equality and Human Rights, which has among its members representatives from PRIAE, Commission for Racial Equality, Age Concern older gays and lesbians section, and Polari, and has had contact with other groups such as Nubian Life, London, which offers various services, including advocacy, to minority ethnic groups.

18.3 Ethnic minority groups

There appears to be a huge gap in the provision of older people's advocacy throughout the country for ethnic minority groups, borne out by the regional visits carried out by the development officer in 2004. Only one northern city appeared to have processes in place to address the various multi-ethnic communities, and only a minority of older people's advocacy schemes across England had made provision for specialist work in this field.

> *'We are concerned that there are so many languages it is not possible to interpret for all of them. In our borough there are 71 known languages. How can we be expected to advocate under these circumstances?'*
> Asian advocate, Midlands region.
>
> *'Everyone thinks that ethnic minority groups look after their own older people. But we are third generation British, and our traditional customs and cultures are disappearing, leaving the older people alone and vulnerable.'*
> Asian advocate, London region.

One city older people's advocacy scheme, with a project specialising in Asian advocacy, reported experiences of abuse from home interpreters who appear to have deliberately not interpreted the wishes of the older person correctly. The client, when

approached by the advocate, told a different story to the one initially presented through the interpreters who were family members.

Another London advocacy scheme posed the question of how ethnic minority groups are looked after in practice, especially if dementia is involved, because there appeared to be very few residing in care homes. Another advocate reported that she had supported an older person with dementia was thought to be possessed by the devil by her family.

These examples demonstrate a massive need for advocacy development, but also some of the difficulties involved in service development. OPAAL would like to see a facilitated meeting between specialist organisations to look at possible ways to take this forward. OPAAL is also delighted to have on its management committee Elcena Jeffers, a representative from the Black Disabled People's Association, who brings issues to the fore when possible.

18.4 Lesbian and gay issues

Polari held a series of seminars in London to highlight some of the difficulties facing older gays, lesbians and trans-sexuals in various contexts. Many of the situations demonstrated that advocacy could have helped the situation and eased the lives of those affected. It is clear that older gays, lesbians and trans-sexuals experience much greater levels of isolation than many other older people, some even finding it necessary to hide their sexuality for the first time in many years. Older gays, lesbians and trans-sexuals in residential care can have a very difficult time and can be very afraid to be open about their lives, making activities such as reminiscence sessions very challenging and even threatening.

***Recommendation 13:*.** There should be a targeted recruitment drive to include as many minority groups as possible in the OPAAL membership, and to ensure they are kept informed about future OPAAL developments.

OPAAL should engage consistently with organisations such as Polari, and PRIAE, affiliating to the latter's Minority Ethnic Elders' Policy Network as soon as possible, and establish opportunities to collaborate.

OPAAL should work with key partners to raise funds for dedicated work in the field of minority participation to ensure better awareness of, and engagement with, independent advocacy.

Section Five:

Conclusions

19. Concluding recommendations

19.1 Introduction

The need for advocacy services was endorsed in the recent publication by Age Concern England and Frances Butler, 'Rights for Real', in which it is stated:

> *'For those who are vulnerable and socially excluded, charities and voluntary organisations may be in the best position to engender change on their behalf. Such organisations are crucial to making sure that the Human Rights Act provides a voice for older people and redress when they need it. Advocacy services are particularly important in ensuring that the needs of vulnerable older people are identified and articulated.'*

OPAAL believes that advocacy is not just needed by vulnerable and socially excluded older people. The analysis of the benchmarking section and the report by Mel Wright 'A Voice That Wasn't Speaking' go a long way to illustrate that advocacy is crucial to ALL older people, whatever their background. There needs to be recognition that each one of us reaches a time in life, at any age, when we need additional assistance, but that this can be more difficult to find in later life for some people.

19.2 Recommendations:

Recommendation 1: OPAAL has agreed that the user involvement network will be taken forward, and that additional development work is progressed to include the formation of a users' network in London. It is recommended that OPAAL use the existing format to pilot the work in regions other than London, so that eventually there is a comprehensive documentation about the value of independent advocacy and how advocacy intervention might have made a difference to older peoples' lives.

Recommendation 2: Whilst work on advocacy standards has developed considerably since the start of the development project, further research and work could be done to develop advocacy standards which are particularly relevant to older people, care home application and dementia advocacy.

Recommendation 3: There is a need to continue development in the south west. Future work should focus on the development of a strong steering group which has commitment and drive to push the project forward even if there is a negative response. It needs to be owned by the relevant steering group, who should be responsible to funding applications, and all development planning. OPAAL does not have the resources to do more than offer expertise and networking links. Unless this steering group is established, OPAAL feels it is unlikely that future advocacy development will succeed.

Recommendation 4: OPAAL should continue to network as much as possible, but should ensure that all meetings, conferences, seminars and training are specific to the aims of the OPAAL business plan and funding requirement. This will mean ongoing prioritising of workload, which is inevitable for any national officer.

Recommendation 5: OPAAL should establish a benchmarking steering group to take this work forward, which could easily operate on a 'virtual' electronic basis for ease of involvement. The work carried out so far is no more than a baseline starting point but it could lead the way to extensive future policy development, particularly as it uses real examples to justify advocacy schemes' involvement.

Recommendation 6: The newsletter should continue to be issued on a regular basis. Positive feedback received from OPAAL members indicates that they would like the newsletter to provide an arena to circulate national developments, internally within OPAAL and externally in connection with government policy developments.

Recommendation 7: OPAAL should:

> work with its membership to monitor changes in the level of service provision, and publicise them appropriately
> review its capability to develop a toolkit for advocacy users, promoters and providers to lobby in favour of advocacy at local level
> review the terms of reference of the national programme (Appendix 11). .. to ensure that both the national working group, and the commissioner training programme, respond to these issues
> endeavour to broaden the debate about how advocacy is funded.

Recommendation 8: In the context of human rights and older people, OPAAL should:

> establish a working link with the British Institute of Human Rights, aiming to improve the understanding of human rights among advocates and improve the use of the Act by advocacy schemes
> continue to represent advocacy with older people within the Age Reference Group of the Commission for Equality and Human Rights

Recommendation 9: Following the regional developments, OPAAL supports the regional model of support, where an umbrella organisation maintains an overview of all advocacy within a particular region, offering opportunities for joint training, recruitment, funding and development. One of the difficulties reported to the development officer throughout the project has been that of isolation. Second-tier support offers a method of bringing advocacy schemes together in a local area, with excellent knowledge of local requirements and local policy. This support enables the advocacy scheme managers to run a service, leaving the second-tier organisation to provide additional support networks.

Recommendation 10: To promote awareness of advocacy, OPAAL should train its management committee members and other supporters in the use of the presentation material. Those who are prepared to do so should make use of this to promote the organisation in their locality or field of interest and report back to feed into future development plans.

Recommendation 11: OPAAL should work with its membership to examine both the possibilities and the pitfalls of supporting 'informal' advocacy in the future.

Recommendation 12: OPAAL will need to consider a number of factors in engaging further within these developments. These concern: the status of advocacy within policy developments; the applicability of different approaches across care-groups; the interface between advocacy and other social care practices; the feasibility of schemes offering multiple options to users.

Firstly, we need to be saying that it is unacceptable that policy developments (as outlined in documents like 'Independence Well-Being and Choice') pay so little attention to the actual working practice of advocates in care-planning. Secondly, we should point out that comparative studies might reveal significant differences in the scenarios faced by learning disability advocates and advocates working with older people. Thirdly, we need to be open-minded and encourage greater dialogue with others working in the field – service-brokers, mediators, lawyers, counsellors, and befrienders, for example. Lastly, we need to consider the feasibility of schemes' offering different options: a 'centre for older people's rights' might provide independent advocacy, service brokerage, and a public law service, for example.

Recommendation 13: To increase the involvement of minority groups, there should be a targeted recruitment drive to include as many minority groups as possible in the OPAAL membership, and to ensure they are kept informed about future OPAAL developments.

OPAAL should engage consistently with organisations such as Polari, and PRIAE, affiliating to the latter's Minority Ethnic Elders' Policy Network as soon as possible, and establish opportunities to collaborate.

OPAAL should work with key partners to raise funds for dedicated work in the field of minority participation to ensure better awareness of, and engagement with, independent advocacy.

20. Acknowledgements:

The success of the development project owes much to the co-operation and support from other organisations and individuals, without which any development or progress would have been almost impossible. It has been encouraging to see advocacy schemes working together, sometimes for the first time, and to receive responses to consultation work from advocacy scheme managers who are already hard-pressed to cope with heavy demands and client services.

This list is not exhaustive, but it does list organisations and individuals with whom the development officer has had a particular working relationship. Thanks are extended to:

The OPAAL Management Committee, and particularly John Miles, OPAAL Chair, for their encouragement and appreciation, particularly during the difficult times.

The Beth Johnson Foundation for supplying an excellent administrative and financial back-up, for mentoring services and sharing ideas, and for generally offering support throughout the life of the project.

The national and regional advocacy networks for sharing their ideas and offering mutual support and encouragement.

Age Concern England for the opportunity to discuss ideas and contribute to new developments.

Age Concern staff nationally who, as individual managers and staff, contributed large amounts of material and time to the project.

Advocacy organisations not associated with Age Concern for their valuable input and time.

Help the Aged for their readiness to offer help and support, and for their practical assistance.

The Benchmarking Group for offering their time and valuable resources to participate and seek out relevant examples. The organisations involved in the benchmarking exercise were (alphabetically):

> Age Concern Buckinghamshire
> Age Concern Richmond
> Beth Johnson Foundation
> Derbyshire MIND
> Hampshire Advocacy Reference Group
> Norfolk Elders Advocacy Alliance
> Sefton Pensioners Advocacy Centre
> Westminster Advocacy Service for Senior Residents
> Wyre Forest Advocacy for Older People

Dr Gary Kitchen, Get Heard, for researching and compiling the mapping exercise and for his additional donated time.

Mel Wright, independent consultant, for researching and reporting on older users' of advocacy in the London region, and for his many hours of additional time.

Andrew Dunning for his valuable expertise throughout the project, for his mentoring services, and for his practical advice and shared experience.

Advocacy schemes and older individuals who contributed to the user network consultation process. Some individuals preferred not to be named, although I offer my thanks to them just the same.

Contributing organisations and individuals were:

Advocacy in Barnet
Bromley Advocacy Alliance
Age Concern Camden Advocacy Service
Advocacy for Older People in Greenwich
Nubian Life
Age Concern Harrow Advocacy Service
Age Concern Hillingdon Advocacy Service
Kingston Advocacy Group
Age Concern Richmond upon Thames Advocacy Service
Cambridge House Advocacy Service
Westminster Advocacy Service for Senior Residents
Lewisham Independent Pensioners Advocacy
Senior Action Group Edinburgh
North Tyneside Independent Advocacy, Women Together Group
Elcena Jeffers
Teresa Lefort
Zelda Curtis
Stan Davison

Cornwall Care and Age Concern Cornwall for their enthusiasm and co-operation in trying to extend advocacy services into care homes in Cornwall, and for their hospitality throughout the process.

The Tudor Trust for making possible through funding the development of the first older people's advocacy national directory and mapping exercise.

New Philanthropy Capital for their efforts in gaining funding support for OPAAL and their ongoing interest in the Development Project.

Jackie Robinson, September 2006

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Section Six:

Appendices

Appendix 1:

Regional visits and extracts and findings from the OPAAL report: 'Advocacy – Who Cares For Older People' (2004)

Discussion One focused on existing practices and attempted to establish ways in which OPAAL could effectively contribute to future developments. Discussions centred around training methods for new volunteers and paid staff, management quality assurance systems, trustee training, office procedures, supervision and service user satisfaction schemes.

Conclusions to the discussions made recommendations for:

> Standardised policy and procedures documents to be made available
> Guidance on quality standards procedures to 'accredit' advocacy schemes rather than individual members of staff
> A national accreditation course with added specialist units relating to older people, to be made available if needed, but not imposed
> Representation on national advisory boards to raise the profile of advocacy and put the case for funding

Discussion Two focused on the evidence basis for advocacy, investigating the use and benefits of statistical evidence recording methods, as a means of attracting funding and pro-actively arguing the case for support. There was a wide-ranging difference in the methods employed by advocacy schemes. There was also discussion around service user satisfaction surveys and the difficulties in gathering relevant feedback, and consideration of case recording and storage methods.

The conclusion to this discussion made a recommendation to develop:

A framework around supervision
Core standards for advocacy
Good practice guides
Policies and principles
Service user satisfaction models
Statistical recording techniques and models

It was widely accepted that much of this material already exists, and that it is not solely the role of OPAAL to address all the issues. However, guidance from OPAAL to assist with the development of materials where necessary is a priority.

Discussion Three considered the case for independent advocacy for older people as a right, and examples of older people's involvement in the promotion of independent advocacy, in line with OPAAL's aims.

Very few advocacy schemes have written strategies to recruit and involve older people, although the majority do admit that most of their trustees, and many volunteers, tend to be older people.

Advocacy is widely recommended, but it was acknowledged that the provision of advocacy for older people is still sparse with big gaps in provision across England, and as yet no requirement on the part of local authority services to extend to include advocacy.

The discussion recognised the value of peer advocacy and looked at examples of peer advocacy schemes, where older advocates offer a service to older service users.

This section also looked at generic advocacy for older people, older people as trustees, and the development of older people's forums and their representation on decision-making boards within the community.

In conclusion the following recommendations were made:
> Development of policies and procedures which encourage the involvement of older people in the delivery of advocacy
> Ongoing campaigning by OPAAL for independent advocacy for older people as a right, as outlined in the OPAAL statement of intent

Discussion Four recognised the difficulties which surround the development of advocacy schemes for older people because of the uncertainty of stable funding sources.

Many schemes have suffered financial cutbacks in recent years, and managers have had to divert their time allocation to funding issues, which can detract from delivery of the core service. Some schemes felt that they are controlled by the requirements of their funding bodies. Business planning in an environment of short-term funding is very problematic, and the provision of advocacy can become like a 'post code lottery'.

The conclusion to this discussion made recommendations for:. ..
> OPAAL to continue to campaign for resources to be made available for older people's advocacy
> More partnership development to widen the understanding of advocacy
> Development of more advocacy schemes to address the current 'post code lottery' of availability
> More work to address the current lack of understanding about what advocacy actually offers

Appendix 2:

Two OPAAL standard presentations

Workshop Format (1) – Problem-sharing

90 minutes **Equipment – flipchart and pens. Post-It notes**

1. Introductions round the group (5 minutes)
2. Introduction to the workshop (5 minutes)
3. Ask everyone to make notes individually about a case they have known/worked on
   Identify the 3 points about it that they most want to see discussed
   If there are non-advocates present, they will be asked to pair up with an advocate (10 minutes)
4. Write on a flipchart the 3 issues from each participant (10 minutes)
5. Divide up the issues raised (10 minutes)
6. Agree with the group what are the advocacy/ non-advocacy issues (10 minutes)
7. Focus on the advocacy issues and aim to identify 4 or 5 topics (eg could be confidentiality, threats to the advocate, conflict of interest etc) (5 minutes)
8. Identify a problem to be solved in each topic. Break into groups to discuss and make recommendations (15 minutes)
9. Bring group back together. Highlight what is/is not resolved (10 minutes)
10. Identify any good practice pointers.
    Ask group to consider following work up at their own staff meetings, agreeing good practice pointers as an outcome for further discussion (10 minutes)

Workshop format (2)

The role of advocacy in health care protection **(90 minutes)**

1. **Introduction to OPAAL.** (5 minutes)
   Personal introductions, aims of the organisation, make-up of management committee

2. **Definition of advocacy** (10 minutes)
   OPAAL definition, Advocacy Charter definition, Bridlington definition
   Case examples

3. **What advocacy is NOT** (5 minutes)
   Information and advice, plus examples

4. **Advocacy principles** (10 minutes)
   Independence – ask group what they understand by this, describe OPAAL's meaning
   Inclusion – ask group what they understand by this, describe OPAAL's meaning
   Empowerment – ask group what they understand by this, describe OPAAL's meaning
   Why these are important

5. **Government developments** (5 minutes)
   Green paper on social care, No Secrets, IMCAs, and how they might link in to existing schemes, IMCA pilots

6. **Who will benefit?** (10 minutes)
   Ask group for ideas – answers to include the individual, the local authorities, hospitals (and less threat of readmission), care homes and staff (and the public image)

7. **How will they benefit?** (10 minutes)
   Ask group for ideas, and give a number of examples to demonstrate the effectiveness of advocacy

8. **Decision making** (10 minutes)
   Ask group what major decisions might be made in hospital, and how are people with mental incapacity consulted at present?. What might happen if only the family are consulted rather than the individual (mention again the 3 key principles)

9. **Hospital based advocacy** (5 minutes)
   What situations might occur that require a hospital based advocacy scheme? (stress the need for independence)

10. **Care home advocacy** (5 minutes)
    How might a resident benefit from having an independent advocate in a care home situation?

11. **Funding issues** (10 minutes)
    Outline the current funding possibilities and highlight the problems of short-term funding etc.

12. **Conclusions** (5 minutes)
    The way forward. How PCTs and LAs can help etc.

Appendix 3:

OPAAL Statement of Intent

THE STATEMENT OF INTENT (2001)

We believe that there are specific circumstances where all individuals must have a right to the support of an independent advocate to ensure that their own interests and preferences are acknowledged and addressed.

Such advocacy services must be defined in terms of their scope and purpose and be based upon appropriately trained and supported personnel, whether voluntary or paid.

As an essential first step, these advocacy services must be available to all older people who are:

> At the point of discharge from hospital

> Directly affected by a change in the management of running of their care service

> At the point of accessing continuing care and community care services

> At the point of being assessed for continuing care and community care services, and

> At all reviews affecting care services in hospital and in the community.

A series of clauses in legislation and the accompanying guidance notes provide the framework, however limited, for effective intervention. We call upon Government to clarify these opportunities and provide the appropriate resources to ensure that these services are made available and that they are free of charge to the individual.

Appendix 4:

Breakdown of responses under the seven categories of the OPAAL baseline mapping of advocacy content

Questions asked of schemes: An identical set of questions was sent out to each scheme to request examples of work undertaken in the relevant section

Examples submitted by schemes: The responses to the questions frequently included an in-depth insight into the way that advocates carried out this work. It was not possible to reproduce this in detail within this breakdown, but it did indicate that many cases take a very long time to resolve.

Advocacy Charter relevance: The Advocacy Charter was introduced in 2002 by Advocacy across London, now Action for Advocacy, which can be found at www.actionforadvocacy.org.uk

OPAAL good practice recommendation: This is intended as a guide for advocacy schemes about how they might develop standards in the future. It is not intended as a definitive guide at this stage, but throughout the benchmarking exercise there were many examples of good practice working which merited inclusion as a recommendation. Advocacy schemes do not always include formal standards in their working practices, but could develop these by using existing practices or by sharing expertise with other schemes.

1. Information

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you provided information	> Providing a list of care homes > Giving information about a blue badge > Sending out factsheets > Signposting to a solicitor for information > Calculating outstanding rent	Clarity of Purpose	Advocacy schemes should include in their training procedures a system of exploration of the differences between information, advice and advocacy and how these might inter-relate
An example where you researched information	> Objecting to Enduring Power of Attorney > Availability of higher education > Researching care homes > Accessing mains water > Local volunteering > Rights under Mental Health Act > Information about CAT scans > Risks in moving care homes for presentation at Tribunal	Clarity of Purpose	Monitoring procedures in place to ensure work relates to advocacy provision, or how work relates to advocacy
An example where you supported someone to identify and make use of information resources themselves	> Researching sheltered housing options > Researching mobility scooters > Exploring transport availability > Objecting to Court of Protection > Selecting appropriate leaflets > Accessing grandchildren	Empowerment	
An example where you supported someone to assert their rights to information	> Blind person facing a temporary move because of refurbishment > Access to financial records > Accessing hospital records > Negotiating with uncooperative hospital records office and lodging complaint > Rights under Mental Health Act > Care home resident unable to access bank account	Empowerment	

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you advocated to get a professional service to research and provide information	> Negotiating with Local Authority to put right damage after flat refurbishment > Liaising with Pensions Service to trace pension details without NI number > Debt advice and CAB liaison > Fighting against social worker and DLA office for right to mobility allowance whilst in care home (Successful) > Working with mental health solicitor to allay fears about sectioning > Liaising with mental health solicitor to pursue complaint > Meeting with pharmacist to discuss drug regime	Empowerment Putting People First	Clear protocols in place for referral to external information and advice agencies and/or departments within the same organisation

2. Access – Instrumental Help

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you yourself adapted information to make it accessible	> Visual use of calendar to explain amounts owed to care home > Adapting government information into accessible format > Adapting medical information downloaded from internet > Translation of information into Urdu and use of advocates who can speak other languages > Adapting material into large print	Equal opportunity Accessibility	Advocacy managers should record specialist staff skills within their scheme, demonstrated by a written or electronic record
An example where you researched the means to make information accessible	> Researching non-instructed advocacy > Regular use of internet to look at mobility, MS, RNID and RNIB sites > Researching communication methods for stroke recovery person > Information in picture format for dementia care home staff	Equal opportunity Accessibility	Advocacy schemes should maintain a local reference file which will enable staff to signpost or liaise directly
An example where you helped someone to assert their right to receive information in an accessible format	> Negotiated for bills in large-print format > Organising video-recorded information for patient on rights under Mental Health Act > Accompanying to assessment and doctors' appointments > Organising a benefits office outreach > Organising information in a plain English format for someone with learning disability	Equal opportunity Accessibility	Advocacy should have a system in place to update local reference files as appropriate, including websites
An example where you advocated to get a professional or commercial service to provide information in an accessible format	> Use of speech therapist > Organising a signer to be present > Obtaining care plans in accessible format > Asking solicitor to rewrite letter in plain English > Working with professional interpreter > Organising personal visit of property agent rather than written format > Organising bank statements in largest font for partially sighted people	Equal opportunity Accessibility Confidentiality	Advocacy schemes should be able to demonstrate an annual system of updating reference information. Advocacy schemes should keep a central record of situations which benefited from specialist intervention, to demonstrate evidence of active social policy work. Advocacy schemes should maintain a coded system to protect confidentiality when maintaining social policy records

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where the need to work in an accessible way altered the shape and style of the advocate's practice	> Working with deaf/blind person required shouting which was only method that could be understood > Leaving dementia client with a visit record sheet as a reminder tool > Accessing clients in a large rural area, establishing meeting places and use of telephone, letter or e-mail > Advocates working in pairs for people with memory loss, taking notes which are agreed with the client > Using visible aids for people with learning disability > Use of large font for visually impaired > One scheme adapts advocacy work as a matter of course to suit client's needs > Concern, but no action as yet, to enable advocates to access minority ethnic communities	Equal opportunity Accessibility	Advocacy schemes should keep a central record of work which has addressed local equal opportunity and diversity failures. This can be used to demonstrate the benefits of advocacy to funders and commissioners. Advocacy managers should record instances where usual practice has been varied, and why. Advocacy managers should submit an annual statement of intention to their local authority or overall manager, to raise awareness of need and for future target setting

3. Choices

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you supported someone to identify the choices available to them	> Housing choices > Dissatisfaction with consultant > Choice of domiciliary care > Choice around payment methods for heating installations > Residential care for sisters > Application for British nationality or Turkish passport > Legal choices around selling share in house ownership	Putting people first Empowerment Clarity of purpose	Scheme should have written guidelines about the nature and scope of advocacy. Schemes should have adequate publicity material for external agencies which explains the role of the advocate. Schemes should have training procedures in place to prepare advocates for such procedures. Schemes should have systems in place to ensure advocates undertake regular refresher courses.
An example where you helped someone understand the choices that a professional service said it could make available to them	> Regular work explaining choices on a mental health ward > Dispute around repayment from sale of house and son in America > Housing options and care needs for client sectioned under Mental Health Act > Housing options for blind person > Choices around day care and respite care to man with Alzheimers Disease > Choices around a discharge care plan > Choice of care worker in domiciliary situation	Empowerment Independence Clarity of purpose	Schemes should have adequate training courses in place to ensure staff have the necessary skills to help client make choices. Schemes should have training updating procedures in place. Schemes must ensure they have insurance protection in case of legal action. Schemes should have a clear policy on independence to ensure no conflict of interest
An example where you advocated to get a professional service to explain that there were choices available to the partner	> Using solicitor to deal with distant relatives who were over-cautious with finance > Using specialist mental health solicitor to get appropriate mental health services > Getting professional to explain choice of care home where social worker stated there was no choice > Engaging help of occupational therapist	Independence Empowerment Putting people first	Schemes should have clear policy on independence. Independence policy should be available to all clients and/or external agencies at start of a case or referral. Schemes should have a method of feedback from external agencies as a means of quality control

4. Decision making

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you supported your partner to understand that a decision needed to be made	> Advocate helped client to understand need for increased intervention needed in care package > Advocate helped client with their applications for larger accommodation and the kind of evidence needed > Advocate helped client with mild dementia to understand the need for Power of Attorney without delay > Advocate helped client with need to make a decision about treatment after 3-month deadline had been reached	Independence Empowerment Confidentiality Putting people first	Scheme needs to demonstrate independence by means of an independence policy. Schemes should have a process in place to deal with conflicts of interest. Scheme must be able to demonstrate how advocates enable clients to understand that advocate's first responsibility is to the client
An example where you advocated to get a professional service to explain that a decision was about to be made	> Advocate took client to bank to sort out financial affairs > Advocate asked nurse to explain procedure about nurses' holding powers to prevent client leaving ward > Problems with care package required visit with new care manager and NHS continuing care co-ordinator > Explanation of increased intervention in care package for client with enduring and deteriorating mental health issue	Independence Empowerment Confidentiality	Schemes should have procedures to train advocates in empowerment principles. Schemes should have training procedures in negotiation skills and in putting people first. Schemes should aim to work in clear language avoiding jargon which might further confuse
An example where you supported your client to make a decision about their care or treatment	> Older person wanted to look at information about moving into care > Client with mild dementia being pressured to move from sheltered into residential care, advocate helped consider all options > Client wanted to appeal against being sectioned after discussing options with Advocate > Advocate provided information about medication and client's rights after consultant wanted to administer injection instead of oral medication	Confidentiality Empowerment Putting people first Independence	

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you advocated within a professional service system to influence a decision about your client's care or treatment	> Advocate provided evidence that client with progressive illness did not want change in way medication given > Advocates support clients regularly on ward rounds of mental health hospital > Advocate persuaded consultant to allow client's discharge from hospital > Client with fear of bureaucracy helped by advocate to understand delay in application for transfer to sheltered accommodation	Empowerment Independence	
An example where you advocated within a professional service system to influence a decision about your client's care or treatment	> Advocate worked with housing service to adapt arrangements to suit client while repairs done to his flat > Care assessment with all professional parties regarding discharge. Advocate influenced decision to agree to discharge > Advocate supported client at panel meeting to argue that he wished to remain at home and not go into residential care	Independence	
An example where you advocated within a professional service system so that your client was able to control decision-making about their care or treatment	> Client depressed and lacking in self-esteem was helped by advocate to understand she could have a say in care package decisions > Client doubly incontinent had trouble with obtaining pads and advocate helped to repair the rift with district nursing staff and GP that had added to the problem > Problems with client's capacity to consent to treatment. Advocate able to provide evidence about client's wishes and medical staff accepted this	Empowerment Independence Putting people first	
An example where you advocated with a professional service system where your partner was unsuccessful in influencing a decision about their care or treatment	> Supported by advocate in wish to go home after being sectioned, but was placed in permanent residential care > Complaint by client against staff and a plea to be allowed home. Advocacy failed on both counts because of misunderstanding and request overridden by consultant > Client wanted 2-bed flat so carer could sleep over. Turned down by housing service	Supporting advocates	Schemes should have policies in place which support advocates in cases which do not have the outcome desired by the partner

5. Complaints and Legal Rights

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you helped someone identify that they wished to make a complaint	> Complaints by partners about food, environment on a ward, staff attitudes, care and treatment etc. > Complaint about home-care agency > Advocate helped with complaint about abusive practices in mental health unit > Advocate highlighted that client had right to complain about domiciliary care > Complaint about building work	Empowerment Putting people first	Advocacy schemes should have in place a policy to ensure that support is appropriate to the user. Advocates should ensure that the user knows how to contact them and the limitations on this
An example where you helped someone ensure that a complaint was recognised and dealt with	> Following complaint, users had not received feedback about progress. Advocates were able to investigate this > Advocate organised change of care home to user's own village > Advocate assisted with right of appeal against unsuccessful complaint procedure. Complaint upheld > Advocate helped to secure refund for shoddy goods	Independence	Advocates should ensure that the needs of the partner are acknowledged and acted upon regardless of the nature of complaint
An example where you advocated to ensure that your partner was fully engaged in the resolution of a complex complaint about care or treatment within the agreed procedures	> User dissatisfied with outcome of complaints procedure. Advocate helped user to meet with specialist solicitor and complaint to Healthcare Commission > Advocate liaised with all parties to obtain satisfactory placement for user with dementia > Advocate secured additional carer for client with multiple care needs > Advocate secured mobility component of DLA for user in care > Client's partner had an advocate and Social Services had made assumptions about the partner which did not suit client. Advocate acted independently for the client to communicate and make a complaint about the situation	Independence Empowerment	

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you have advised someone of their position with respect to legislation and guidance	> Advocates reefer to Mental Health Act on a regular basis > Advocate obtained advice through Citizens Advice and advised user accordingly > Information and help to draw up Power of Attorney > Advocate organised for Social Services to take on Power of Attorney appointeeship > Change in level of care for user > Advocate assisted in a boundary dispute which went to Court	Putting people first Independence Empowerment	
An example where you have advocated using your knowledge of legislation or guidance to alter service outcomes	> Advocate was able to explain the limitations of a Guardianship Order and helped user return to own home > Complaint about level of service offered by Social Services had a successful outcome > Advocate used knowledge of case law to achieve positive outcome > Advocate supported user to argue case for a relationship within a care setting, against wishes of family. Complaint went to high level, and resulted in care home writing a policy to cover this > Advocate worked to secure housing for partner after her house had been returned to Local Authority whilst she was in hospital	Empowerment Putting people first Clarity of purpose	

6. Empowerment

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you have ensured someone can get control of their financial affairs	> Advocating for someone with mental health problems who was in debt > Advocating to get Court of Protection order revoked, requiring alternative consultant intervention and solicitor	Empowerment	
An example where you have supported someone to end an episode of abuse	> Advocating for someone being physically and mentally abused by son, involving police, solicitor and Court proceedings > Advocating for someone having problems getting financial and money information from son who had power of attorney	Confidentiality Empowerment	
An example where you have advocated about an adult protection procedure	> Advocate brought in o assist adult protection team to support client being financially abused by daughter > Advocate called in to assist lady with communication difficulties. Husband cleared of abuse allegations, brought about by these difficulties, and lady able to return home according to her wishes	Putting people first	
An example where you have advocated for someone accused of abuse	> Advocating for a client who had a history of abuse, but who had been incorrectly placed in residential home, appropriately moved to EMI unit > Wife wanted husband to return home. Medical staff refused on grounds he had abused carers in his residential home. With advocacy intervention he was allowed home.	Putting people first Empowerment Supporting advocates	Sensitive issues require adequate staff support and schemes should ensure these are in place at all times
An example where you have advocated to ensure that an adult protection procedure is instigated	> Advocated for a client who had made a 'gift' to carer in residential home. Initially denied by carer, but later admitted. Advocate highlighted POVA element relating to gifts after Social Services had denied there was a problem > Advocate reported incident of physical abuse to home manager who took appropriate action	Confidentiality Putting people first	Advocacy schemes should primarily ensure that the wishes of the partner are taken into account at all times

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example where you have advocated to ensure that institutional neglect is acknowledged and acted upon	> Client had a stroke and his wishes were not acknowledged in his care home. Family member asked advocate to monitor his care plan. Advocate instigated regular residents meetings and discussed with care home manager	Empowerment	

7. Self-Advocacy, Group Advocacy

Questions asked of schemes	Examples submitted by schemes included	Advocacy Charter relevance	OPAAL Good Practice recommendation
An example of a partner who has gone on to become a practising advocate	> No examples provided	Empowerment	
An example of a partner who now contributes directly to the development of management of advocacy	> Client with cerebral palsy was in partnership for some time before deciding to become a trustee. He is now a valued member and able to represent the service users views. > Regular use of client feedback to change and/or develop services	Equal opportunity	Schemes should have procedures in place which encourage and make possible the inclusion of older people in the shaping of policies and practices

Appendix 5:

Elder Abuse: Exploring Advocacy Potential (AEA conference Jackie Robinson, June 2005)

Introduction

At the start, it is important that everyone is aware of what we are talking about when we speak about advocacy. In the context of OPAAL's work, advocacy is defined as being

'a one to one partnership between a trained, independent advocate and an older person who needs support in order to secure or exercise their rights, choices and interests.'

In other words, the advocate is the eyes, ears and mouth of the person they represent.

The three key principles are
> independence – services to be free from conflicts of interest,
> inclusion – advocacy schemes should be accessible to all older people, including at management level and
> empowerment – enabling older people to take control.

Advocacy generally therefore involves people making a case for themselves and advancing their own interests, which may require the input of trained people representing others and supporting them to secure and exercise their rights.

There is a fine line between offering advice, information and advocacy. They are closely related, and by necessity they are interlinked. However, the advocate is principally there to ensure that their partner or client's voice is heard, and to take whatever action is necessary to make sure that the wishes of that person are taken into account at all times. This should become clearer by the end of this report.

Advocacy is an expressive practice as well as an instrumental one, which has been described by Henderson and Pochin thus – 'it is this personal element, this consent, this commitment, this trust, which gives advocacy its legitimacy.'

So how does this help the older person?

At a most basic level advocacy has the potential to contribute in three ways to the resolution of abusive situations.

Firstly, the advocate may serve as a witness, and counter the secrecy which can, and often does, surround abuse.

Secondly by offering recognition of the abused person, they may disrupt negative expectations held by the abuser, and reinforced by others, countering the depersonalisation associated with abuse.

Thirdly, at least at a preventive stage, they may contribute to empowerment, by working with the abused person to question and alter low expectations of themselves.

In advocacy, the advocate is able to

- Lend a voice
- Have access to the necessary information
- Enable their partner to make an informed choice
- Offer support
- Assist with liaison with the appropriate agencies and people
- Work alongside their partner on specific issues and goals.

As far back as 1988 an investigation was made by Chough as to why residents who are abused in care homes keep quiet. Among the reasons revealed were because:

- They are vulnerable and need the services provided
- They have to live with the consequences if they complain
- They despair, thinking no-one will listen
- They do not know their rights
- They fear threats
- They have feelings of ambivalence towards abusers
- They think they will be blamed
- They have low levels of self-confidence which inhibit their communication

The same reasons could apply to older people in the community.

So how can an advocate change this? What makes advocacy more effective than other approaches?

An article written by Jane Lawson in 2000 explains the advocate role in some depth.

One advantage is TIME. An advocate will spend as long as it takes to listen to an older person. They will encourage the person to tell their story, ask critical questions and encourage a process of self-reflection, so that the older person can think for themselves to weigh up the pros and cons of their situation. This may take a long time, and will certainly only happen when the abused person is ready to share information with the facilitator, and able to trust them enough to confide in them.

So what are the key roles for an advocate in abuse situations?

CASE STUDY 1

A client in early stages of dementia had her son and daughter in law come to live with her. Whilst the son began to abuse her financially, the daughter in law began to abuse her physically, once even requiring stitches in her hand.

The client was referred to an advocacy scheme by a social worker. An advocate was there to support the client in her wishes. The advocate visited her very often, to let the son and his wife know of her involvement.

The client did not want to prosecute her son, but she wanted them to leave the house. The advocate was able to support the client in getting an eviction order served on them. She worked very closely with the statutory services during the time that the eviction order was actually served, to ensure that the client was not present, at her own request. She was offered respite care during that time, and after the son and his wife had gone, the advocate supported her on her return to her own home.

So how does an advocate actually help in a practical sense?

There are 12 principle factors according to Lawson:

Where abuse is suspected, but not proven, an advocate might be introduced to establish a relationship of trust so that the victim feels more able to share a confidence.

The advocate might act as a sounding board for the vulnerable adult to consider whether they should continue to accept the abuse being suffered, for example, looking at the ‘What if’ situations.

The advocate might help the victim to communicate what is happening to a relevant professional, in order to gain support.

The advocate might ensure that professionals who are appraised of the situation by the victim listen to that person’s wishes as to how best to proceed at any particular time and engage the victim fully in the assessment

The advocate will facilitate access to information about all of the potential options and resources available in a particular situation

The advocate will discuss the level of risk involved with the vulnerable adult and ensure that this will be understood and re-evaluated

The advocate will explore issues such as self-esteem, self-confidence, ability to make choices, and seek to improve these qualities in the individual

The advocate will be an independent person

The advocate will ensure that issues of confidentiality are taken into consideration appropriately

The advocate will ensure that the capacity to make decisions is properly assessed, and that any action is in the person's best interests

The advocate will support the person by participating in case conferences and give support before, during and afterwards

The advocate will ensure that careful consideration is given to how and where a person is interviewed during any investigation, to minimise anxiety and trauma.

The second case study involves financial abuse:

CASE STUDY 2:

A client in an advanced stage of Alzheimers had a niece who appeared to be very supportive, but was suspected of financially abusing her. She was referred to an advocacy scheme by a health professional. The advocate attempted to form a relationship with the client by regular visits, and by speaking to carers, social services and neighbours who were known to have been good friends. After investigations done at the insistence of the advocate, when social services were loathe to investigate, it was definitely established that the niece was financially abusing the client, who had continued with this behaviour even during the period of investigation. With the involvement of the advocate, the client was made a vulnerable adult. The niece was confronted with the facts, and although she denied it the advocate was able to prove without doubt that she had been financially abusing.

A decision was made not to prosecute by all the professionals involved. However, the advocate did complain on behalf of the client about social services lack of commitment initially in looking at the possibility of financial abuse around this client.

The No Secrets paper recommended that prevention of abuse should be 'the agencies' primary aim', but there is evidence that people do not know where to go and who to ask for assistance and information. The No Secrets Select Committee reinforced what I have previously said, that much abuse is not reported because many older people are unable, frightened or embarrassed. In order to address this, as set out in the BGOP paper 'Placing Elder Abuse in the Context of Citizenship', there is a need to adopt a 'whole system' citizenship approach which incorporates

independent living, whole system working and citizenship.
In order to achieve independent living, to ensure such principles as rights and self-esteem and choice and control, there might be a need for an advocate to speak for and inform the individual concerned.

Whole system approaches are only effective if the individual is able to understand exactly what is available. A seamless service throughout communities is only as good as the individual is aware of its existence, and an advocate's intervention is one key way to ensure that that individual has the necessary information.

In considering citizenship, as Stephen Ladyman has expressed, 'Vulnerable adults need to feel enabled and empowered and encouraged to complain if they are being abused.'. Advocacy is crucial to ensure that this is possible, that there is no abuse of human rights and that the individual remains an equal member of society.
As I stated at the beginning, the advocate is the ears, eyes and mouth of the older individual, and the means to ensure that every older adult remains a full citizen, regardless of their state of health or living condition.

For all of these reasons, OPAAL is striving to ensure that advocacy is available to all older people as a right, and not as a privilege. Adult protection procedures and frameworks need to permit and encourage the deployment of advocacy. Older adults at risk should have a right to draw on the support of advocacy schemes and the skills of advocates to try to resolve their problems on their own terms. The provision of advocates should complement the mobilising of community concern within a robust framework, to ensure that the risk of elder abuse is minimised and that there are, indeed, No Secrets.

Appendix 6:

OPAAL's response to Independence, Well-Being, and Choice

Independence, Well-Being and Choice – Consultation Document

Questions:

1. Does the vision for adult social care as set out summarise what social care for adults should be trying to achieve in the 21st century?

   Yes, but under **exercise of choice and control**, the use of advocacy should be mentioned along with independence and access to information**.**

2. Are these the right outcomes for social care?

   Yes, as long as the emphasis is retained on service user participation.

3. What are your views about how we can strike an appropriate balance in managing risks between individuals, the community and the social care worker?

   Through the use of trained, independent advocates as recommended in the Mental Capacity Act to ensure that those least likely to be heard are given an opportunity to express their views.

4. Should we take forward proposals to minimise the need for people to provide broadly the same information, for instance by sharing information between agencies such as the local authority and DWP?

   Agency information should be shared, but ensuring input from the voluntary sector in a true partnership, which does not happen at present. This will need additional resources.

5. We welcome views on moderninsing assessment and putting individuals at its centre. We are particularly interested in the practicalities of self-assessment. Do you think that there should be professional social work involvement in some or all assessments?

   Self-assessment is more effective through the use of trained, independent advocates who can be the ears, eyes and mouth of the individual if necessary, or be present to give confidence and ensure true representation of the service-user's wishes.

6. Do you have views on whether the SAP, the CPA and person-centred planning (PCP) should be further developed to provide a tool for use with all people with complex needs?

   All types of assessment might require the use of an independent spokesperson to ensure that the needs of the individual are uppermost.

7. How can we encourage greater take-up of direct payments in under-represented groups such as older people and people with mental health problems?

   The system of direct payments is complicated. There needs to be a simpler and more user-friendly approach, and access to an independent person such as an advocate to act on behalf of the individual.

8. Extending the scope of direct payments, (i) do you think we should review the exclusions under the direct payments regulations, (ii) do you thing that extending direct payments should initially be a power or a duty for local councils? And (iii) what do you think about the proposal to extend direct payments via an agent to groups currently excluded, namely those unable to give consent or manage a payment, even with assistance?

   i. Yes
   ii I think this should be a duty for local authorities as long as the system is comprehensible for everybody
   iii This will be OK as long as the agent is an independent person, such as an advocate, who is trained to assist appropriately. This will need additional resources.

9. Changing the name of direct payments (i) which name for direct payments is the most appropriate, are there any others, and (ii) when do you think the change should be introduced?

   i. Personal budget is a better name which communicates better.
   ii. There is still such confusion about the current system, there should be a long lead-in to any change or people will be totally confused.

10. We are committed to the introduction of individual budgets to give people greater control over their lives. We would welcome views on the proposals to pilot individual budgets.

    Pilot schemes are an effective way to introduce a new system as long as there is adequate explanation.

11. We are proposing to introduce a care navigator/broker model and would welcome views on these proposals. What are your views on the skills needed to perform the function and whether such a model might free social worker expertise to deal with the most complex cases?

    A care navigator/broker is yet another expensive layer of bureaucracy. Use the availability of the independent advocates across the country which are economical and trained. They already work with social workers, and cover a wide range of issues, so they would have a greater understanding of the likely problems and advantages. A 'care navigator' would need to be independent and free from other services, need to be trained and have the skills to empower the individual where necessary, need to have an understanding of the welfare system, and need adequate resources to carry out the function. Such people already exist and should be encouraged to take up this role.

12. What do you think will be the impact of shifting the balance of services from high-level need to earlier, preventative interventions on the eligibility criteria and what this might mean for FACS?

    Shifting the balance of services is paramount importance, both for the individual and preventative care, and for the cost to the state, taking into consideration the complete package for the individual. The earlier the assessment, the less the ultimate cost to the local authority. This is a difficulty for FACS and it will be difficult to maintain this system. However, there does need to be clear criteria of some measure.

13. N/A

14. N/A

15. N/A

16. Do you support the proposal to develop a strategic commissioning framework?

    Yes there is a need to develop a strategic commissioning framework.

17. Is the proposed shift to a preventative model of care the right approach?

    A preventative model is good, and ultimately cost-effective. However, to be truly effective, particularly for older people, there must be access to independent advocacy to ensure independence, inclusion and empowerment for the older person. So many older people cannot or will not speak for themselves, or do not understand the system, and however this is simplified, this will always be the case unless an independent person is made available for clarification.

18. What are your views on approaches to promoting and developing partnership working across agencies and effective models for so doing?

    Partnership working is of paramount importance, but it must be a true partnership with effective communication across ALL sectors, including the voluntary sector. Such models do exist, but there can be little trust in the early stages, and the statutory sectors can appear to maintain the superior position. This is not empowering for the more vulnerable members of society.

19. What help and support do local authorities and other social care providers need to work with people using services and carers to transform services?

    During a decision-making process local authorities and social care providers should welcome, and indeed, promote, the involvement of an advocate where an older person has asserted a preference for independent support to ensure that their wishes and preferences are heard.

20. Do you have innovative models of provision that support the outcomes of our vision?

    There are successful models of provision that support the outcomes of the vision. The recent report by the Westminster Advocacy Service for Senior Residents considers the benefit of advocacy work to the statutory sector, and the recent Office of Fair Trading market study on Care Homes makes frequent reference to the need for independent advocacy. These are just two examples but there are more available.

21. Do you have views on appropriate performance measures to encourage the implementation of the vision?

    Paragraph 10.5 recommends that the 'voices of people receiving social care should be heard at all times' but this will only be possible if systems are in place to ensure there is assistance for people who cannot readily speak up for themselves. Advocacy systems will provide this support, and ensure that the most vulnerable members of society receive adequate support and consultation. Advocacy schemes across England are currently working on performance measures, and it would be advisable to create liaison procedures to avoid confusion and duplication.

22. How can central government best enable LSPs develop and monitor progress on cross-cutting issues?

    Local Strategic Partnerships should be democratically developed and fully representative, with service users at the core of the procedure. This would ensure that progress is relevant and needed.

23. Do you think the direction proposed for strengthening and developing skills in the workforce is right?

    Developing skills in the workplace might be better addressed if it worked from the bottom levels up, thus providing training and incentive for the care assistant who is at the sharp end of delivering a service. Current lower levels of staffing are often poorly paid with a lack of training availability. More use of employee volunteering and/or backfill schemes at all levels would ensure a more rounded view of the society in which people work, leading to improved understanding.

24. How can we improve and better integrate local workforce planning?

    Through the use of backfill work and work shadowing to give everyone a greater understanding of each other's respective roles.

25. What actions are needed by government and others to assist employers in recruiting, retaining and developing the workforce?

    Much work in the social care sector, particularly in the voluntary sector, relies on short-term funding. This means that forward planning and consistency is very difficult to achieve, and yet it is quite common for projects to be funded more than once. Initial longer-term funding could lead to an improved service, better staff morale and staff retention, better integration because there is more time available, and a better outcome for the service user.

26. How can we strengthen the links with the VCS and increase community capacity?

    This is an excellent proposal, but as described at (25) it does depend on longer-term funding of projects, and a more secure funding base for the voluntary sector. There needs to be greater liaison between the statutory sector and the voluntary sector, and a recognition that 'voluntary' does not mean an inferior workforce. Consultation processes with the service users, such as older people themselves, would determine what is wanted and needed, particularly through the use of advocacy to reach those unable to speak for themselves.

Appendix 7:

Mapping Older People's Advocacy in the English Regions

The aim of this report is to provide a comprehensive picture of older people's advocacy in the English Regions.

The idea for the mapping came about as a response to the work of the Older People's Advocacy Alliance UK, which had identified the lack of information about the extent of independent provision for older people and the difficulty of locating schemes in response to enquiries as a barrier to development.[1] Independent research has also recommended that information about local advocacy services should be available to older people.[2] The mapping project itself was suggested to OPAAL UK by Get Heard Consultancy, which also played a key role in developing the idea and securing funding.

Criteria for Inclusion

The OPAAL Management Committee agreed in May 2005 the following criteria for inclusion in the directory:

a) Must provide an advocacy service to older people as their principal service; or
b) Must provide a generic advocacy service where at least ten per cent of the users are older people; or
c) Must have a dedicated advocacy section within their organisation to provide a service for older people.

The fundamental aim of the project was to establish what resources are available for one-to-one *advocacy* with older people, distinct from general information, advice or support. OPAAL defines advocacy as: "a one-to-one partnership between a trained, independent advocate and an older person who needs support in order to secure their rights, choices and interests".

To be included in the directory, therefore, voluntary organisations needed to have staff or volunteers whose role was defined as advocacy. It was agreed that statutory services, such as the Independent Complaints and Advocacy Service (ICAS), would not be included.

1 Jacqueline Robinson, *Advocacy – Who Cares for Older People?* OPAAL UK, 2005.

2 Pat Margiotta, Norma Raynes, Dimitri Pagidas, John Lawson and Bogusia Temple, *Are You Listening? Current Practice in Information, Advice and Advocacy Services for Older People,* Joseph Rowntree Foundation, 2003.

Methodology

An initial database was compiled of projects providing advocacy to older people, drawing on OPAAL membership records and a variety of online and paper resources. We devised a short advocacy mapping form that was piloted with three organisations (one in each of the three categories above).

The mapping form was then circulated by email to all organisations on the database in the first quarter of 2006. The information was collated onto the database and the directory produced. Each organisation was allotted to a region and Strategic Health Authority on the basis of postcode, which allowed analysis of provision across these areas.

For the most part the categories utilised above were straightforward to apply. However, the second category required some reinterpretation as we proceeded. The intention behind this particular category was just to capture those advocacy organisations that were "generic" in the sense of working with a range of age groups but which also worked with significant numbers of older people.

Some advocacy organisations have a specific focus – for example, on mental health – and therefore may not describe their service as generic. In practice this did not raise serious difficulties since organisations appeared to appreciate what we were trying to do and were not deterred by this sort of technicality.

The original intention behind category b) was to identify advocacy *organisations*. As the mapping progressed it became apparent that there were some advocacy *projects* that did not work specifically with older people and were not part of advocacy organisations. For example, advocacy projects working with disabled people, or carers, or those with mental health needs as part of a wider range of services.

Midway through the mapping some debate occurred about this criterion within OPAAL. But the timescale required that the project needed to be completed with no definite conclusion reached about which additional projects should be included. In some cases it is clear that such projects ought to be included – for example, generic projects within CVS organisations – or where significant numbers of older people were being worked with. We recommend that OPAAL needs to give further thought to this aspect of the criteria as the mapping develops.

Results

136 organisations appear in the following pages. The results are presented region-by-region with organisations arranged alphabetically within each region.

The directory is as complete as possible within the timescale, but it would be foolhardy to claim to have identified every project providing advocacy to older people, even within the categories stated. 123 mapping forms were returned. Reminders were issued and telephone calls made to all organisations on the initial database, which accounts to some extent for the high rate of return.

We included a further 13 organisations where there was evidence of specific projects with older people or contact had indicated that work with older people was being carried out. However a small number of other organisations were omitted as the form had not been returned and it was not possible to establish to what extent they worked with older people. During the next phase of the project the mapping will be put online so that new projects can be added and existing ones removed where they no longer operate.

In our view the mapping is much more than a record of existing advocacy provision for older people. Indeed, it raises major strategic issues for the future of advocacy for older people in England and should prove to be a vital tool in developing advocacy provision for this group.

Membership

Membership is one such strategic issue. OPAAL has just over 100 member organisations, not all of whom are providers of advocacy to older people. It is obvious that the number of organisations providing advocacy to older people in England alone exceeds OPAAL's membership considerably.

Returns showed that just over half of organisations in the directory are members of OPAAL, with 61 non-members. Whilst we can say that the majority of organisations *were* members of OPAAL, a very significant proportion were not – and some in this group appeared to have very little knowledge of the organisation.

These results represent a major challenge to OPAAL as the putative standard-bearer of advocacy for older people in the UK. We recommend that developing membership amongst advocacy providers needs to be reviewed as a priority. Increasing membership and awareness of OPAAL amongst the organisations included in this directory can only enhance the credibility of OPAAL's voice.

Analysis

The results of our analysis are set out in the Table below. This simple Table contains a great deal of information about the regional and sub-regional distribution of advocacy for older people across England. Using the Table it is possible to identify overall numbers of projects in each area and also the distribution of organisation types we have uncovered. In this short introduction we will draw attention to points of particular significance.

It has been recognised for some time that London leads the way as a provider of advocacy. London has similar numbers of older people to the East of England, West Midlands and the South West but rather higher levels of advocacy provision. However the North West has much higher levels of provision than might be expected in comparison with other regions outside London.

The North East has by far the lowest number of projects identified of any of the regions. This is to some extent accounted for by the fact that the region has the lowest older population, with less than one third that of the South East. The region with the highest older population, the South East, with 1.5 million people over state pension age, is in the middle group in terms of the numbers of projects it supports.[3]

But these figures do not in themselves lead to firm conclusions about where the "gaps" in provision might be. There did not seem to be clear evidence to show that any one region was lagging behind the others. The main conclusion is that coverage is clearly very far from comprehensive in any of the regions.

Perhaps the most useful approach to identifying gaps in provision comes when breaking down the directory further into sub-regional Strategic Health Authority (SHA) units. It may be that scrutiny of levels of provision in each SHA will give OPAAL one possible strategic approach to development that will fit smoothly with the present Regional Development Plan.

The average number of organisations across the 28 SHAs is approximately 5 per area. Using this as a rule of thumb, we can see that advocacy for older people is far from evenly distributed across such areas. The SHA area with the highest level of provision in England appears to be Cumbria and Lancashire in the North West, with 11 organisations, followed by Greater Manchester and North West London with 9 in each. At the other end of the scale, some areas have very little advocacy, with just 1 project identified in Kent & Medway in the South East and County Durham & Tees Valley in the North East.

These figures give very serious cause for concern about the lack of availability of advocacy for older people in so many areas. Making contact with SHAs where provision appears to be nugatory, and working with them to stimulate development, would be one obvious step forward for OPAAL.

There is also great variability in the distribution of types of organisation providing advocacy in each area. The directory lists 16 older people's advocacy organisations, 49 other advocacy organisations or projects which work with some older people (some of which also have specific projects for older people), and 71 non-advocacy organisations which nonetheless have a specific advocacy project to work with older people.

3 National Statistics Online, *Regional Profiles,* April 2006.

Table: Breakdown of Results by Region, Strategic Health Authority & Organisation Type

Table: Breakdown of Results by Region, Strategic Health Authority & Organisation Type

Region, SHA	*Criteria*			*Total*
East Midlands	**a**	**b**	**c**	
Leicestershire, Northamptonshire & Rutland	1	1	2	4
Trent	0	3	4	7
	1	**4**	**6**	**11**
East of England	**a**	**b**	**c**	
Bedfordshire & Hertfordshire	1	1	1	3
Essex	2	0	2	4
Norfolk, Suffolk & Cambridgeshire	1	0	2	3
	4	**1**	**5**	**10**
London	**a**	**b**	**c**	
North Central London	0	2	1	3
North East London	0	1	2	3
North West London	2	2	5	9
South East London	2	2	1	5
South West London	0	2	4	6
	4	**9**	**13**	**26**
North East	**a**	**b**	**c**	
County Durham & Tees Valley	0	1	0	1
Northumberland, Tyne & Wear	0	2	2	4
	0	**3**	**2**	**5**
North West	**a**	**b**	**c**	
Cheshire & Merseyside	2	1	2	5
Cumbria & Lancashire	0	7	4	11
Greater Manchester	1	0	8	9
	3	**8**	**14**	**25**
South East	**a**	**b**	**c**	
Hampshire & Isle of Wight	1	4	0	5
Kent & Medway	1	0	0	1
Surrey & Sussex	0	0	4	4
Thames Valley	0	1	4	5
	2	**5**	**8**	**15**
South West	**a**	**b**	**c**	
Avon, Gloucestershire & Wiltshire	1	3	3	7
Dorset & Somerset	0	1	2	3
South West Peninsula	0	0	6	6
	1	**4**	**11**	**16**
West Midlands	**a**	**b**	**c**	
Birmingham & the Black Country	0	1	3	4
Shropshire & Staffordshire	0	1	2	3
West Midlands South	0	5	1	6
	0	**7**	**6**	**13**
Yorkshire and The Humber	**a**	**b**	**c**	
North & East Yorkshire & Northern Lincolnshire	1	4	1	6
South Yorkshire	0	1	2	3
West Yorkshire	0	3	3	6
	2	**8**	**6**	**15**
FULL TOTAL	**16**	**49**	**71**	**136**

More than half of the provision in the directory is therefore provided by organisations whose main goal is not advocacy. 57 of these organisations are part of the Age Concern federation, which make up 42% of the mapping. The number of organisations working just to provide advocacy to older people is clearly very small. Meanwhile, it is clear that generic providers also play a very significant role in providing advocacy to older people.

Further breaking down these figures by organisation type does reveal some disparities. For example, the directory contains no older people's advocacy organisations in the North East or the West Midlands. The East of England, by contrast, has 4 such organisations.

Even where services exist, capacity is low. Respondents were asked how many older people were receiving one-to-one advocacy at the time the mapping form was completed. Such organisations tend to be operating to capacity at any one time, so we felt this would give a reasonable measure of the levels of overall provision. 121 organisations answered this question and worked with just under 5,000 older people, an average of 41 per organisation. Only 12 organisations were providing one-to-one advocacy to 100 or more people at the time the mapping was carried out.

Lessons for the Future

It has been said that advocacy for older people "is a relatively recent endeavour".[4] We should not be surprised, perhaps, that a mapping of this kind has not yet been carried out before in England, nor that development of advocacy for older people appears to be rather hit and miss. In the course of this piece of work one large provider of advocacy to older people was forced to severely reduce the service as a result of loss of funding. Many organisations on our initial database were found on investigation to be no longer providing advocacy for older people, usually because funding was no longer available. And many existing projects face a fragile future, very much dependent on short-term funding sources.

Meanwhile expectations are being raised by initiatives such as the Mental Capacity Act for England and Wales, due to come into effect in 2007, and its provision of Independent Mental Capacity Advocates to support and represent people who lack capacity over important decisions affecting them.

4 Andrew Dunning, *Information, Advice and Advocacy for Older People: Defining And Developing Services,* Joseph Rowntree Foundation, 2005, p.16.

It is easy to forget that the notion of advocacy is almost unknown to older people themselves and the general public. One piece of research drew on the findings of three focus groups with older people and found that "no one had ever heard of such a service".[5] Another found that "the word does not seem to be generally recognised" amongst older people.[6] It is very hard for older people to demand a service of which they may have no concept.

But compiling this report made us see that awareness of advocacy for older people is very limited even amongst many organisations who themselves work with older people. Advocacy has its adherents, but they are currently outnumbered by those for whom information and advice provides the default response to how to support people to get their voices heard. Potential providers themselves may not think of advocacy as a solution to this problem.

At policy level advocacy specifically with older people seems to have a very low profile. A comprehensive recent review of health and social care services for this age group does not mention advocacy.[7] When we asked advocacy providers who responded to the mapping whether they believed advocacy with older people was sufficiently recognised, 97% of those who answered this question said they did not.

Advocacy organisations tend to be fiercely independent and may well not be looking to be "developed" by external agencies. Nonetheless they are likely to welcome an organisation that is playing the key role of speaking up for older people's advocacy.[8] There is little doubt that advocacy for older people can be hugely beneficial. Advocacy providers give eloquent testimony below of the benefits it can bring. In order to succeed, the advocacy movement needs organisations like OPAAL to ensure that this work moves up the policy agenda. This mapping will hopefully prove another step towards achieving this goal.

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July 2006

5 *Are You Listening? Current Practice in Information, Advice and Advocacy Services for Older People,* p.54.

6 Laurie Kerr and Vivien Kerr, *Older People Doing It for Themselves,* Joseph Rowntree Foundation, 2003, p.11.

7 Audit Commission, *Living Well in Later Life: A Review of Progress against the National Service Framework for Older People,* Audit Commission, March 2006.

8 Dr Gary Kitchen, *Lancashire Advocacy: An Evaluation,* Get Heard Consultancy, 2003.

Appendix 8:

The Cornwall Care Project

January 2006 to July 2006 Proposed Pilot Scheme

Aim: To introduce independent advocacy services into 18 Care Homes in Cornwall, working with Age Concern Cornwall Advocacy, Information and Advice Services for older people. The aim is to address the concerns contained in the Office of Fair Trading Market Study into Care Homes, to run a pilot scheme, which will demonstrate the effectiveness of independent advocacy, and to ensure that residents have the maximum opportunity to live as full citizens and have a full understanding of the appropriate choices that accompany this.

Advocacy is defined by OPAAL (UK) as:

'A one-to-one partnership between a trained, independent advocate and an older person (care home resident) who needs support in order to secure or exercise their rights, choices and interests'

The key principles are independence, empowerment and inclusion.

As demonstrated by the Office of Fair Trading report, older people living in residential care homes can be restricted in these principles, which are key to maintaining their full citizenship rights. For this reason, Cornwall Care has invited OPAAL to develop advocacy services into their 18 care homes.

Why is this work needed?

The Office of Fair Trading Market Study into Care Homes was published in May 2005. Throughout the document, reference was made to the need for independent advocacy in Care Homes, to ensure residents are given the opportunity to remain fully inclusive citizens. This is a view supported by OPAAL (UK), members of which have expressed concern about the current lack of advocacy nationally in care homes for older people.

Quotes from the report:

Section 7.58. *"We have looked at claims that older people and their representatives may be reluctant to complain due to a lack of support and fear of repercussions. Some charities and consumer groups have expressed concern that older people may lack the*

ability to make their complaints heard. The experience of groups who are involved with advocacy is that older people find complaints procedures more accessible when an advocate is working on their behalf. Advocacy allows them to make their voice heard more easily and they can enjoy support through difficult situations they may not otherwise have had the confidence or ability to address.

Section 7.60. *"Advocacy can prevent complaints from escalating by providing a source of mediation, ultimately resolving issues more quickly to everyone's benefit. By actively demonstrating that they promote and encourage the use of advocates by residents, care homes could develop an advantage over other homes less keen to do so."*

Section 1.47.. *"Older people in care homes are in a vulnerable situation, and many will not enjoy the support of friends and relatives. Even for those who do, making a complaint can be a daunting prospect. We believe that the provision of advocacy services would enable older people to voice their concerns more easily and obtain appropriate redress. Through the provision of advocacy services older people would be supported by an individual who would provide them with a one-to-one source of help and support, and would be able to represent the older person throughout the process of resolving complaints."*

Section 7.67. *"Therefore we recommend that the Department of Health and the devolved administrations should run pilot projects to measure the benefits to older people, care homes and Authorities of advocacy services being provided to older people entering or living in care homes."*

Office of Fair Trading recommendations:

Section 7. "*The recommendations frequently relate to complaints, but in many instances of care home issues, the advocate is handling general enquiries or dealing with problems external to the home or involving relatives or friends."*

Section 7.52. *"While levels of complaints and dissatisfaction appear to be low, there are concerns about the ability of older people and their representatives to access complaints procedures. We are therefore making recommendations on three key issues:*
> *Raising awareness of complaints procedures*
> *Advocacy services for older people, and*
> *Improving the collection and analysis of complaints data."*

Future development plans:

There is currently very little advocacy of this nature available. Schemes that do exist do not have sufficient evidence to demonstrate the effectiveness or otherwise of their schemes.

This is an opportunity to introduce a new independent advocacy scheme into 5 care homes in Cornwall, fully supported by a management team, and which will be monitored and recorded throughout. The aim of this will be to demonstrate:

> The need for such a service to exist
> The difference made to the residents of Cornwall Care homes or facing discharge from hospital into Cornwall Care homes
> The opportunity for the potential involvement of residents in managing/steering the scheme in the future
> An opportunity for greater citizenship for older residents
> The effectiveness of partnership inter-agency working
> A template for other regions to adopt
> A way in which advocacy can remain independent alongside the delivery of other related services within an organisation

Who will carry out this work?

It is important that any advocacy offered as a pilot is independent of other services. A peripatetic advocate will be recruited for a short-term 6-month contract, who will be based at home but will be able to cover all the care homes in Cornwall.

The advocate will be line-managed and supervised by Age Concern Cornwall, which offers advocacy, information and advice from the same office. OPAAL will monitor the content of the work to ensure that information and advice are separate from advocacy services, but also to document how the relationships develop. It is important that this advocacy service remains separate from any other services offered by either organisation, in order to ensure that the results are defined and recorded accurately.

The Development Officer at OPAAL will oversee the whole project, record the outcomes and write the final report in conjunction with the appointed advocate and the participating agencies.

It will be the responsibility of the development officer to ensure that the OPAAL Management Committee is informed of progress at all times throughout the course of the project.

How will the scheme run?

The project will be dependent on the availability of funding, to be undertaken by the OPAAL development officer.

The project will aim to start as soon as possible after the New Year 2006. It will run for a 6-month period, but it is important that the pilot scheme will finish by the end of August 2006 to allow time for the results to be collated and reported by the end of the development project at the end of September 2006. The project worker will be expected to present evidence of the methodology and outcome from the pilot at the OPAAL conference in July 2006.

The project worker and OPAAL development officer will work closely with:
a) Quality Officer at Cornwall Care
b) Chief Executive and Advocacy Manager, Age Concern Cornwall.

The project worker will focus on advocacy only, but will liaise with or refer residents to Age Concern Cornwall for assistance with information and advice.

Appendix 9:

OPAAL RESPONSE TO THE IMCA CONSULTATION

September 2005

An introduction to OPAAL (UK)

The Older People's Advocacy Alliance works with independent advocacy schemes throughout the United Kingdom. It is a membership organisation of approximately 200 organisations and individuals. It aims to:

> Promote independent advocacy with older people
> Contribute to the development of standards
> Improve access to advocacy for older people
> Develop better practice in the field
> Build the involvement of older people in the organisation
> Develop links with minority and ethnic communities.

OPAAL's statement of intent states that:

OPAAL believes that there are specific circumstances where all individuals must have a right to the support of an independent advocate to ensure that their own interests and preferences are acknowledged and addressed.

These services must be available to all older people who are:

> At the point of discharge from hospital
> Directly affected by a change in the management or running of their care service
> At the point of accessing continuing care and community care services
> At all reviews affecting care services in hospital and in the community

The three key principles underlying the work of OPAAL are

INDEPENDENCE – (from professional services and conflicts of interests from a provider), EMPOWERMENT – (the service user/advocacy partner taking control) and INCLUSION, or ACCESSIBILITY – (hard-to-reach people)
CONFIDENTIALITY and TRUST

Definition of advocacy:

OPAAL's definition of advocacy is:

'A one-to-one partnership between a trained, independent advocate and an older person who needs support in order to secure or exercise their rights, choices and interests.'

OPAAL also supports the following definition offered by a member organisation:

'The advocate is there alongside the older person. They're in their shoes, so to speak, and standing up for their rights. The advocate takes the time to check what the older person really wants and explains the options and things happening around them in a way that can be fully understood …… sometimes the advocate has to say things to the hospital staff that shouldn't have to be said.'

(Bridlington Advocacy Awareness Project –
Advocacy with Older People in Hospital – OPAAL/Help the Aged 2001)

Specific responses in relation to the consultation on Independent Mental Capacity Advocates

General observations:

There is no mention throughout the consultation document about who the advocate should be answerable to. There needs to be safeguards in place from the outset to ensure that the IMCA is accountable and safeguards are in place.

Will the IMCA be given the opportunity to sit on consultation panels which relate to the service user?

When does the decision-making process stop?. At what point is there a cut-off?

At present decision-making processes and procedures are unclear. It is unclear if the IMCA has face-to-face meetings with the decision-makers, or how communication is carried out. Once a decision is made, how is it challenged, and will this delay the whole process by an unacceptable amount of time?. It is unclear about how the decision-maker will operate and how the process will work in practice. No attention is given as to what course of action the IMCA will follow if he/she does not agree with the decision-maker. These factors should all be addressed within the Code of Practice, and OPAAL accepts that much of this will be addressed through the pilot schemes.

There is little or no reference made to the Human Rights Act throughout the document.

Question 1: Consultation question on funding:

OPAAL is concerned about the allocation of time and resources suggested in the consultation document, at £100 per case and an average of 4 hours per decision.

Consultation with the service user at all levels is time-consuming, with the resultant demands on cost, but this is compounded when working with people who are mentally incapacitated. In order to ascertain and reflect on the true wishes of the service user, it will be necessary to spend considerable time with that person to get to know them and to build trust. There is no quick way to speed up this process, which is of paramount importance if, as the Act states, it is about 'putting people who lack capacity at the heart of the decision-making process'.

The situation is made worse in rural areas, when there is considerable travel time and cost involved.

It also takes time to research the case, gather full information and interact with other specialists if necessary.

Management time and cost also need to be built in to the process. The whole IMCA process will need to be professionally managed, which involves additional resourcing and cost.

Question 2: Which option is the best approach for commissioning the IMCA service?

At OPAAL we are disappointed that so little has been done to plan around a consultation with service users, and we would welcome some additional consultation time specifically with relevant groups, and particularly with older people. OPAAL would be pleased to advise further on this and to assist with the process.

a) From the commissioning options offered, OPAAL would prefer Option 3. However, we also feel it is important to keep an arm's length approach, with externally-held funding. This could be done, for example, through Local Strategic Partnerships, with, say, a committee to oversee which included elected members. IMCA commissioning should not be done by people who commission other services like physiotherapy, for example.

b) Some organisations have expressed concern about a fear of services being commissioned unfairly, and would prefer a central approach for this reason.

c) OPAAL prefers that the service should be compulsory. There is an important issue around how the tendered schemes might be evaluated, and this should be covered in the Code of Practice. The whole notion of capacity cuts across the way that advocacy is currently organised.

We would like Department of Health to reflect on whether tendering is the most valid way to commission services. Advocacy schemes at present are not provided through a tendering system, which is not felt to be the most appropriate in this case.

Question 3: Consultation question on national standards:

One of OPAAL's main aims is to contribute to the development of standards, so we do support the need for national standards for the IMCA service. We support accreditation for the advocacy organisation, and accreditation for the individual IMCA, seeing this as the first wave of national advocacy standards for everyone.

Organisational standards should be developed in consultation with existing advocacy schemes, many of which already have such standards in place. These should cover the usual general management standards, with additional elements to cover advocacy specifically, such as independence and confidentiality etc.

It was not felt relevant to introduce additional layers of standards to organisations that currently apply them, but on the other hand, standards should be nationally agreed and made available to those schemes which are not yet working to set standards. It is important that this is done in consultation with all types of existing advocacy provider.

Question 4: Consultation question on training and skills:

National accredited training should be undertaken by IMCAs and made available to individual advocates in all organisations.

One national course provider should be selected, such as the Open College Network, which has the infrastructure to deal with a national training scheme. It should be delivered by existing advocacy schemes which are experienced in training and are themselves accredited.

IMCA training should include the following elements.

It is important for the IMCA specifically to know

> how to make decisions about capacity, bearing in mind that capacity is not a medical judgement in itself

> how to debate capacity. (2-days training)
> medical ethics (2 days)
> decision-making process in the NHS and LAs
> how to challenge decisions
> communication skills training
> links with other programmes such as the independent mental health advocates

In addition, the IMCA should be trained in core advocacy skills. Although they will be working in an advocacy role, they may have come from other casework backgrounds. The core advocacy skills are well-defined in the publication 'The Right Result' by Rick Henderson and Mike Pochin, and include the following:

Foundation units:
What advocacy is about
Disability awareness and attitudes
Communication: getting started
Communication: relationship building
Choices and decision-making
Conflicts and complaints
Approaches to problems

Advocacy in context units:
Difference and diversity
Sexuality
Families, friends and volunteers
Working with professionals
Health, older people, dementia and learning disabilities
Choice and where to live
Choice in daytime opportunities
Education and learning disabilities
Risk management
The legal situation

There is much more to be considered, including the relationship between skills and knowledge, collaborative working and communication at all levels. Advocacy training should be done in collaboration with all providers, including the proposed IMHA advocates, and this can be done through liaison with existing advocacy schemes and training providers.

There will need to be additional management training, which will have a cost implication for the whole process. Trustees of advocacy organisations will also need to be aware of their statutory obligations in respect of the IMCAs and trained accordingly.

The importance of cross-sector training is paramount if the IMCA role is to be fully understood and given the necessary support.

Question 5: Consultation question on independence:

Independence is at the core of OPAAL principles and standards, and OPAAL is currently undertaking a consultation process to determine the current situation with older people's advocacy schemes.

Independence stops the service from being compromised, and should be visible. There should be no conflicts of interest with other service provision, whether this be in the statutory, private or voluntary sectors. In cases where independence could be perceived as being compromised, there must be policies in place to ensure that the process is transparent.

Question 6: Consultation question on accountability:

If there are standards in place and a requirement to observe these standards, then there must be a system of accountability. This can only be done by organisations which have a comprehensive understanding of advocacy, and who are independent. OPAAL can only see one way to do this, which is through an Advocacy Safeguards Agency, such as already exists in Scotland. Guidance should specify key objectives for monitoring the IMCA service. The Advocacy Safeguards Agency would have a responsibility to investigate complaints against an IMCA in such a way that the IMCA would not feel compromised.

The current organisations such as CSCI and Healthcare Commission are likely to be perceived by service users and/or advocates as not being sufficiently independent of public services.

Question 7: Consultation question on function:

It is not clear in what circumstances the IMCA will be operating. There is no detail about what decision-making processes are associated with this service. This should be included in the Code of Practice or guidance, but with maximum room for local discretion built in to guidance.

Question 8: Consultation question on challenging the decision-maker:

OPAAL considers that challenging decisions should be part of the basic training requirement for the IMCA, as listed in the training section. The Code of Practice should be clear about what is required for this.

OPAAL also considers that IMCAs should be able to bring simple cases to court without the need for legal representation, which should be covered in the training. This should be understood as part of the job requirement from the outset.
IMCAs should also be able to challenge the original decision that the person lacked the capacity to make the decision in question, with processes in place to facilitate this, and set out in the Code of Practice.

Question 9: Consultation question on additional functions of the IMCA:

The IMCA status should be covered by confidentiality for such things as case-recording, and service user communication. Any additional functions must not be seen to compromise this situation.

There is nothing specifically to add in this section.

Question 10: Consultation question on reviews:

There was concern about the practicality of this. The IMCA initially could fulfil this role, but given the limitations on time, over a period of years, it would become unworkable for an IMCA to accumulate all the review cases. In cases of dementia, for example, they would have to start the advocacy relationship from scratch each time a review was carried out, which will take time, and the sheer numbers would be impractical.

This is an opportunity to redefine the boundaries between IMCAs and existing advocacy services. To act in a best-interest role, the IMCA might appropriately, for example, set someone up with an advocate from a local scheme. They would therefore know that there is a named individual who is there to safeguard a person. This would be an effective way to introduce the wider field of advocacy to the review process. However, it does not address the problem of the sparsity of advocacy services throughout the UK.

OPAAL does welcome the idea of including the IMCA in the review process, but has concerns about how this might happen.

Question 11: Consultation questions on regulations on serious medical treatments:

OPAAL thinks that a specific list of treatments would be difficult to define exactly. Cases should be led according to capacity and circumstances rather than medical condition, with regulations focusing on these characteristics and those of the decision rather than a medical condition.

Question 12: Consultation question on extending the IMCA service:

OPAAL itself would favour options ii) or iii). Option ii) because it reflects the need for additional time and cost to provide a higher quality of service. Option iii) because it is important to be aware of the risks associated with disputes.

OPAAL would like to see a procedure where anyone can request support, but laid out in specific guidelines in the Code of Practice. Thus any party could request an IMCA but the decision whether to appoint one would rest with the decision-maker. There is always a need to resolve a dispute or a recognition of conflict.

Conclusion and general thoughts:

1. There needs to be more clarification about what constitutes 'family and friends'. If an IMCA is not to be involved because of the involvement of family and friends, for example, would the latter have access to medical records, and would this be acceptable to the person who lacked capacity?. These are issues which need to be addressed. Similarly, there needs to be a clear indication about what constitutes 'mental capacity'.

2. There should be greater cohesion between the Mental Health Act Advocate and the Independent Mental Capacity Advocate, and any new systems should aim to be inter-connected.

3. The way that advocacy services react to people with mental health needs is currently disparate in nature, and more needs to be learnt in this respect, and how this will interact with the IMCA.

4. New procedures should be introduced for a trial period with a review time built in to the process. This is in addition to the existing pilot schemes which are part of the consultation process.

Appendix 10:

Report on the 2006 OPAAL Conference: Age, Advocacy and Citizenship

This conference sought to obtain guidance from delegates about how to take issues around human rights and older people forward in the context of advocacy.

The conference day was divided into workshop sessions, with presentations from the Executive Director of the British Institute of Human Rights, the OPAAL development officer, Gary Kitchen, author of 'Mapping Advocacy in the English Regions' and the accompanying report, and Mel Wright, consultant for OPAAL on the developing the involvement of older people who have used advocacy.

The conference saw the launch of the two publications, 'Mapping Advocacy in the English Regions', and 'A Voice That Wasn't Speaking', both of which form a part of the National Development Programme, funded by the Department of Health, which will end in September 2006. The conference aimed to add recommendations from the workshops to this final report.

A synopsis of each workshop and the recommendations is outlined in this report.

A10.1 Guest Presentation

Speaker: Katie Ghose

Katie Ghose is Executive Director of the British Institute of Human Rights (BIHR). Katie told the conference that she saw great potential for advocacy schemes and the BIHR to work together to ensure the application of human rights for older people, and she was looking forward to some joint working and improved training in human rights for advocates.

The presentation covered the following main points:

About human rights:

> The context of the current Human Rights Act aimed to achieve more responsive, tailored services for individuals, and clearer, higher. standards across the board

> The key features were a starting point for negotiation, an immediate challenge for poor practice, and specific rights very relevant to many older people, such as the right to life, the right not to be subjected to inhuman/degrading treatment, the right to private and family life
> There was low awareness and use of the Human Rights Act within the voluntary and community sectors, but also a huge demand for greater knowledge and skills. This all pointed to a need for improved training.

Potential uses for the Human Rights Act included:

> An opportunity to co-operate/negotiate with/challenge individual workers in the system
> Identification of abusive or other unacceptable practice/cultures within institutional settings
> An opportunity to 'put your house in order'
> A means to identify disproportionate actions, such as separation of older couples within a residential care setting
> A tool to find out more about what older people really want, think and need

Human rights as an engagement mechanism: the involvement of older people in identifying needs and wishes:

> Fairness, respect, dignity, equality – all values that can bring people together across divides
> The advocacy movement: using human rights to engage service providers directly with older people and organisations. Recognition of the dual roles of local authorities and the voluntary and community sectors to provide service provision

What action is needed?

> Recognition of the practical value of human rights for advocates for older people
> The production of a range of practical tools that empower and equip older people and advocates to turn human rights into reality
> BIHR's role was to work with voluntary and community sector organisations to develop and deliver a programme of capacity building, especially for those organisations that are tackling social exclusion and inequality
> The development of frameworks/approaches that can be widely adopted and used (such as a partnership with the Department of Health)
> More research, including capturing advocacy examples
> Exploring the potential for a human rights school for advocates, sharing successes on websites, booklets, etc.

A10.2 OPAAL Evaluation Programme workshop

Presenter: Meena Patel

Meena Patel is an independent consultant working with the Older People's Programme. The OPAAL evaluation programme has been running throughout the period of the national development programme and has produced an initial baseline survey, an interim survey which focused specifically on two English regions, the North East and Norfolk, and a final survey to ascertain what effect, if any, the national development project has made on advocacy schemes.

Although this was a small group of attendees, the presence of an advocacy manager, a generic advocacy network manager, and an independent fund-raiser was particularly felicitous. It was almost possible to do some deals.

The evaluation aims to address the actual effectiveness of OPAAL. There was a good exchange at the workshop about the balance between the instrumental benefits of advocacy and its more expressive impact. John Miles, OPAAL Chair, expressed doubts – in response to one advocacy organisation's attempt in 2005 at a cost-benefit analysis – that a regulatory impact assessment for advocacy would be feasible. Others thought that it would not be desirable, whilst one funding organisation still believed it would be useful – and stated that he thought it would be difficult to appeal to some private fund managers without such an impact assessment. This was clearly an issue of considerable interest.

Some delegates thought that OPAAL should be more involved in challenging commissioners over short-term funding. They were doubtful about the impact of Compacts and the like.

Workshop Recommendations:

Those present contributed sympathetically to a number of options to which they felt OPAAL should respond:

> **models** for funding agreements
> **training/educating** commissioners. It was agreed to use the Leeds publicity video at the first Older People's Programme/OPAAL session with commissioners, and suggested that OPAAL might encourage communication channels and more self-regulatory discipline between commissioners – perhaps as an output of the national working group.
> **linking** national, regional, specialist and local advocacy networks consistently and more rigorously (weaving the tapestry as one member put it) – an idea strongly endorsed later by the Hampshire Advocacy Reference Group.

> **supporting and challenging** advocacy providers to be more proactive with the public about what they do, and encouraging further use and deployment of data for social policy purposes.

A10.3 Promoting Care Home Advocacy Workshop

Presented by Peter Scourfield and representatives from Cornwall Care

Two representatives from Cornwall Care introduced the work of the organisation. Cornwall Care has been pro-active in the delivery of new services aimed at greater social inclusion for its residents, and has won national awards for its dementia training programme. It manages 18 care homes throughout Cornwall, including older residents in developments and using their skills whenever this is possible.

Peter Scourfield is a university lecturer from Anglia Ruskin University, Cambridge, who has a special interest in promoting advocacy in care homes. Peter has recently published a report outlining the lack of advocacy in care homes at present, which considers the detrimental effects of such an omission.

There was recognition of some of the problems which exist in the care home field, the main ones being:

> A lack of awareness of advocacy by care home staff and residents
> A lack of training in care homes both to increase awareness of advocacy and in advocacy itself.

These problems could be addressed by greater contributions from both national and local organisations, including care home associations, national and local government.

How could training be offered in care homes?

It was agreed that this is a role that OPAAL could develop. With an appropriate training pack, training could be developed for care homes, and via the Commission for Social Care Inspection or other similar body.

There was a lack of understanding about advocacy within adult protection teams.

Advocacy schemes present at the workshop were not aware of any occasions where a care home had referred a resident to an advocacy scheme.

Advocacy awareness-raising:

There was a need to train care home staff to raise the profile, relevance and importance of advocacy to the residents. This would need to be a rolling programme which takes into account a potentially rapid staff turnover.

There was concern that raising awareness might cause problems in raising expectation, but that this could be addressed through improved training.

A good package from OPAAL could be developed which could be distributed as requested for staff to deliver advocacy awareness-raising.

Workshop recommendations:

How best to promote advocacy in Care Homes?

> Joint work with Social Services or the Commission for Social Care Inspection (CSCI) if possible
> A welcome pack to be given to each resident when they enter a care home with reference to advocacy
> Improved training for care managers about what advocacy is, why it is important and the benefits of consulting with residents with or without advocacy support.
> More work could be done to demonstrate the benefits of advocacy, making use of existing examples, consulting with users of advocacy, or liaising with local advocacy schemes if any exist.

A10.4 Older People with a Learning Disability Workshop

Presenter: Noelle Blackman, Respond

Noelle Blackman manages the organisation Respond, which develops a range of services for adults with a learning disability.

Noelle showed a video about a group of older people with learning disabilities which showed how people with a learning disability are mainly independent and are still active. She advised that funding is a problem for this group, with the amount of money spent less than that available for the young. Day Centre restructuring is a major issue, and older people with learning disability are used to dependency on others. There is no peer network, but there is work going on to help people become more independent.

Older people with learning disabilities are less worldly, for example, not understanding issues around bereavement, and they have difficulty with numeracy and literacy.

Around 1.5million people have learning disabilities in the UK, and this is estimated to rise in the next 15 years. People are surviving longer than previously, partly due to earlier diagnosis. Many people with learning disability are now older than they were expected to live, with women generally surviving longer than men. The life expectancy is influenced by the severity of the learning disability. Some are living with aged parents, and are not necessarily visible to the professionals. Many are now living in the community, and sometimes the needs of ageing overshadow the learning disability. Those with Downs syndrome, for example, are prone to early dementia, and the signs are often missed.

Comments from the workshop:

> Milestones reached are often not recognised by people with learning disability
> The passage of time is not recognised
> Money from government is spread equally for all sections of society
> There is a need for a care assessment package
> Older people in normal situations face similar problems to those with learning disability
> Older people with learning disability may face loneliness and isolation

A10.5 What Advocacy Means In Practice Workshop

Workshop presenters: Carol Older, Jackie Robinson

Carol Older was until recently the Advocacy Manager for Age Concern Buckinghamshire with a team of 8 people. Following closure of the Advocacy Department, Carol now works as Manager of the Information, Advice and Advocacy Department in Age Concern Milton Keynes. Carol was a member of the benchmarking group.

Jackie Robinson is the National Development Officer for OPAAL and co-ordinator of the benchmarking exercise.

One question often asked by interested parties is ‘What do advocacy schemes actually do?’. It is not always easy to respond to this. OPAAL has undertaken a benchmarking exercise to look at advocacy situations and how advocacy schemes have responded. This has created a baseline from which to progress at a future time.

It engaged the assistance of up to 9 advocacy schemes to participate by sending examples of actual cases undertaken.

This workshop considered the importance of understanding the outcomes of advocacy as a basis for assessing its effectiveness. Three questions were considered:

1. How important is it to understand the outcomes of the advocacy process as a basis for assessing the effectiveness of advocacy?

The principle points raised by the delegates were as follows:

- The process is as important as the outcome
- The process **IS** an outcome – an example was given of a complaint followed through with the assistance of an advocate. Whilst the complaint was not successful, advocacy intervention enabled the partner and gave him confidence for the future
- Funding bodies look at numbers and value for money when assessing applications. They may need to be educated to look at case studies, not just numbers of cases, and the value of prevention work is as important, or more important, than problem-solving
- It is important to know who needs/wants to see the outcomes. It can be important to consider **ALL** the stakeholders' views and perspectives. Black and minority ethnic groups are not sufficiently represented at present
- Presentation of statistics may need to be varied, and there is a difference between local and national outcomes
- Reporting methods are very important. There need to be:
  - Proper written records
  - Classified headings of the type of work undertaken
  - Good feedback and regular user surveys, which should be fed into training
  - Advocates should be trained in the importance of the above
  - Greater use of other minority languages to match demand
  - Outcomes should be demonstrated for staff as well as advocacy users. This can help to demonstrate the value of staff training, particularly for job-seeking volunteers, which should attract funding

2. What would you suggest to be the most appropriate way to use evidence and actual examples of advocacy? How could this be achieved?

The principal points raised were as follows:

- Information should be collated, and advocacy schemes encouraged to self-assess
- Evaluations should be extended
- Funders should be made more aware right up to the highest level
- Use the language of Government when asking for funding
- Use direct quotes from advocacy examples, and use advocacy stories in an anonymous way

> Record **ALL** the issues from one case, not just the main issue, and use the successful outcomes from all issues
> Record volunteer hours to demonstrate workload

Workshop recommendations:

3. What can OPAAL do to help with the process?

> **Develop networks**
> **Campaign nationally for greater recognition**
> **Educate as appropriate**
> **'Advocate' for advocacy schemes and managers**
> **Promote advocacy standards – poor working practices by one advocacy scheme can have a knock-on effect in the way advocacy is accepted**

A10.6 Involving Older Users of Advocacy Workshop

Presenter: Mel Wright

Mel Wright is an independent consultant who has extensive experience of involving older users and who was responsible for the development of this OPAAL project.

This workshop considered the practicalities of involving older users of advocacy in developing policy and practice. In particular, it considered the different ways to involve users, such as:

> Peer support
> Network approach
> One-to-one meetings
> Group meetings
> Reaching those who would like to be involved, but are housebound
> Other models of user involvement, such as Kilburn Older Voices Exchange (KOVE)

The workshop focused around the report 'A Voice That Wasn't Speaking' which is featured in this report, and which can be found on the OPAAL website on www.opaal.org.uk . More details can be found on page 36 of this report.

The work around the involvement of older users will be continuing into the next phase. Mel Wright will be looking to access additional numbers of older people, and to look at how their experience might be used to best advantage in the development of advocacy.

A10.7 Mapping Advocacy for Older People Workshop

Presenter: Dr Gary Kitchen

Dr Gary Kitchen runs an independent consultancy, Get Heard. He was responsible for the whole of the mapping project and the accompanying report, which is included in this report on page 130.

This workshop looked at the process of mapping advocacy for older people across England. It focused on the report and directory 'Mapping Advocacy in the English Regions'. The full version can be found on the OPAAL website www.opaal.org.uk and Gary's accompanying report is included in this publication in Appendix 7.

Discussion took place about the most appropriate to maximise the use of the directory, and how best to take the work forward.

Workshop Recommendations:

> OPAAL should look at organising regional conferences on the basis of the information in the mapping, focussing on the regions with the least number of advocacy schemes, particularly specifically for older people

> It is extremely important to raise the profile of advocacy for older people. More needs to be done both locally and nationally. OPAAL could publish some guidelines about how this might be approached. It could make use of the existing conference presentation pack by offering appropriate training around the regions in how to promote advocacy by using the materials available.

> There was some confusion about the different advocacy organisations nationally and how, or if, they fit together. It is in the interests of everyone involved in advocacy to find a way to work together to raise the profile of advocacy, and OPAAL should strive to ensure that older people's advocacy in particular receives the recognition it needs to develop additional services.

> There was discussion about training for advocacy and whether this was something colleges should be encouraged to develop. OPAAL should enter into discussion with other advocacy organisations to ascertain how advocates feel about this, and whether accredited advocacy training would be seen as an advantage or would deter people from offering their services. It was important to establish if accreditation would deter older people, in particular, from becoming advocates, and how this might affect long-term citizens' advocacy.

> OPAAL should ensure that the directory of advocacy is maintained and updated regularly so that it continues to be a useful document.

A10.8 The development of adult protection procedures workshop

Presenter: Daniel Blake, Action on Elder Abuse

Daniel Blake has recently completed a 2-year survey and report about how adult protection procedures are applied in England. A full copy of the report can be found on the website:. www.elderabuse.org.uk

Unfortunately due to problems beyond his control, Daniel Blake was delayed in reaching the conference, and the workshop was not able to be delivered as planned.

For any enquiries or for further information, please contact the organisation directly on info@elderabuse.org.uk

A10.9 Advocacy and Citizenship workshop

Presenter: John Miles, OPAAL Chair

John Miles took as his background material the book by Andrew Dunning 'Citizen Advocacy for Older People:. a good practice guide' (1995)

Dunning argued that advocacy is in danger of becoming a consumerist issue. The workshop aimed to define the difference between consumerist and citizen advocacy. It considered some of the difficulties around the definitions, and rather than make recommendations, focused on clarifying the definitions between consumerism and citizenship. The workshop aimed to bring out ideas that may not previously have been considered.

The following issues were considered:

1. What is citizen advocacy?
Advocacy is an act of citizenship, but this means that we talk about the 'other person', whilst perhaps we should be talking about the advocate as a citizen. How far does advocacy help us as citizens when we use it, and why is it that we look at advocates as citizens and users as people?

2. Citizen as a context
This considers the concept that advocacy is another barrier to the use of a service. We have citizenship in common, but advocacy is about a larger freedom, thus it becomes 'citizen versus consumer.'.

3. Examples of when we are consumers, and when we are citizens

The group considered examples of when we are citizens and when we are consumers:

Citizen: helping organise the summer fete, recycling or sorting goods (but we act as consumers when we use the council service for recycling), drawing benefits as a citizen, how we use benefits as a citizen, paying council tax – we pay as a citizen, and use the services paid for as a consumer.

Whilst anything voluntary in the interest of a community is a citizen, a consumer is taking something in your own interest.

Consumer: people with dementia, for example, who use a service were previously a person or citizen, but using the NHS service, or any other service, as a consumer.

Citizenship features heavily in government resources, citizens are more likely to conform when using a service (and thus becoming a consumer).

4. Discussion Group: Citizen advocacy versus consumer advocacy

In respect of advocacy, the examples given were:

> A client who had problems with a shower, who thought it was a value shower. This was a consumer issue, but she felt that her citizenship had been denigrated because she felt she had been conned. It was, however, no less upsetting as a person to be conned either as a consumer or as a citizen. Ultimately, the most important thing to that person was the impact on her as a person. However, if the obligation on the shop is to apologise, consumer merges as citizen.

> Someone wanted to complain about a public service. This is consumerist, but ultimately confronting the problem is in the interest of others, the system and therefore concerns citizenship.

> Supervising a volunteer advocate where the partner, a mental health user, pushed for change in their care co-ordinate and found there was a policy of choice in place. It was pointed out that if there was a policy or written document in place, it is more likely to be thought of as a citizenship issue.

> Housing issues are more along the lines of citizenship, but, for example, if government is pushing for more housing in London and the South East, this is consumerist. If it were a citizenship policy, government would not facilitate this because there is already an overcrowding problem.

> In a housing problem, partner is constantly being fobbed off to different parts of the system. Advocacy work becomes more than working with individuals and more about challenging the system, and is therefore about citizenship.

5. Consumer advocacy:
The situation in care homes was considered with a referral to the National Minimum Standards.

Dunning stated: 'the limitations of consumer advocacy are that the responsibility is on the provider to behave in certain ways in a relationship with a resident.'

The most far-reaching recommendations or words from government have been from the Office of Fair Trading Market Study into care homes. These are stronger than the National Minimum Standards because they refer to the availability of an advocate.

In contrast, something much stronger is to be found in the Independent Living Bill introduced by Lord Ashley (2006), which pushes the boundaries further, with nothing about context apart from having to be a disabled person (under the Disability Act).

This is not clear cut, but it strikes as more about citizenship advocacy. The Independent Living Bill is much more about standing up and being counted rather than the trend of moving closer and closer to government and engaging in working groups.

6. For advocacy for older people, rights are critical
In citizenship issues, there is no clear divide. Consumerist elements keep coming back and merging in, and this can be helpful.

There are things we can use (language and tools) in life to promote and engage in citizenship that cannot be found in contracts of consumerism.

Feedback/observations:

Q. Is 'human rights' the new thing?. Was it consumerism under the Thatcher regime, and now a trend towards human rights?
A. We are very new to embedding human rights into practice in the UK (Katie Ghose, Executive Director, British Institute of Human Rights). If there is a principle of rights to and ownership of advocacy, we could create a more citizenship approach.

A10.10 The Development of Support Systems for Older People workshop

Presenter: Dave Martin, Better Government for Older People

This workshop considered recent developments following the publication of the report 'A Sure Start to Later Life: ending inequalities for older people', and the different meanings around 'support'.

> The initial presentation focussed on the extent of social exclusion and the bigger picture around older people. The key aspects around the new approach for older people are for the public sector to work in partnership to:
> Develop strategic aims and integrated delivery for local older citizens
> Consider the whole person and their full range of needs and aspirations
> Deliver services within a 'community leadership' driven community planning process, and most importantly,
> Put older people at the heart of the process

Delivery of such a process is planned through the development of LinkAge Plus, which aims to build a robust evidence base to support the case for joined up services in terms of delivering better outcomes for older people.

LinkAge Plus Pilot Projects are working with the Department of Work and Pensions to develop this further and to advise on how this can be delivered practically on the ground. It is recommended to use the services of a 'trusted third party' who could be an independent advocacy scheme, or else other routes such as churches, working men's clubs, communities of interest, or other charities.

There are 8 pilots across England. The pilot schemes will be exploring the effects on the following areas:
> Quality of life improvements for older people
> Improved well-being and independence
> Accessibility
> Customer experience and choice
> Improved delivery of services
> Efficiency
> Capacity building
> The limits of holistic working
> Costs and benefits for wider application

The key implications for advocacy within this are for people to find a role in older age in disseminating useful information to their peers. One implication for government is to target 'advocates' and to facilitate their role. Another implication is to seek to 'jin up' services more so that people in contact with Government departments for one

issue are led towards other help they are likely to need.
Advocacy schemes should involve themselves in developing their role within this, but the pilots must decide where advocacy fits. Advocates need to be independent, therefore statutory agencies and/or families could not fulfil this role. Advocates need to be involved at the very earliest stages possible

The workshop divided into groups to discuss the following questions:
> When is a 'trusted third party' an advocate?
> Does it matter?
> Can a 'government' member of staff be an advocate?
> Who gets to decide?
> When and under what circumstances?
> What services?. What customer experiences?

Workshop Recommendations:

> This workshop gave rise to active discussion, at times quite heated. There was no definitive reporting on the questions above, but it was agreed that this could be a field of work that OPAAL might find productive.

> OPAAL should monitor the ongoing developments and offer support to advocacy schemes which are local to the pilots to ensure that they are kept informed about progress. To date no information has been passed to the advocacy schemes within the relevant regions, and they appear to be unaware of the Link-Age Plus developments.

> See also Chapter 14 of the report and OPAAL recommendation 11.

Conclusion to the Conference:

The discussions and recommendations that occurred in the workshops throughout the conference have been included in this report.

Some of the recommendations are being addressed by the new National Project Manager who will be developing the ideas as part of OPAAL's next phase of work.

All the recommendations will be considered for future development and used to some extent to shape OPAAL's future and for inclusion in future business plans.

Thanks are extended to all those who took part, and whose valuable contributions have helped shape the future of how OPAAL contributes to older people's advocacy development in the future.

Appendix 11:

OPAAL's new national project (2006 – 2009), funded by the Big Lottery

During the life of this national project OPAAL must make progress in improving public understanding of advocacy, and in achieving both professional acceptance of its importance, and political support for its development. Working to improve the sustainability of schemes, helping them achieve better working partnerships and user engagement, and to develop quality frameworks, will all be important.

Creative solutions, involving the use of the internet, will be needed to ensure better access to advocacy among minority communities, and to overcome barriers to take-up and participation. The National Project Manager (NPM) will also be expected to engage with initiatives to increase the availability of advocates.

Over three years the NPM will embed some of the initiatives already developed adding a new strategic dimension to achieve more substantial policy changes in favour of advocacy. He or she will:

> convene a national working group of interested parties including government and older peoples' representatives
> maintain and extend our national benchmarking group of advocacy schemes
> oversee a regional development programme in the south-west of England, increasing the availability of advocacy by 40%
> conduct a study on, publish recommendations, to improve, the commissioning of advocacy for older people
> take forward an older advocacy user development network

On coming into post the NPM will have a valuable opportunity to shadow the current National Development Officer, Jackie Robinson, during her last three months in post. Contacts can also be made in Scotland and Northern Ireland The national working group will involve the NPM in liaison and networking across the four nations of the UK, and in maintaining a supportive presence in Wales, in particular.

It will be important for the national working group to establish and maintain links with government, with the human rights movement, and with initiatives to promote equal opportunities, counter discrimination, social exclusion and isolation, and to improve quality of life and promote independence.

The National Project Manager will be expected to support management committee members in achieving the best outcomes for their initiatives on behalf of OPAAL. Where the organisation is successful in fund-raising for new schemes or development studies the NPM will oversee their implementation.

OPAAL: information for candidates 28/03/2006

INSIDE BACK COVER

“They have been a great help to me. I’m learning a lot about what’s going on and keeping abreast with things. They made a real difference – when I complained about a service they helped me.”

Advocacy user in London talking about the scheme they used, quoted in ‘A Voice that Wasn’t Speaking, OPAAL, 2006)

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