

Name of Committee and Date of Committee Meeting

Cabinet – 16 September 2019

Report Title

Adults Independent Advocacy Services - Commissioning and Procurement Approach

Is this a Key Decision and has it been included on the Forward Plan?

Yes

Strategic Director Approving Submission of the Report

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Ward(s) Affected

Borough-Wide

Report Summary

This report primarily concerns the commissioning and procurement of independent advocacy services for adults, though there is also some provision for young people aged between 16 and 17 years old.

Independent advocacy services are necessary to meet all of the Councils statutory requirements under the Care Act 2014, the Mental Capacity Act 2005, the Mental Health Act 2007 and the Health and Social Care Act 2012. Statutory independent advocacy services provide support to people:

- who may require assistance throughout the care and support assessment and through the review process,
- who lack mental capacity to make decision about themselves
- who are detained under the Mental Health Act
- who require support to complain about services provided by the NHS.

The majority of people who receive these services reside within Rotherham, with a smaller number of people placed in care and support services located outside Rotherham also eligible to receive support.

Independent advocacy services which are non-statutory (or generic) are available to people living in Rotherham who have difficulty articulating and negotiating their health and social care needs. This support empowers people to effectively navigate the health and social care system. Typically non statutory advocacy support is used to accompany people to official meetings with social workers and allied health professionals to discuss matters relating to health and social care.

Independent Advocacy Services that support people to challenge benefit claims are outside the scope of this consideration. Should any issues relating to benefits come to the attention of the health and social care advocacy service people are referred to the Citizen’s Advice Bureau, Kiveton Park Advice Centre or if appropriate to the Department of Work and Pensions.

The existing contractual arrangements for provision of independent advocacy services are due to reach their full term at 31 March 2020.

The table below illustrates the advocacy type and the incumbent provider:

Legislative reference	Type of Advocate	Provider
Care Act 2014	Independent Care Act Advocacy	Absolute Advocacy
Mental Capacity Act 2005	Independent Mental Capacity Advocacy	Absolute Advocacy
Mental Health Act 2007	Independent Mental Health Advocacy	Absolute Advocacy
Non statutory advocacy	Generic Advocacy	Absolute Advocacy
Health and Social Care Act 2012	NHS Complaints Advocacy	Healthwatch

This report seeks approval to:

- include the NHS Complaints Advocacy (currently delivered by Healthwatch) in the scope of this advocacy procurement exercise,
- commence a tender process in line with Option Two outlined in the report, with the objective of mobilising new independent advocacy services from 1 April 2020 for a contract period of 3 years + 1 + 1 arrangement.

Recommendations

1. That the procurement of independent advocacy services be aligned to the service delivery model in preferred Option 2, described in this report.
2. That the statutory NHS Complaints Advocacy Service be included in the scope of this procurement exercise.
3. That the contract term be 3 years + 1 + 1.

List of Appendices Included

- Appendix 1 Equality Screening Tool – Independent Advocacy Services (Adults)
- Appendix 2 Equality Analysis – Independent Advocacy Services (Adults)

Background Papers

None

Consideration by any other Council Committee, Scrutiny or Advisory Panel

No

Council Approval Required

No

Exempt from the Press and Public

No

Adults Independent Advocacy Services - Commissioning and Procurement Approach

1. Background

- 1.1 Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them; defend and safeguard their rights; and have their views and wishes genuinely considered when decisions are being made about their lives.

The key principles of advocacy are:

- Independence
- Confidentiality
- Person Centred Approach
- Empowerment
- Equal opportunity
- Accountability
- Accessibility

Advocacy is often conflated with advice, but they are different. Advice is telling or instructing someone what the advisor thinks they should do based on their professional opinion. Advocacy is about supporting the person to express their own views and make their own decisions using information provided to do this.

- 1.2 The existing arrangements to provide both statutory and generic non statutory Independent Advocacy Services were implemented following a competitive tender process undertaken in 2016. Following a successful application, Cloverleaf, an independent charity, was awarded a contract to deliver services from 1 September 2016 for a contract period of 26 Months. The service, delivered under the name of Absolute Advocacy provides statutory Independent Mental Capacity Advocates (IMCA), Independent Mental Health Advocates (IMHA) and Care Act advocates in addition to a generic advocacy service which is non-statutory. Generic advocacy benefits any person that has a health or social care related problem, particularly those who are disadvantaged by society and need independent support to make their views heard.

The contractual arrangements put in place in 2016 brought all the independent advocacy services under a single provider arrangement, having been previously delivered by a range of different organisations.

- 1.3 The Statutory Advocacy NHS Complaints Advocacy Service (NHSCAS) is currently delivered by Healthwatch Rotherham. This arrangement is out of step with that of other local authorities where all the types of statutory advocacy are delivered by specialist advocacy providers. The service was commissioned under historical commissioning arrangements as a service separate to other statutory advocacy contracts.

The NHS Complaints Advocacy element as a stand-alone approach does not offer efficiencies or options to offer wider support to people accessing the service if required; it is therefore beneficial to include it as part of the future procurement arrangements for all health and social care advocacy.

Both the Healthwatch and Absolute Advocacy contracts are due to end at 31 March 2020 and this presents an opportunity to align all health and social care statutory advocacy into a single procurement process. If approved this would secure a comprehensive independent statutory advocacy service and increase efficiency by providing multi-skilled advocates with streamlined access for people who require support.

It is proposed that the Healthwatch function will be commissioned separately and is subject to a separate Cabinet report.

1.4 Advocacy services were historically commissioned as a result of a series of legislative changes implemented over time and therefore the contracts did not form part of a strategic approach and could either overlap or create unintentional gaps. Prior to the above arrangements being implemented the provision of independent advocacy services presented a complex picture in Rotherham for the following reasons:

- There was an under-provision of Care Act advocacy
- Budget expenditure disproportionately supported non-statutory advocacy services which needed to be rebalanced to support the development of statutory advocacy services, particularly for the Care Act
- Provision of generic advocacy services were inequitable across all of the cohorts supported by Adult Care
- Meaningful performance, qualitative and quantitative data was not routinely submitted by all services to the Council and value for money could not be easily ascertained and assessed
- Contractual arrangements were fragmented and monitoring approaches inconsistent
- Multiple contracts containing a variety of overheads was not an efficient use of resources
- Contractual arrangements with neighbouring authorities for Independent Mental Health Advocates and Independent Mental Capacity Advocates services were causing concern in terms of capacity and equity of access for Rotherham residents.

The existing single provider contract arrangements which include Independent Mental Capacity Advocacy, Independent Mental Health Advocacy, Care Act and non-statutory advocacy were implemented in September 2016. Frequent and comprehensive contract monitoring has taken place over the contract period and this has supported the Council to carry out a thorough review of the commissioned independent advocacy in the borough supporting health and social care. The Council now has a clear understanding of qualitative and quantitative performance of both statutory and generic advocacy (ref to section 2.3.1) which was not the case when the contracts were previously let in 2016.

2. Key Issues

2.1 NHS Complaints Advocacy Service (NHSCAS)

The Statutory Advocacy NHS Complaints Advocacy Service (NHSCAS) is currently delivered by Healthwatch Rotherham. Healthwatch and Absolute Advocacy contracts are both due to end at 31 March 2020. This presents an opportunity to align all statutory advocacy into one competitive process and offer a focused access to a range of independent advocacy services. The Healthwatch function will be commissioned separately and is subject to a separate cabinet report.

2.2 Service Review/Co-production:

A review of the current single provider model has been undertaken and a series of co-production events has involved people who have accessed independent advocacy services, professionals and service providers. The events have focused on three key areas:

- What is working well?
- What is not working well?
- How can the advocacy offer be improved?

The strengths, weaknesses of the current single provider model and future opportunities are detailed below.

2.2.1 Strengths:

Streamlined access:

As the service is streamlined under a single provider model the referral pathway is clear for professionals and for individuals accessing the advocacy offer. Response to requests for statutory advocacy service are managed appropriately – with 7-10 working days targets to respond to Care Act advocacy service and 48 hours targets for allocation of independent mental health advocacy being met.

Multi – skilled and efficient use of capacity:

The service delivers a range of statutory and generic advocacy services to people who are in turn supported by the provider to navigate through their options of advocacy types rather than being 'handed over' to different agencies. Advocates employed have relevant experience and are multi-skilled in Care Act advocacy, independent mental capacity advocacy, independent mental health advocacy and hold relevant qualifications in social work and specialist areas such as understanding autism and dementia. As the single provider model delivers a range of advocacy types the provider is able to triage and use of service capacity efficiently and provide a timely response to requests by drawing on a network of skilled staff.

Continuity:

In the single provider model, staff are multi skilled and undertake training in a range of advocacy types - Independent Mental Capacity Advocacy, Independent Mental Health Advocacy, Relevant Person Representative, Care Act Advocacy and generic advocacy. Other specialisms such as training in autism are also undertaken. This means that people accessing the service who require different types of specialised support are supported by the same advocate for a number of issues and receive consistent service. During co-production people expressed strongly that advocates must have relevant experience and skill bespoke to the issues for the individuals.

This single provider model allows an efficient use of contract monitoring resources to support robust oversight and allows efficient use of commissioning and procurement resources.

2.2.2 Weaknesses:

Low levels of Generic (non-statutory advocacy) provision:

In the current model statutory advocacy is often prioritised over generic (non-statutory) advocacy as the statutory advocate is responding to critical issues requiring an immediate response i.e. when a person is detained under the Mental Health Act. There are delays in allocating a generic advocacy service which could lead to escalation of issues if they are unaddressed in a timely way.

In February 2019 there were 14 people recorded who were awaiting a generic advocate to be allocated with a similar picture in June 2019.

People who are placed on the generic advocacy waiting list are triaged and there is regular telephone contact with them from the advocacy service, at least every two weeks and priority is given to people who need support for planned meetings.

Lack of interface with specialist organisations:

The current service is not required to interface with specialist organisations whose remit is directed towards the relief by reason of disability and concern particular to a client group i.e. a learning disability organisation who support only people with learning disabilities and so on for mental ill-health, sensory impairment, etc. As campaigning organisations these services have insight into the common issues faced by people with particular disabilities. The current model fails to utilise this resource to benefit people who fit in to these client groups.

Lack of group/peer and self-advocacy (non-statutory):

The current service model does not offer group advocacy, peer advocacy and self-advocacy which are all types of generic or non-statutory advocacy:

- Group advocacy can support people who have commonalities of issues in situations where there is for example service change/redesign and the affected people can be supported to influence change as a group.
- Peer advocacy can offer support from people with disabilities to others with similar disabilities. The advantage of this type of advocacy is that the experience of the peer advocate can add insight to the issue for the recipient of the service which adds quality and offers a better experience.
- Self-advocacy can offer people the opportunity to gain skills to advocate for themselves – investment in this type of advocacy chimes with the Directorates direction to encourage people to not become reliant on formal services if at all possible.

The views of people accessing health and social care services:

People who access care and support services are not accessing independent advocacy to be supported to have their views heard i.e. for quality monitoring purposes.

Understanding the role of advocacy:

The term 'Advocacy' is poorly understood by the public and people who need to self-refer report that this is difficult as the service is not obviously accessible/available for example 'a drop in' service would suit people who may wish to self-refer.

- *'People don't understand what an "advocate" is. What is the role of an advocate?' comment by a professional and people accessing services – co-production event May 2019.*

Often people conflate advocacy specifically for health and social care with other types of advocacy, information and advice for example to support welfare benefit claims/appeals or to support legal processes. It is necessary for the new service to offer more assistance to people to navigate the access to advocacy services and for clarity as to the offer and scope.

Should issues regarding welfare benefits emerge as part of the initial discussions between advocates and the person they are supporting, they will refer the person to contracted advice providers in Rotherham such as Citizens Advice Rotherham and District or Kiverton Park Advice Centre.

Utilisation by Health Professionals:

The service is not high profile throughout all professional groups – i.e. GP's in particular. Referrals from this professional group are low e.g. during 2018-19 only 16 people were referred for independent mental capacity advocacy who were undergoing serious medical treatment which seems out of step with the high prevalence of mental ill-health and dementia in the borough.

There are also lower than expected numbers of referrals to the service for people requiring statutory advocacy: i.e. people:

- referred for Care Act Advocacy especially for people
 - o going through a Section 42 Enquiry
 - o who are unpaid Carers
 - o undergoing assessment and review.

2.2.3 The existing single provider model ensures the majority of the principles and standards of advocacy which are cited by the Social Care Institute of Excellence are delivered. The service offers independence, confidentiality, promotes individual empowerment, demonstrates accountability and provides skilled, high quality service. However there are deficiencies around equitable and easy access to the service and self-referrals are low.

2.3 Demand:

2.3.1 Service Activity Statutory Advocacy:

The table below illustrates the activity of the advocacy service by advocacy type over the period of a year (2018-19):

	New Referrals	Total Hours	Average hours per case
NHS Complaints Advocacy Service	104	Not recorded	Not recorded
Care Act Advocacy	233	1833	10
IMCA	140	3511	11
Paid Relevant Person Representative	116		27
IMHA	387	1163	8
Total	1096	6507	

2.3.2 Service Activity Generic Advocacy:

In 2018-19 there were a total of 132 referrals for generic (non-statutory) advocacy. Of this number less than half (48) were self-referrals. The majority of this type of advocacy was accessed by people requiring support to communicate with professionals or to have support at meetings.

2.3.3 An increase in demand for independent advocacy is expected for the following reasons:

Demographic:

The population in Rotherham is expected to increase by an average of 830 per year over the next ten years. Demand for independent advocacy services is predicted to rise as the aging population grows and mental ill health and dementia prevalence rates rise.

Mental ill – Health:

The prevalence of severe mental ill-health (percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers) in Rotherham has increased from 0.84% to 0.93% and numbers on practice registers have increased from 2,155 to 2,433 between 2012/13 and 2017/18 (Persons, All ages) (Source: Quality and Outcomes Framework, NHS Digital).

Dementia:

Dementia prevalence rates in Rotherham are significantly increasing. The number of detected cases of dementia has increased year on year and this trend is predicted to continue. The number of people aged 65+ with dementia is predicted to increase from 3,750 in 2020 to 5,115 by 2030. This represents a growth of 62% from 2014.

Older People:

Rotherham's older population (age 65+) is predicted to increase by 4.5% by 2020 with an additional 8% (or 4,700) increase from the year 2020 to 2025.

Adults 18-65 - Adults of working age:

In respect of adults 18 to 65 years of age, there are currently around 850 people with moderate or severe learning disability and around 16,350 people with a moderate or severe physical disability. From 2020 and over the next 5 years, these numbers are expected to remain relatively stable.

2.3.4 Legislative change:

Care Act 2014:

The statutory requirement for local authorities to provide Care Act Advocacy was introduced in 2015. The estimated demand for this new type of statutory advocacy was calculated using a Department of Health formula. At the time that Care Act advocacy was introduced, care and support funding reforms being considered by the Government and additional Care Act assessments and reviews were predicted to increase. Decisions on funding reforms have been delayed and the demand for Care Act Advocacy has not met the original levels estimated. However it is anticipated that the demand for Care Act advocacy will possibly grow during the proposed new contract period as a result of newly elected government leadership indicating renewed intentions concerning Adult Social Care funding reforms.

Mental Capacity (Amendment) Act 2019:

It is expected that the demand for independent advocacy will increase as a result of the Mental Capacity (Amendment) Act 2019 to be implemented at some point in 2020 – the formal date has not yet been determined. Statutory advocacy services provide advocates to support people in hospital or care homes who lack mental capacity to make decisions and are deprived of their liberty (Deprivation of Liberty Safeguards). Following a Supreme Court judgment known as “Cheshire West”, an amendment to the Mental Capacity Act the Mental Capacity (Amendment) Act 2019 will replace Deprivation of Liberty Safeguards (DoLS), with Liberty Protection Safeguards (LPS). Again, this is anticipated to be introduced in 2020, but with no fixed date.

DoLS has been judged to be an unwieldy slow process and had limited application to care home settings whilst the needs of those residing in other settings were overlooked. The LPS is a new model for authorising deprivations of liberty in care and is expected to increase the demand for Independent Mental Capacity Advocates as the LPS will apply to a wider cohort of people in settings other than care homes i.e. supported living, shared lives, private and domestic settings; and is expected to accelerate the pace at which cases are dealt with. The implementation date for LPS has not yet been determined but The Department of Health and Social Care estimate that 30% of LPS authorisations will involve an advocate, potentially driving up future support requirements.

2.3.5 Adult Operating Model:

In line with the Care Act 2014 the Adult Operating Model places emphasis on early intervention and the promotion of independence where possible. Independent advocacy is important to support people to access information and advice before they approach the Council for a formal Care Act assessment.

3. Options considered and recommended proposal

3.1 Option 1 - Single Provider Service Model:

The current service delivery model for the independent advocacy service is the single provider model. In this model the statutory NHS Complaints Advocacy is the only type of statutory advocacy that sits outside the offer (delivered by Healthwatch). The model has positively delivered the elements explained at paragraph 2.2.1 in terms of streamlined service.

In this option there would be no change to the Single Provider Service Model. This option is not recommended as this fails to address the issues identified Section 2.2 and the opportunities to improve the service model will be missed.

3.2 Option 2 – Recommended - Lead Provider Service Model:

In the Lead Provider model the contract would be awarded to a provider to deliver the statutory advocacy function:

- Independent Mental Capacity Advocates (IMCA),

- Independent Mental Health Advocates (IMHA) and
- Care Act advocates
- NHS Complaints Advocates

The Lead Provider would be responsible for the whole contract, ensuring the service is accessible, for the triage of people accessing the service, supporting people to navigate the service options and the efficient allocation of the most appropriate types of advocates to support people.

Where specific expertise for disabilities is required and where there is a requirement for generic (non-statutory) advocacy, under this model the Lead Provider would involve other organisations capable of providing service. This could include smaller organisations and voluntary sector groups. The services provided would include individual issues based advocacy, group and peer advocacy or to stimulate self-advocacy.

The recommended Option 2 reflects the outcomes of the service review and the co-production exercise and is considered to be an improved service model by which to deliver high quality independent advocacy services for Rotherham residents, maximising the resources available to ensure inclusivity.

Option 2 retains the strengths of the single provider model:

- the access pathway remains streamlined,
- advocacy capacity continues to be used efficiently,
- continuity for people who are accessing the service is retained
- cost-efficiency may be achieved due to economies of scale

Option 2 also;

- addresses issues of delays in accessing generic advocacy,
- provides opportunity to develop non statutory advocacy such as group advocacy, peer advocacy and self-advocacy options,
- utilises resources of organisations supporting people with particular disabilities,
- enhance the service offer where specialist knowledge is required for clients with particular disabilities and to offer greater insight to statutory advocates where required.

The lead provider is able to triage and prioritise referrals and work in collaboration with stakeholders where required.

The value in this model is:

- Single point of contact simplifying access
- Reduced delays caused by 'hand offs' to alternative agencies
- Consistency for people accessing the service referenced across a number of providers
- People have support to navigate the service from the first point of contact with the lead provider taking the strain for the person accessing the service

- Prioritisation to aid waiting list management
- Streamlined access improves integration between health and social care
- Specialist organisations either existing or establishing in Rotherham would have positive impact for people with particular disabilities
- Good practice is shared through a number of providers collaborating as competition is broken down and a network of providers develops
- Helps to remove the Council as the dominant purchaser increases independent aspect as the lead provider collaborates with specialist organisations.
- Cost effective as transaction and quality monitoring cost are reduced as the lead provider manages the quality assurance of partner providers.

The Lead Provider model requires collaboration with organisations that have specific aims which are directed towards the relief by reason of disability and concern particular to a cohort i.e. a Learning Disability organisation who support only people with Learning Disabilities and so on for Mental ill-health, Sensory Impairment, etc.

4. Consultation on proposal

A number of co-production events have been undertaken to gain views on the future of independent advocacy services. These events included people who access the service, professionals and service providers.

Event Type/Venue	Date	Target Audience
Forum/Town Hall	18 April 2019	People who Access Services
Forum/Town Hall	14 May 2019	Professional Stakeholders
1:1 Meetings with provider organisations	10 July – 30 July 2019	8 x Providers in the market
1:1 – optional discussion/ Woodlands - Dementia Unit	16 August 2019	People who experience Dementia and access the IMHA service
1:1 – optional discussion /Swallownest Court – Mental Health service	August 2019	People are or were detained under the Mental Health Act

5. Timetable and Accountability for Implementing this Decision

- 5.1 The publication of the tender is scheduled to take place 30 September 2019 to enable new services to commence 1 April 2020.

6. Financial and Procurement Advice and Implications

- 6.1 The budget setting process approved by Council in February 2019 set the Annual budget to support independent statutory and generic advocacy as:

Financial Year	Budget (£)
2020- 2021	397,000*
2021-2022	397,000*

*NHS Complaints Advocacy Budget Included

6.2 The budget has been set at an appropriate level to meet anticipated demand during the initial contract term. The budget will be subject to annual review as part of the Council's annual budget setting process.

7. Legal Advice and Implications

7.1 The Council's statutory duties are set out in the following:

- Care Act 2014 – sections 67 – 68
- Mental Capacity Act 2005 – sections 35 – 41
- Mental Health Act 1983 – section 130
- Health and Social Care Act 2012 – section 185

7.2 In all statutes apart from The Care Act, the section requires that the Council make such arrangements as it considers 'reasonable' or 'appropriate' to make available persons to 'represent' and 'support' those to whom each Act refers. The Care Act provides that the Council must (if certain conditions are met) arrange for a person who is independent of the authority to be available to represent and support the person to whom the section refers.

7.3 The criteria to qualify for advocacy services is different under each statute, but most general is under the Care Act, by which a person is entitled to advocacy support if they would experience 'substantial difficulty' in relation to 'understanding' information, 'retaining' information 'using or weighing' information or 'communicating the individual's views, wishes or feelings'. There is also a separate duty to arrange an independent advocate for adults who are subject to a safeguarding enquiry or Safeguarding Adults Review (SAR). Further, the Guidance advises that an independent advocate be at least considered whenever a joint package of care is being planned between the CCG and social services.

7.4 Central Government has issued Regulations under the Care Act 2014 - in the Care and Support (Independent Advocacy Support) (No 2) Regulations 2014 – setting out the matters to which the Council must have particular regard.

7.5 Chapter 7 of the Care and Support Statutory Guidance provides further detailed material on Care Act independent advocacy duty.

7.6 The Council's duties are detailed and substantial. In the event that such independent advocacy services were not provided in each case where appropriate, there would follow an appreciable risk that the provision of the specific care and support be unlawful - and subject to Judicial Review or complaint to the Ombudsman.

8. Human Resources Advice and Implications

- 8.1 As this is an externally provided service, there are no human resource implications for internal staff of Rotherham Council.
- 8.2 The employees supporting the Absolute Advocacy and Healthwatch Rotherham service may be subject to Transfer Undertakings (Protection of Employment) Regulations 2006, depending on the outcome of the tender process.

9. Implications for Children and Young People and Vulnerable Adults

- 9.1 Securing the independent advocacy service represents a positive step in supporting vulnerable adults and young people aged 16-17 (undergoing transition to adult services). The service offer will help young people say what they want, secure their rights, represent their interests and obtain services they need under the Care Act, if they lack mental capacity or require support with making an NHS complaint. The aim is that the new model of advocacy support will better fit with the Children and Young People service offer to support a more seamless transition.

10. Equalities and Human Rights Advice and Implications

- 10.1 Equality analysis of the beneficiaries of the service shows service uptake largely proportionate to numbers of people recorded living in Rotherham with protected characteristics (see attached Equality Analysis). Where people with protected characteristics are under-represented the new service will be designed to overcome any issues identified.
- 10.2 The recommendations in this report will promote assisting those most vulnerable in society to express their wishes and feelings, and defend their rights.

11. Implications for Partners

- 11.1 Statutory advocacy is commissioned by the Council for recipients of health care i.e. people who are detained under the Mental Health Act, receiving Continuing Health Care, have a diagnosis of dementia, etc. Health partners from the NHS Rotherham Clinical Commissioning Group and Rotherham Doncaster and South Humber Mental Health Trust have participated in the co-production activity to support the development of the service delivery model.

12. Risks and Mitigation

- 12.1. The timeframe for the Mental Capacity (Amendment) Act 2019 to be implemented is uncertain and guidance on its implementation has not as yet been published. Estimating accurately the level of increased demand for independent advocacy is not possible. The Council must await further announcements from the Department of Health and Social Care. The expectation is for the service provider to deliver to the statutory guidance issued will be built into the new service model.

13. Accountable Officers

Nathan Atkinson, Assistant Director Strategic Commissioning
Jacqui Clark, Head of Prevention and Early Intervention

Approvals obtained on behalf of Statutory Officers:-

	Named Officer	Date
Chief Executive	Sharon Kemp	02/09/19
Strategic Director of Finance & Customer Services (S.151 Officer)	Judith Badger	19/08/19
Head of Legal Services (Monitoring Officer)	Bal Nahal	27/08/19

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