



Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Voice, Choice and Control

Recommendations
relating to the provision
of independent advocacy
in Wales

An independent
voice and champion
for older people.

Our Role

The Older People's Commissioner for Wales is an independent voice and champion for people across Wales. We work to ensure that older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services that they need.

We work to ensure that Wales is a good place to grow older, not just for some but for everyone.

What we do

Our work is always driven by what older people say matters to them. We:

- Promote awareness of the rights and interests of older people in Wales
- Challenge discrimination against older people in Wales
- Encourage best practice in the treatment of older people in Wales
- Review the law affecting the interests of older people in Wales

How we can help you

We can help individual older people, their families and carers in the following ways:

- We can intervene directly if an older person has experienced difficulties with a service provider
- We can support an older person to make a complaint and monitor how their complaint is dealt with
- We help put older people in touch with organisations best placed to resolve their issues

If you would like a copy of this document in Braille, large print or audio format, please contact the Older People's Commissioner for Wales.

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Foreword

All older people should feel that they have voice, choice and control over their lives and that they have the right support to make informed decisions, particularly in situations within which they are vulnerable. Older people, in care homes in particular, often lack the proper support to make their voices heard.

This report, the first that I have published in my role as Commissioner, shows that too often older people are not sufficiently supported at times of major decision making, that advocacy is not widely understood or accessed, and there is a lack of consistency throughout Wales in the way in which independent advocacy is provided. The findings make it clear: we have a long way to go in Wales to improve the current situation. Advocacy arrangements are not fully understood, are inconsistent, and, in effect, are often unavailable to those who need them.

As the independent voice and champion for older people in Wales I have ensured that the voices of older people in care homes are at the heart of this report. We spoke directly with many older people in care homes across Wales and also gathered evidence from relatives, care home managers and staff, and stakeholder organisations. I am very grateful to all those who spoke to and assisted us, those who submitted evidence, and to all the care homes we visited. It is through this much valued co-operation that we have been able to gain a picture of the experiences of older people living in care homes and the advocacy support available to them.

I have set out a series of recommendations which are designed to ensure that older people have access to the independent support they need to enable them to express their needs and wishes, to be heard and understood, to make major decisions, and to determine for themselves as far as is possible what happens in their everyday lives.

These recommendations are aimed at Welsh Government, regulatory bodies, commissioners and providers of care in the regulated sectors. You will see from the next steps I have set out that I am committed to working collaboratively in partnership

with all relevant bodies to ensure we have a way forward and actions that make a real difference to the lives of older people.

I want to see a Wales that leads the way in providing advocacy services; a Wales that gives meaningful voice, choice and control back to older people.

Sarah Rochira

The Older People's Commissioner for Wales

The case for change

Voice, choice and control are important to us all. They are about identity, self-determination, self-expression and human rights. The lack of them damages confidence, self-esteem and wellbeing.

Independent advocacy supports people in circumstances of vulnerability to exercise voice, choice and control.

Where older people are considering entering care homes following discharge from hospital, are facing care home closures or have no family or friends to support them, their opportunity to exercise voice, choice and control is frequently limited. These older people are also in a particular situation of vulnerability.

The Commission's work shows there is limited availability of independent advocacy in care homes and that independent advocacy is a term which is generally misunderstood.

There is a strong case for increasing the availability of advocacy for older people to increase their voice, choice and control.

Overview

The role of the Commission is to be an independent voice and champion for older people. All our work is driven by what older people tell us matters most to them.

One of the issues that the Commission has been contacted about most frequently is the subject of care; specifically, making a decision around entry to a care home, older people's experiences of care homes and concerns over care home closures. Other issues raised include the complexity of continuing health care funding, paying for care and concerns over the quality of care provided.

A consistent theme underpinning many of the concerns raised is the lack of information needed to support difficult decision making at times of vulnerability, and a widespread sense of lack of choice and control.

As a result of these on-going and significant concerns, particularly in respect of the impact upon people's lives, the Commission took the decision to publish recommendations relating to the provision of independent advocacy when entering a care home, living within a care environment and when a care home is closing. Improving advocacy and support for older people will be a continuing and major theme of work for the Commission over the next four years.

The first stage of our work was commissioning Advocacy for Older People in Wales - an initial scoping studyⁱ undertaken by Andrew Dunning of Swansea University. This report was important in setting a baseline in respect of current provision of advocacy in Wales. The research showed that there was generally very low understanding of the role, importance and impact of advocacy amongst professionals and those who might benefit, and consequently very variable provision, access to and take up of advocacy services. It also urged further consideration of the need for more comprehensive legislation to meet the advocacy needs of older people.

The findings of this research were further confirmed by Advocacy Counts 3ⁱⁱ undertaken by Age Cymru which found that despite there being many examples of good practice, there is an overall 'postcode lottery' in the provision of advocacy services, a very low baseline of trained advocates, a generally poor understanding of the role of advocacy and a failure to consistently utilise volunteers as advocates to support people.

Given the growing body of evidence around the importance of advocacy and the consistent concerns raised by older people in care, coupled with the lack of specific research around advocacy within care settings, we commissioned Advocacy and Care Homesⁱⁱⁱ. This research specifically investigated the provision of independent advocacy for older people who live in care homes. It called for advocacy to be embedded within care home regulations and standards to reflect its status as an important safeguard for the protection of older people.

The final stage in this work was to undertake a formal review of advocacy in care homes across Wales. To give a voice directly to older people on this issue. Through this work we gained unprecedented access to people resident in care homes and spoke to relatives, care home managers and staff to explore the extent to which advocacy and its value is understood and the extent to which advocacy is currently used. Interviews with older residents were used to establish the extent to which they felt they were able to exercise voice, choice and control and whether they were aware of the role and availability of independent advocacy.

Alongside the above, in March 2012 the Commission issued a report to the First Minister calling for improved guidance on care home closures. This followed significant concerns raised by older people and their families, and research undertaken by Swansea University^{iv}, which showed an urgent need to review and update current guidance.

The key concerns that we highlighted in our report to the First Minister were:

- A lack of clarity in the current guidance about how it would apply where the threat of closure is a result of a strategic or policy decision rather than due to concerns about the quality of care, safety concerns or financial viability;
- Ineffective consultation processes that failed to effectively engage with older people, and as a result left them feeling excluded, vulnerable and anxious;
- Limited consideration of the use of independent advocacy services for older people in care homes threatened by closure, especially Independent Mental Capacity Advocates (IMCAs) for those older people who lack capacity.

Work is now underway by Welsh Government to publish revised guidance in relation to care home closures.

Within Wales, we have many dedicated front line care staff who are passionate about ensuring that people who live within care settings have a good quality of life. However, many older people are being denied meaningful voice, choice and control at critical times in their lives because of a widespread lack of understanding of the importance and role of advocacy and specifically independent advocacy. Whilst there are significant examples of good practice across Wales, we are far too tolerant of variation. Areas of specific concern include decision making around entry to care, support in relation to care home closure and every day decisions whilst living in a care setting.

All of the above paints a very clear picture. We are letting down older people at their time of greatest need because the value of advocacy is poorly understood and we do not have a good enough approach to the use of independent advocacy. This needs to change.

This Review sets out a series of simple recommendations for implementation by public bodies including national and local government, Local Health Boards and those that represent the independent care sector. These recommendations are designed to systematically improve the voice, choice and control that older people have across Wales through better and increased understanding of the specific use of independent advocacy and by increasing the baseline of knowledge of wider advocacy's role and importance.

In developing and setting out our recommendations we have reflected the voices of older people and of others who engaged with us. We have also factored in the extensive information that we collected through our research and through written correspondence with a selection of care homes throughout Wales, all Local Authorities and Local Health Boards, as well as through focus groups with Inspectors and advocacy providers.

We expect these recommendations to lead to a sustained step change in the way that advocacy is perceived and understood, and an increase in the consistency and quality of independent advocacy services across Wales which is recognised and valued by both older people and those who support them.

Next steps

Following the publication of our recommendations the Commission will be undertaking the following action to support and ensure that the position in Wales in relation to awareness of advocacy, and use of independent advocacy for people in the specific circumstances outlined in this report, improves.

September 2012 to November 2012

Commission consults on recommendations.

November 2012 to March 2013

Commission works collaboratively with partners to develop a range of good practice tools and support, including audit tools, to increase the availability and use of independent advocacy, including through the role of volunteering.

April 2013

Commission publishes good practice guidance (under Section 12 of the Commissioner for Older People (Wales) Act 2006).

April 2014

Commission undertakes a further review of advocacy provision with the expectation that there will have been improvement in the way that advocacy is perceived and understood, and an increase in consistency and quality of advocacy services across Wales which is recognised and valued by older people.

Overall outcomes

It is intended that this programme of work will ensure that:

- Care staff understand and promote the concept of voice, choice and control and the role of advocacy within this.
- There is increased awareness and understanding of advocacy, including the role and impact of independent advocacy, across Wales.
- Older people in key situations of vulnerability who are making critical decisions around moving to or changing a social care setting are aware of and have access to independent information, advice and advocacy.

- Awareness of the role of, and evidence of the use of, independent advocacy are embedded in regulation and inspection arrangements.
- There is a coherent and consistent approach to the commissioning, contracting, provision and monitoring of effective independent advocacy services across Wales.

Short term recommendations

Our key areas for longer term improvement are set out in the body of this report. However, we have identified four actions that we would expect to be undertaken which would have an immediate impact on the provision of independent advocacy. The Commission recommends that:

1. There is a commitment on the face of the Social Services (Wales) Bill to enhancing the provision of independent advocacy (see page 11).
2. Welsh Government publishes enhanced guidance relating to care home closures.
3. Local authorities identify a baseline in current provision and future need for independent advocacy in the areas where they operate.
4. All older people who are considering moving in to a care setting receive information on the independent advocacy services currently available and details of how to access them.

Wider Policy Context

There are a number of other major strands of work being taken forward in Wales which are directly linked to, and share the aspirations of, the recommendations laid out in this report.

Social Services (Wales) Bill

This Bill is designed to give voice and choice to older people. It is our view that a major area where the Bill needs strengthening is in respect of advocacy services. It must include explicit reference to the provision of independent advocacy services to people in potentially vulnerable settings, whether or not they are deemed to have capacity as part of a formal definition of social care. Our response to the Bill^v makes it clear that without this the Bill will not achieve its aspirations. The timing of this report is explicitly intended to inform the development of the Bill as it proceeds towards enactment.

Welsh Government Programme for Government

The Welsh Government programme of business acknowledged that advocacy provision needs to be improved and gives a firm and binding commitment to develop a business case for advocacy services for older people. It is our view that this should be taken forward as part of the Social Services (Wales) Bill and should be informed by the recommendations contained within this report.

Compliance with requirements of the Mental Capacity Act 2005 to instruct an Independent Mental Capacity Advocate

Through the research undertaken to inform this report, concerns were raised around the extent to which those who have a statutory duty are fulfilling, in the care home setting, their legal obligations in respect of IMCAs. Concerns related to people who lack capacity and have no close relatives or friends to speak for them, when decisions are made about serious medical treatment or a change of residence, for example moving to or from a care home. There is a need for local authorities to collect information on the availability of IMCA services in their local area and the frequency with which IMCAs are instructed. We will be considering whether there is a need for the Commission to specifically pick this up as a separate strand of work and issue separate guidance.

The National Assembly for Wales' Health and Social Care Committee Review into Residential Care for Older People

The National Assembly for Wales' Health and Social Care Committee is undertaking an inquiry into residential care for older people. The Commission has already provided written and oral evidence to the Committee based on the evidence provided to us by older people, as their independent champion. This report will be submitted as further evidence to the Committee. (See Appendix 3 for terms of reference).

What do we mean by advocacy?

Our work has made it clear that there is considerable misunderstanding about what advocacy is, and a number of different definitions exist. Appendix 1 provides a range of different definitions including that used by the Older People's Advocacy Alliance (OPAAL) and Action for Advocacy. However, whilst it is useful to have a common language the focus that we need to see within Wales needs to be not upon words but on action.

For the purposes of our Review we decided to focus specifically on two areas: improving understanding of the general role and impact of advocacy, and on independent advocacy arrangements.

Advocacy comes in many shapes and forms ranging from self-advocacy, often supported on a voluntary basis by third sector organisations, through to statutory advocacy where, in certain circumstances, individuals have a legal right to access and be supported by an independent advocate.

This is illustrated in the advocacy “ladder” below:

- **Self-advocacy**, which essentially means ‘speaking up for yourself’ to represent your own needs, wishes and interests.
- **Collective advocacy**, self-advocacy groups and organisations that provide mutual support, skill development and a common call for change.
- **Peer advocacy** takes place where one person advocates for another who shares a common experience, difficulty or discrimination.
- **Citizen advocacy** is a one-to-one, long-term partnership between an independent, unpaid ‘ordinary person’ and a disadvantaged ‘partner’.
- **Volunteer advocacy** is independent and unpaid, but the advocate may work with a number of partners on a short-term issue or casework basis.
- **Paid advocacy** describes the role of advocacy workers who share the characteristics of volunteer advocates but are paid for the task.
- **Professional advocacy** may refer to the partial advocacy role of staff in health, social care and other settings.

- **Public advocacy** describes the activities of organisations that campaign on behalf of a particular group of people or collective issue.
- **Legal advocacy**, which is the most established and widely recognised form.

Source: Action for Advocacy

The benefits of independent advocacy for people in key situations of vulnerability (entering a care setting from hospital, living within a care setting, experiencing care home closures)

Research shows that even when an older person may be surrounded by family or professionals on whom they are dependent for care and support, they may still feel powerless or unable to voice their opinions. In such circumstances, they may find it daunting or feel unable to influence or challenge major decisions that are made about and impact on their life, further reinforcing their sense of powerlessness.

Independent advocacy services can:

- Play a vital role in providing support where individuals are unable to speak up for themselves.
- Act preventatively to safeguard older people at risk of abuse.
- Support higher standards and practices in care.
- Help residents to make clear their views and wishes, express these views effectively and gain respect for their preferences and choices.
- Help negotiate and resolve conflict.
- Ensure improved support services for people during times of major decision making to prevent problems or crises and reduce the need for services to address those problems.
- Add to the valuable support family, friends, carers and professionals provide.

Independent advocacy also benefits service providers as it can:

- Help resolve difficulties and support compliance with care standards.
- Provide a framework to support difficult decisions and negotiations.
- Help staff to support the resident to resolve issues and balance needs, wishes and risks.
- Lead to better use of available resources through identification of gaps and areas of duplication.
- Create more informed providers of services who are better able to meet older people's needs themselves or to make more appropriate referrals to other agencies if necessary.
- Help create an open culture where safety, respect and dignity can flourish.
- Deliver better informed, targeted and sensitive commissioning.

The availability of independent advocacy should be regarded as an important hallmark of good quality residential provision for older people. It is a key factor in providing a service which puts the resident at the forefront of provision rather than systems, processes and routine. It is a crucial means by which older people in residential homes can be empowered to say what they want, secure their rights, represent their interests and receive the specific services they need. It is pivotal in achieving a good service while promoting social inclusion, equality and justice.

Summary of findings and recommendations

The previous sections outline the need for and rationale behind increased understanding of advocacy and increased provision, access and use of independent advocacy in three specific circumstances (entering a care setting from hospital, living within a care setting, and experiencing care home closures). This section of the report outlines in detail five key areas for systematic and systemic improvement and associated recommendations.

1 Everyday voice, choice and control

Some older people lack voice, choice and control over their living environment and their everyday life. There is a misunderstanding of what meaningful voice, choice and control really is. This can result in some people withdrawing socially and emotionally. Sometimes compliance can be misinterpreted as positive acceptance when actually it represents resignation to a situation over which the older person has no control.

2 Understanding and awareness of the role and impact of advocacy services

The term advocacy is not consistently understood by residents, relatives, care home managers and care home staff. A narrow view has emerged which sees it as synonymous with safeguarding, dispute resolution and complaints. There also appears to be a lack of training about advocacy services available for care home managers and staff. There is a notable lack of awareness amongst residents in relation to the availability of advocacy and, in particular, how and in what circumstances they might access it.

3

Availability of and access to independent advocacy in specific settings

Older people are not always supported at times of major decision making and transitions because access to and availability of independent advocacy is limited. Independent advocacy is particularly important in certain circumstances including older people's entry into care homes, or when faced with impending closure of a care home.

4

Inspection, Monitoring and Provision

There is a lack of consistent and comprehensive inspection and monitoring of independent advocacy provision. This has contributed to a general lack of awareness and understanding of advocacy. The role of the Care and Social Services Inspectorate Wales is crucial in supporting the profile and importance of advocacy within care homes, and there is a need to raise awareness and provide training on advocacy for Inspectorate staff.

5

Commissioning and Contracting

The current provision of independent advocacy lacks consistency and a clear framework. There is currently no coherent and consistent approach to assessing need and planning for advocacy provision and funding. Commissioning contracts with care homes do not explicitly stipulate the arrangements care homes should have in place for independent advocacy.

Overall, it is clear from the work that we have undertaken that independent advocacy for people in particularly vulnerable or at risk situations is simply not as good as it needs to be, and that systematic and sustained improvement must take place.

Short term recommendations

Our key areas for longer term improvement are set out in the body of this report. However, we have identified four actions that we would expect to be undertaken which would have an immediate impact on the provision of independent advocacy.

The Commission recommends that:

1. There is a commitment on the face of the Social Services (Wales) Bill to enhancing the provision of independent advocacy.
2. Welsh Government publishes enhanced guidance in relation to care home closures.
3. Local Authorities identify a baseline in current provision and future need for independent advocacy in the areas where they operate.
4. All older people who are considering moving in to a care setting receive information on the independent advocacy services available to them and details of how to access them.

Further recommendations

Section 1: Everyday voice, choice and control

Care home providers should:

- a. Encourage a culture in care homes that promotes voice, choice and control for all residents within which staff understand their role and the role of other advocacy services.
- b. Embed awareness of this and the importance of independent advocacy in training for staff.
- c. Care homes should keep a written record of residents' needs for advocacy and any action that has been taken to meet those needs.
- d. Review the level of everyday voice choice and control experienced by older people, using the views of older people as a foundation for evaluation, and make public the results.

Section 2: Understanding and awareness of the role and impact of advocacy services

- a.** Welsh Government's planned business case should highlight the importance of advocacy, and specifically independent advocacy, in giving people voice, choice and control.
- b.** The role and impact of advocacy services, and the specific role of independent advocacy within this, should be embedded in training for care home managers and staff.
- c.** Independent advocacy should not only be associated with concerns in relation to a care home, making a complaint or resolving a dispute.
- d.** Audits of the use of independent advocacy should be undertaken by Local Authority and Local Health Board Commissioners and care home providers, which make specific reference to the circumstances when it has been used.

Section 3: Availability of and access to independent advocacy in specific settings

- a.** Welsh Government's planned business case should make specific reference to the role of advocacy for people entering a care setting from hospital, living within a care setting, experiencing care home closures.
- b.** Local Authority and Local Health Board Commissioners, and care homes should:
 - Identify the key points at which older people will be given information, advice and access to independent advocacy.
 - Be clear how they will deal with the situation in which an older person has no capacity, fluctuating capacity, or no relatives involved.
 - Increase provision and effective access to independent advocacy services across Wales, ensuring that care homes are held to account for enabling older people to access independent advocacy.
- c.** All staff providing support to people entering a care setting from hospital, living within a care setting, or experiencing care home closures, should receive training of the role and benefits of advocacy in these particular circumstances.

Section 4: Inspection, Monitoring and Provision

Care and Social Services Inspectorate Wales should:

- a. Monitor and inspect the availability of independent advocacy to care home residents and the extent to which managers and other workers have been trained in the benefits and role of independent advocacy.
- b. Ensure that inspections of care homes include an evaluation of the record of older people's needs for advocacy and any action that has been taken to meet those needs.
- c. Strengthen the provision within care standards for the delivery of advocacy services.
- d. Issue guidance to Commissioners, Local Authorities, Local Health Boards and care providers in Wales stating that the human rights principles and the UN Principles for Older Persons should be incorporated into the commissioning process and service delivery for older people.

Section 5: Commissioning and Contracting

- a. Local Authorities and Local Health Boards must improve the commissioning, contracting, and monitoring of independent advocacy services across Wales through:
 - A coherent and consistent approach to assessing needs and planning for advocacy provision in their area.
 - Requiring care homes to evidence that staff are aware of the benefits and role of independent advocacy.
 - Requiring care homes to demonstrate that they are promoting and enabling the provision of independent advocacy.
 - Developing agreed and consistent quality standards that underpin the provision of all independent advocacy.
- b. Welsh Government should improve the commissioning of effective independent advocacy services across Wales through:
 - Ensuring its planned business case for advocacy encourages a coherent and consistent approach to assessing needs and planning for advocacy provision.
 - Requiring independent advocacy to be built in to the commissioning process.

Detailed findings

1 Everyday voice, choice and control

Voice, choice and control is important. It is about identity, self-determination, self-expression and human rights. However, it is often misinterpreted as being linked to day to day routines and activities rather than significant life decisions. This misunderstanding combined with a lack of awareness of independent advocacy can lead to negative outcomes for confidence, self-esteem, health and wellbeing.

Key Points

- **Some older people lack control over their living environment and choice in their everyday life. This can result in some people withdrawing socially and emotionally.**
- **Sometimes compliance can be misinterpreted as positive acceptance when actually it represents resignation to a situation over which the older person has no control.**

1.1 Life in a care home and making day to day decisions

During our research, we spoke to residents about what they liked or disliked the most about the care home in which they lived. There were 4 main measures that emerged by which the residents assessed their satisfaction with the care home: the homeliness of the physical environment, the friendliness of the care staff, the relationships they had built up with other residents and the sense of safety and security that having carers available 24 hours a day gave them.

We heard many positive reports from residents about living in a care home.

“I mean it’s a brilliant place. They’re like family, the people who live here, the people like me and the carers, we’re all friends.”
(Resident)

“We get everything we want... it’s so homely and that everybody’s friends here like the staff and everybody... I’ve had all kindness here for two and a half years and I don’t have any complaints about the place.”
(Resident)

Older people that we spoke to expressed frustrations at being unable to return home or live independently.

“I’d like to be at home you know, but as things are now, like I am, health, it doesn’t make me go home. But I would, as I have said before, I’d go home if I could and have carers.”
(Resident)

“I don’t like it here, like the people, I don’t like living here... it’s not my life.”
(Resident)

There was a high level of dementia and cognitive impairment amongst the residents of the care homes we visited. Some of the residents we spoke to commented on this and explained what it was like living in a care environment where there were varied cognitive abilities among residents.

“Some of them [residents] here are not sensible [dementia]. I do get upset when I think about it.”
(Resident)

We found that some residents reported strategies of avoidance which often meant they remained in their rooms, separate from their fellow residents.

We found an assumption within care homes that regularly seeking residents' views and opinions regarding their basic comfort and care needs meant that they were able to exercise choice and control over their lives. This included what they wanted to eat, what they wanted to wear and what time they wanted to get up or go to bed. For many residents, this was what they had come to associate with 'good' care. Although influence over these types of decisions is incredibly important, this does not necessarily represent meaningful voice, choice and control.

“Oh they come and ask, are you happy, is there anything else you need or whatever...”

(Resident)

We found that much of the residents' day to day decision-making was heavily influenced by the structures and routines of the care home. We noted that for many residents, whilst they felt they had the freedom to make most of their own decisions, they did so within certain parameters.

“...they [care staff] decide [what time to get up in the morning]. I was up this morning at quarter to six I think it was.”

(Resident)

“You can get up as you like. But we feel that the night staff want to go home...”

(Resident)

In many cases, we found that older people submit to the structures and routines of the care environment in order to increase their chances of being accepted into the culture of the home. In our scoping work we found research that called for a better understanding of the impact of decision-making on older people's adjustment to life in a care home, in which advocacy would play an important role.

Many residents also stated that their families (who either lived nearby or who visited daily) and care home staff were involved in making day-to-day decisions for them. Some residents reported that they were happy to leave the way in which the care home was run to the care staff and did not wish to be burdened by making decisions.

“There are more people with more intelligence than what I have, are quite capable of doing that [making decisions], you know.”

(Resident)

“No I don’t have any family at all here...I’ve got friends within the staff, [name of carer] is one of them...she’s quite good...she’s been here years.”

(Resident)

We found that a number of factors contributed to the perception of a home providing a good quality service. These factors include resident choice and control, strong leadership, training or qualifications, clear complaints processes, the use of key workers, accessible whistleblowing policies, codes of practice and good communication. We also found, however, that even where the concept of independent advocacy is understood, it is not seen as an important contributor to the factors above.

None of the residents we spoke to reported having seen or spoken to an advocate in relation to making an important decision, even in care homes where there was known to be regular advocacy provision. Care home staff partly attribute the low take up of advocacy in care homes to many residents not having the mental capacity to ask for or seek it. Some remarked, however, that only those with no family involvement or no mental capacity should be eligible to receive it.

Section 1 Recommendations

Care home providers should:

- a. Encourage a culture in care homes that promotes voice, choice and control for all residents and sees staff as having a key role in this.
- b. Embed awareness of this and the importance of independent advocacy in training for staff.
- c. Care homes should keep a written record of residents' needs for advocacy and any action that has been taken to meet those needs.
- d. Review the level of everyday voice choice and control experienced by older people, using the views of older people as a foundation for evaluation, and make public the results.

Overall outcome:

Care staff understand and promote the concept of voice, choice and control and the role of advocacy within this.

2

Understanding and awareness of the role and impact of advocacy services

The starting point for any improvement in the voice, choice and control that older people feel and have must be a significant overall improvement in the general understanding of the role of advocacy, both generally and in specific circumstances. This knowledge is particularly important for front line staff.

Within the wider lack of understanding, independent advocacy is particularly misunderstood. Our work has revealed that independent advocacy is not a term that is widely understood by residents relatives and staff alike.

Key Points

- **The term independent advocacy is not consistently understood by residents, relatives, care home managers and care home staff.**
- **It is often perceived incorrectly, mainly as a means of safeguarding and resolving disputes and complaints.**
- **There is also confusion about how advocates might be used most effectively.**
- **There are concerns among some care home managers that its presence may be seen as reflecting poor standards of care.**
- **There also appears to be a general lack of training about advocacy services available for care home managers and staff.**

However, when we spoke to residents and explained the principles of advocacy, residents felt that the benefits were clear.

“I think it would [be good] because they’re not in the circle are they? They’re an outside person because their observation is different to ours”

(Resident)

Advocacy was not widely understood amongst relatives. Some reported they had never heard of it before and others thought it was legal jargon. Again, despite being unfamiliar with the term, many relatives appear to have understood the principles of advocacy and recognised the importance of having someone to speak on behalf of residents. In general, relatives equated the need for advocacy with residents either being without family support or ‘unable to stick up for themselves.’

“When you have no one to help you, it’s someone to help you discuss your business and such.”

(Relative)

The principles of advocacy were partly understood by care home managers and care home staff. They tended, however, to place emphasis on advocacy as a method of safeguarding and protection, dealing with complaints and dispute resolution. There was also a common belief that advocacy was primarily for people with dementia who were unable to express their own views and wishes or those with little or no close family involvement.

“Advocacy... it’s somebody acting on behalf or with a person who doesn’t have capacity.”

(Care Home Manager)

“I think maybe if they’ve got conditions like dementia or they haven’t got a certain mental capacity to make decisions by themselves, on their behalf”

(Care Home staff)

Residents were asked to whom they would turn if they had any concerns or if they wanted to complain about something. Most of the residents reported that they would either speak to the care home manager or one of the care staff.

“[Name of care staff] is my keyworker, to her, or I can tell [name of care home manager] as well, but I can tell [name of care staff] better. She’ll sort it out.”

(Resident)

In contrast, many care home managers were keen to state that, in general, residents were adequately advocated for by existing arrangements within the care home and by relatives, removing the need for independent advocacy services.

“Every member of staff here will advocate for residents and do so on a daily basis.”

(Care Home Manager)

Care staff felt they were often well equipped to advocate for residents on day to day decisions, stating that they were more ‘attuned’ to the likes, dislikes and personalities of the older person.

“The first port of call is the care staff because we have most contact with the person...down to washing, dressing, eating and then if things are getting a bit, where they’d be needing more input and more assistance then it would go through the hierarchy.”

(Care Staff)

In many circumstances it is true that the role of care staff in advocating on behalf of residents is an important and legitimate one which may well be the most appropriate support. Care staff similarly have an important role in encouraging and supporting people to self-advocate. However, this is different to independent advocacy and it is this misunderstanding that is at the root cause of some of the problems that we identified.

Other residents would only turn to relatives to advocate on their behalf.

“No, well if anything was worrying me like money or illness I would ask them to get my daughter...she’ll take over the business, she’s a good girl...”

(Resident)

“No, not here, no it’s only my family that I rely on.”

(Resident)

Relatives may not, however, always be best placed to make decisions on behalf of an older person.

“You know, a lot of ours have got families but then, of course, families don’t always express what people want either, you know?”

(Care Home Manager)

Relatives often felt ill-equipped to advocate on an older person’s behalf, particularly in dealing with important issues and in formal settings. Some felt an independent advocate would be more appropriate, having an ‘independent eye’ and holding more sway.

“Personally, I think it’s someone that helps and sticks up for people, especially with bureaucracy and with councils or services...”

(Relative)

The quote above reinforces the important role of independent advocates in helping an older person to navigate complex or professional systems and ensuring their views are listened to within this context.

Care staff referred to independent advocacy services as ‘plan B’ for situations that were too big to be dealt with inside the home or in situations where the resident’s relatives lived far away. One care home staff member importantly noted that, in many cases, the nearest relatives of a resident are often of a similar age and may be in poor health themselves, which means they are limited in terms of the support they can provide.

One care home staff member also reported that, in their opinion, all residents of care homes required advocacy if they wished to challenge the structure and routines of the care home.

“Because I think, there’s a structure within a home, we all need some kind of structure but obviously you need to help that person if they want to step outside the box and they’re looking to do something a little different, help them fulfil that wish. But families can also try and take over and we’ve got to make sure that it’s what the older person, it’s in their best interest and what they need...”

(Care Home Manager)

All care staff interviewed felt that the views, opinions and wishes of residents were very well represented within their care homes. Many care staff referred to examples that evidenced how things were changed to accommodate the wishes of the residents. Many of these examples, however, were limited to the basic comfort and care of residents and involved changes to menu choices, activities and seating arrangements as opposed to wider choice and control.

Few of the care home managers reported using or having used independent advocacy services with the absence of such services tending to be attributed to a lack of local independent advocacy providers.

Many of the care home managers were also unable to report on the levels of take up on advocacy within their care homes. This meant it was not clear how many of the residents had actually used independent advocacy services, how they accessed these services and what the outcomes were.

Some care home managers appeared to share the view that the presence of an independent advocate within the care home may reflect poor care, suggesting some concerns that the presence of independent advocacy services might indicate failings with the standard and quality of care within the home.

“I know they have used an advocate before just a few years back...but since I’ve been here we haven’t had reason to.”

(Care Home Manager)

Good Practice

It was positive to note that the care homes we spoke to made frequent reference to ‘open door’ policies where residents were at liberty to approach either the care staff or care home manager with suggestions or complaints at any time. Other care homes referred to residents’ meetings, care planning and service user feedback and opinion surveys. Some care homes referred to existing advocacy provision where monthly meetings were held between the advocate and the residents. The advocate would then feedback relevant information to the care home manager.

As previously highlighted, while many care home managers were supportive of residents accessing independent advocacy services, we also heard views expressed that they are best placed to determine whether or not residents need these services. Some reported, for example, that they would only resort to independent advocacy if the situation involved either a complaint or dispute.

There is a risk that this practice might restrict access to advocacy and it is important that decisions made in this regard demonstrate transparency and accountability.

This narrow view of advocacy also suggests that it may have become ‘problematized’ in some settings when it is negatively associated with safeguarding, complaints and disputes as opposed to a means of providing support for residents to exert meaningful choice and control

over their lives. This is likely to result in a lack of support available to residents to access advocacy in other situations.

Such gatekeeping practices cannot be ignored. They can result in the undermining of the personhood and self-determination of the older person, contravening the United Nations' Principles for Older Persons, specifically their access to social and legal services to enhance their autonomy, protection and care (Principle 12; UN Principles for Older Persons) and the right to make decisions about their care and the quality of their lives (Principle 14; UN Principles for Older Persons).

Front line care staff are vital in promoting and helping residents to access independent advocacy. It is imperative that they have a sound understanding of its role and purpose as well as the scale of local provision and how it can be accessed.

Care home managers reported that there was no formal training on advocacy available to care staff within the care home. Care staff also reported that they had not received, nor were they aware of, training in relation to advocacy for residents, although several made reference to having done awareness raising training such as Protection of Vulnerable Adults (POVA), Deprivation of Liberty Safeguards (DOLS) and Independent Mental Capacity Advocacy.

The role of staff in independent advocacy

An Independent Advocate must be truly independent if advocacy is to be as effective as it can be for older people. Although some professionals, such as a social worker or nurse, can have an advocacy-type role as part of their overall job, if your 'problem' is connected to the policies, guidelines or practices of the local council social services department or NHS hospital, then it may sometimes be inappropriate for the social worker or nurse to 'advocate' on your behalf. This is because in order for you to get your chosen outcome, the social worker or nurse has to 'risk' challenging their own manager or their agency's practices and policies. Although some professionals have attempted to do this, it is difficult because, ultimately, they are employed by that organisation. Your voice may never be heard properly or it may be brushed aside due to a conflict of interest.

Extract from 'Counsel and Care Guide 25: Independent Advocacy'

Many care staff felt that they already possessed the necessary knowledge and skills regarding advocacy from the other forms of training they had received in relation to POVA and DOLS, and that advocacy in care homes was sufficiently monitored and promoted under existing arrangements. This in itself reinforces the misunderstandings between independent advocacy and advocacy linked to Adult Protection.

“I think the staff have been offered if we want anyone to come in and speak with us...but I think that all of us feel we...that we didn’t need anybody.”

(Care Home Manager)

Some care home managers reported that the cost of providing additional training on advocacy would be a significant burden upon the business viability of the home. Others felt that advocacy was inherent in the culture of the care home and passed from experienced carers to new carers as an on-going process.

Whilst we heard views that care home managers are well placed to provide advocacy, and do not require further training, this needs to be considered in the context of findings elsewhere in this report that misunderstandings of advocacy exist and need to be addressed.

Section 2 Recommendations

- a.** Welsh Government’s planned business case should highlight the importance of advocacy, and specifically independent advocacy, in giving people voice, choice and control.
- b.** The role and impact of advocacy services, and the specific role of independent advocacy within this, should be embedded in training for care home managers and staff.
- c.** Independent advocacy should not only be associated with concerns in relation to a care home, making a complaint or resolving a dispute.
- d.** Audits of the use of independent advocacy should be undertaken by Local Authority and Local Health Board Commissioners and care home providers which make specific reference to the circumstances when it has been used.

Overall outcome:

There is increased awareness and understanding of advocacy, including the role and impact of independent advocacy, across Wales.

3

Availability of and access to independent advocacy services in specific settings

Independent advocacy has a vital role to play for older people in certain circumstances. It can ensure older people obtain services to which they are entitled, and that those services meet their needs and interests. It gives people voice, choice and control regarding day to day preferences or at key points of transition such as when institutional care is being considered.

Key Points

- **Older people are not always supported at times of major decision-making and transitions and this can have a significantly negative impact on their wellbeing.**
- **It is often perceived incorrectly, mainly as a means of safeguarding and resolving disputes and complaints.**
- **Independent advocacy is particularly important in certain circumstances including older people's entry into care homes (which is often preceded by a crisis such as bereavement or period of ill health) or when facing major decisions and changes to their lives such as the threatened or impending closure of a care home.**
- **Sufficient time to make a considered decision is vital.**

3.1 Entry into residential care

There can be few decisions more important, more difficult or potentially more stressful than the decision to leave your home in order to live in a residential care setting. Decisions about older people's entry in to care can all too easily be made by relatives or professionals whose interests and views might not concur with those of the older person. Such decisions might also be taken whilst the older person is in a particularly vulnerable position, such as at the point of hospital discharge. Even when an individual does feel they have voice and control their choices are often significantly undermined due to lack of basic information regarding the options available to them.

For some residents that we spoke to as part of our research the decision to enter care was straightforward. One resident said that although she had the offer of living with one or other of her children, she opted to move into a care home instead and appeared to find the decision empowering.

“[I] have refused to go to my children to live because living here is nicer for me.”

(Resident)

This was not the case, however, for many of those with whom we spoke.

“No, they sent me to here [the care home]...which I didn’t want to come...Shouldn’t have come...had to come.”

(Resident)

Some residents spoke of being influenced by ‘others’ in accepting that long-term care was the best option for them. Although some reflected that admission to the care home turned out to be the best or safest option for them, they were often unable to clarify to us to what extent they felt they had a say in this decision and whether they were concerned about the implications of going against the recommendations of a relative or medical/health professional.

**“...because I kept falling so much my daughter, she was so upset over it, so she said; “Mam, you have to go into a home, you have to...”
Otherwise I was always getting on, loved my place, loved it absolutely.”**

(Resident)

Other residents also spoke of having little or no involvement in the decision that they should enter the care home and it coming as a complete shock.

Well I had rather a shock when I came here. I wanted to know who on earth put my name in here and I think it must have been the hospital. None of my family would admit it but I think it must have been the hospital.”

(Resident)

“Well I had a shock when I came into it, I didn’t know nothing about it see because I couldn’t, well I’m not walking properly now but when I broke my leg I was, they gave my son a book with homes ... No it was sprung on me and I was very, very much concerned you know really how I came to be here and I’m thinking it may have been the hospital”

(Resident)

Many of the individuals spoken to did not report being aware of the range of options available to them and for some there was a strong sense of powerlessness in determining their future.

Admission into care is often preceded by a crisis or period of ill health. The older person can be particularly vulnerable at this time, meaning that the physical and emotional effort required to make important decisions can be particularly great. Similarly, pressure from relatives or the need for hospital beds to be ‘freed up’ can restrict the choices available and can result in older people not being empowered to make decisions that are right for them, or within their individual preferences.

It was clear from our conversations with older people that their transition into care is often problematic and a significant factor in how they come to view themselves. This is supported by other research that demonstrates how older people come to view themselves as ‘objects to be placed’ and commodities of the care home system following their transition into care^{vi}.

Advocacy linked to hospital discharge can also have a significant and positive affect on the following:

- extended hospital stays affecting mobility and independence;
- discharge planning;

- slow setting up of care packages delaying discharge;
- patients, families and carers disengaged from the discharge process;
- key decisions about discharge into residential care made at a time when the older person concerned is too ill, vulnerable or exhausted to make the physical and emotional effort to make an informed decision.

There is a strong case for an independent advocacy process where advocates acting on behalf of patients, families and carers would challenge what is all too often seen as an automatic pathway into residential care at a time when an individual older person is experiencing a significant dip in their physical, mental and emotional health.

An independent advocate in this circumstance could help ensure that the full breadth of community based services or packages of alternative community services are fully considered by medical, nursing and other clinical NHS staff, social services professionals as well as patients, family members and carers. These could include:

- rehabilitation/convalescent beds in other hospital settings;
- step down beds block contracted in Nursing or Residential Homes offering a range of health/social care provision to prepare “sub acute” service users to return home;
- intermediate care teams;
- reablement teams;
- social care discharge teams (intensive/tapering care up to 6 weeks);
- tuck in/get up services;
- community nursing;
- chronic conditions teams (health and social care);
- community physiotherapy, occupational therapy, speech and language therapy;
- community Mental Health Teams (older people with dementia, Alzheimer’s disease);
- adaption and equipment services (including joint equipment stores);

- joint rehabilitation day units;
- day hospitals;
- extra care sheltered housing;
- night care static or mobile provision;
- third sector support services including; minor repairs, gardening, shopping, domestic help;
- Crossroads Care (supporting carers) and other carer support agencies;
- Voluntary agencies offering a range of mainstream and support for older people with a broad range of physical disabilities, chronic conditions, sensory hardships, mental health services etc.

Independent advocates can clearly play a significant role in exploring with service users, families and carers the range of provision and packages of care available as a means of avoiding unnecessary admissions to hospital or other settings. There is therefore a strong and pressing case for the provision of a hospital discharge independent advocacy system across Wales for older people.

3.2 Care Homes under threat or in the process of closure

There are significant benefits in an independent advocate supporting individuals living within care homes closing or under threat of closure. These benefits extend not just to residents but also to relatives, staff and home owners. A well informed and conscientious independent advocate could ensure that the voice of residents and key other stakeholders are heard in such areas as:

- Putting and maintaining the health and well being of residents at the top of the closure agenda.
- Ensuring continuity of care as the resident transfers to a different home.
- Ensuring that the closure assessment process takes into account needs, choices and preferences.
- Ensuring that timely and well planned communications help to reduce distress, rumour and misinformation, demanding that a clear strategy for closure (if there is no alternative) is articulated to all stakeholders.

- Ensuring that care arrangements meet emotional and social requirements as well the practical arrangements linked to their future.

Of the sixteen care homes we visited, three were under threat or in the process of closure and this featured significantly in all of the discussions we had with those who were involved.

The uncertainty of the situation caused residents significant distress and tended to overshadow any positive experiences they had of living at the care home.

The residents conveyed a sense of powerlessness at not knowing what was going on regarding the decision to close the care home and their relocation. This also caused them to question their personal value and importance and view themselves as commodities of the care home system, to be moved and placed wherever others decided.

“Thinking about what’s going to happen to me because we’re in the dark. If we had more information about what was going to happen, as I get older, thinking and talking to myself, that we’re here and they’re expecting us to die one by one before they can do anything and that worries someone.”

(Resident)

“We don’t get to know what happens...we can’t understand what’s happening. But I think that we should get to know that because some worry awfully. I do because I have nowhere to step into.”

(Resident)

We found that there is often a lack of meaningful engagement with residents, and that independent advocacy is often provided too late, if at all.

We also found that relatives often feel ill-equipped to advocate for residents where the care home is in the process or under threat of closure. Relatives reported that they themselves were unfamiliar with the formal

and often complex processes involved, such as how to access relevant and full information on timely basis. They also felt that their views and opinions were sought but seldom have any impact.

In relation to care home closures, our research found a sense of powerlessness of not knowing what is happening and as a result residents often have feelings of not being of any worth. Residents are in danger of seeing themselves as commodities, being in the dark and wondering what happens next. Lack of management engagement is often seen as a characteristic of many closures or threat of closures, leaving relatives without the knowledge, information and skills to advocate for their loved one.

Bringing together the experiences of older people with evidence from all the other research we have undertaken, demonstrates that the views of residents and relatives are often sought but seldom acted upon when weighed against the financial and other reasons for closure.

Section 3 Recommendations

- a. Welsh Government's planned business case should make specific reference to the role of advocacy for people entering a care setting from hospital, living within a care setting, experiencing care home closures.
- b. Local Authority and Local Health Board Commissioners and care home providers should:
 - Identify the key points at which older people will be given information, advice and access to independent advocacy.
 - Be clear how they will deal with the situation in which an older person has no capacity, fluctuating capacity, or no relatives involved.
 - Increase provision and effective access to independent advocacy services across Wales, ensuring that care homes are held to account for enabling older people to access independent advocacy.
- c. All staff providing support to people entering a care setting from hospital, living within a care setting, or experiencing care home closures, should receive training of the role and benefits of advocacy in these particular circumstances has been used.

Overall outcome:

Older people in key situations of vulnerability who are making critical decisions relating to the possibility of moving in to, or changing, a social care setting are aware of and have access to independent information, advice and advocacy.

4 Inspection, Monitoring and Provision

Good independent advocacy services need to be of an acceptable, consistent and recognised standard. Whilst statutory advocacy providers have standards set down by Government, independent advocacy schemes have no formal framework of standards underpinning their delivery and are monitored and reviewed by a variety of organisations^{vii}.

Key Points

- **There is a lack of consistent and comprehensive inspection and monitoring of independent advocacy provision.**
- **This has contributed to a general lack of awareness and understanding of advocacy.**
- **The role of Care and Social Services Inspectorate Wales (CSSIW) is crucial in supporting the profile and importance of advocacy within care homes and there is a need to raise awareness and provide training on advocacy for Inspectorate staff.**
- **A more consistent approach to the inspection process could support a stronger focus on outcomes for older people and provide support for facilitating choice and control.**

Our Review reported variations in relation to CSSIW inspections. Some care home managers reported that the CSSIW inspector had asked whether the residents had access to advocacy services, while some said that inspectors had not asked anything related to the provision of

advocacy. Questions from the CSSIW inspector tended to be in relation to Deprivation of Liberty Safeguards and whether anyone living at the home was subject to such measures. CSSIW does not routinely ask questions relating to the provision of advocacy in care homes. Advocacy arrangements outside of Independent Mental Capacity Advocacy are not routinely considered or monitored during inspections.

Standards 8 and 11 of the National Minimum Standards for Care Homes for Older People in Wales do not explicitly state what is expected with regard to the provision of advocacy within a regulated setting.

The Standards also do not include clear guidance and sufficient detail regarding advocacy requirements, and do not define the role of the care home manager with regard to supporting access to advocacy.

4.1 Views from independent advocates

Independent advocacy providers that we heard from perceived a fear and misperception of independent advocacy amongst care home managers and staff within care homes. Advocates reported that their service provision monitoring indicates a high proportion of referrals related to hospital discharge arrangements. This indicates that, of those referrals received, independent advocacy is playing a role in the hospital discharge and care planning stages for older people, particularly in relation to transitions into long-term care environments.

Advocates also view their role as one of safeguarding and protection. Independent advocacy providers often wear multiple 'hats' (e.g. IMCA, IMHA) in addition to generic advocacy, which can lead to a blurring of roles and responsibilities. Advocates report difficulties in operating the same model of provision across all the care homes they engage with due to significant variations in the culture, context and standards of care.

Advocates report a rise in 'crisis advocacy', particularly in the case of care home closures. In many cases, however, they consider that these are often 'token gestures' as major assessments and decision-making have already been completed. They are of the view that there is a lack of understanding of advocacy when decisions are taken in the best interests of the person amongst health and social care professionals within hospital discharge and social work teams.

Section 4 Recommendations

CSSIW should:

- a. Monitor and inspect the availability of independent advocacy to care home residents, and the extent to which managers and other workers have been trained in the benefits and role of independent advocacy.
- b. Ensure that inspections of care homes include an evaluation of the record of older people's needs for advocacy and any action that has been taken to meet those needs.
- c. Strengthen the provision within care standards for the delivery of advocacy services.
- d. Issue guidance to Commissioners, Local Health Boards and care providers in Wales stating that the human rights principles and the UN Principles for Older Persons should be incorporated into the commissioning process and service delivery for older people.

Overall outcome:

Awareness of the role, and evidence of the use of, independent advocacy is embedded in regulation and inspection arrangements with evidence of improved access and delivery of support.

5 Commissioning and Contracting

Commissioning and contracting frameworks have the potential to drive significant improvement in understanding of and access to advocacy throughout the care system in Wales. However, the funding and commissioning of advocacy for older people by Welsh Government, Local Authorities and Health Boards has been subject to varying degrees of attention and prioritisation. There is a general view that funding for non-statutory advocacy in particular is insufficient.

Key Points

- **The current provision of independent advocacy lacks consistency and a clear framework.**
- **There is currently not a coherent and consistent approach to assessing need and planning for advocacy provision and funding.**
- **Commissioning contracts with care homes do not explicitly stipulate the arrangements care homes should have in place for independent advocacy.**

Local Authorities

As part of our work on independent advocacy we contacted all 22 Local Authorities to ask about advocacy arrangements in their area. The vast majority of Local Authorities from whom we requested information did not have a specific advocacy strategy for older people in care homes. Some Local Authorities relied on case-by-case decision-making, whereas others had a more proactive approach and more widespread provision.

Many Local Authorities stated that advocacy was a component part of other broader strategies covering care management and commissioning arrangements for older people, including mental health and physical disabilities.

There was a mixed picture in the provision of advocacy across Local Authorities in Wales. Many relied upon spot purchasing or modest service level agreements which would be drawn upon on a case-by-case basis and often covered multiple service user groups. Several Authorities reported they had commissioned advocacy services specifically for care homes, as a one-off, due to a programme of care home closures within the county; few reported operating joint commissioning strategies.

The majority of Local Authorities stated that their care management and social work services would be available and most appropriate for older people who may be considering the move into a care home. Some Authorities did make reference to locally commissioned advocacy services and hospital discharge schemes provided by third sector organisations, but social work and care management featured prominently in all but a few cases. Where services were commissioned, monitoring was usually achieved through service level agreements and inherent requirements for reporting.

There were numerous references to services setting their own standards and 'self-monitoring' in the responses we received. The process employed by one such service, for example, was to set their own standards and self-assess against these. This process was then independently reviewed and an annual certificate awarded. In addition, the Local Authority, through the commissioning and monitoring process, reviewed the organisation's annual report.

Many of the responses received from Local Authorities lacked information about how they assessed the need for advocacy in their area. There were some references to mapping exercises undertaken previously, but it was unclear how prominently the provision of advocacy featured in their design or outcomes. Some Authorities also made reference to the need for investigation of this kind to determine such information.

“Advocacy is discussed but seen as an area that rarely is identified or requested. Community Care attribute lack of demand due to the excellent work carried out by social workers and other support organisations in helping the person have a voice to identify their own needs and support. The council are developing their citizen directed support and direct payments services as people in [area] are assisted to manage their own affairs, including what support they do or do not need addressing”

(Local Authority)

Good Practice

A Local Authority reported a new model for advocacy services of which a communications strategy will be a key component. As part of wider remodelling of services, the provision and availability of independent advocacy for older and vulnerable people in care will be a standard requirement from all who are commissioned to provide residential or nursing care.

Local Health Boards

Many of the Local Health Boards cover more than one Local Authority area (some up to 6). As a result they reported different levels of involvement and interaction with various strategies, service level agreements and schemes currently in place or under development across their respective geographical areas.

Few of the Local Health Boards reported specifically commissioning advocacy provision for older people in care homes, instead outlining their involvement in joint-commissioning arrangements and their process for signposting individuals elsewhere. A number, however, stated that they did have a number of contracts and service level agreements with local independent advocacy providers. Based on the information received from Local Health Boards, the use of nurse assessors to support access to advocacy services also seems to be limited.

Good Practice

A nurse assessor's role in regularly reviewing individual care plans and placements and considering whether care needs are health or social care related (determining how care is funded), suggests that they could be well placed to provide advocacy support, as is the case in the one Local Health Board with an advocacy strategy. As part of this strategy, every nursing home has a nurse assessor allocated to them, to provide support and advice for older people within the home, as well as signposting residents to appropriate advocacy services.

Local Health Boards referred to the various services that were available and commissioned by other agencies. They reported making more use of these services in situations where there were questions of mental capacity, or where social care or nursing assessments were disputed.

Good Practice

One Local Health Board referred to an existing contract in place with a local independent advocacy provider to support older people who are inpatients in making significant decisions such as entering a care home. These services are usually focussed on providing support to older people in hospital who may not be able to return home and are considered vital by both Inspectors and independent advocacy providers.

Some of the Local Health Boards reported using external evaluations by local universities that were results-based and outcome measured. Typical responses were annual reviews and appraisals of service level agreements and contracts. One Local Health Board used performance management reports that required providers to have achieved (or be working towards achieving) the Action for Advocacy Quality Performance Mark. Service user feedback evaluation is a requirement of the performance monitoring.

Some Local Health Boards would examine performance data as part of the review process, specifically with regard to access to waiting times for and provision of advocacy for older people. Others would make use of intelligence provided by Local Authority partners' commissioning plans.

Similar responses emerged to the Local Authorities where many Local Health Boards had an expectation of providers to ensure promotion of advocacy services. In addition, the usual methods of displaying information on wards and public areas and at occasional 'road shows' were utilised, giving patients and relatives information during assessment processes. One Local Health Board mentioned that there was to be a campaign in 2012 where advocacy would feature prominently as part of the launch for the Mental Health (Wales) Measure, 2010.

Care Homes

The sample of care homes we selected to provide information in relation to their arrangements for advocacy produced a variety of results. Many care homes said they had made no arrangements, with others stating they had policies and procedures in place. On closer inspection, however, a distinct lack of awareness and understanding of independent advocacy was demonstrated.

A number of the care homes did not differentiate between those who advocate for residents on a day-to-day basis and those who provide support in terms of more important decisions. This reflects what we found during the care home visits. The responses stated that a range of individuals were providing advocacy, including care staff, relatives, generic independent advocates, IMCAs and legal representatives.

The majority of care home managers provided information concerning policies on DoLS, The Mental Capacity Act and POVA. The ways in which these policies were implemented, however, were inconsistent and dependent upon the care home manager, who would assume responsibility for commissioning and allocating training and disseminating information to care staff and residents.

Overall, this paints a picture of independent advocacy being considered in relation to formal safeguarding, rather than everyday voice, choice and control.

Section 5 Recommendations

- a. Local Authorities and Local Health Boards must improve the commissioning, contracting, and monitoring of independent advocacy services across Wales through:
 - A coherent and consistent approach to assessing needs and planning for advocacy provision in their area.
 - Requiring care homes to evidence that staff are aware of the benefits and role of independent advocacy.
 - Requiring care homes to demonstrate that they are promoting and enabling the provision of independent advocacy.
 - Developing agreed and consistent quality standards that underpin the provision of all independent advocacy.

- b.** Welsh Government should improve the commissioning of effective independent advocacy services across Wales through:
- Ensuring its planned business case for advocacy encourages a coherent and consistent approach to assessing needs and planning for advocacy provision.
 - Requiring independent advocacy to be built in to the commissioning process.

Overall outcome:

A coherent and consistent approach to the commissioning contracting, provision and monitoring of effective independent advocacy services across Wales.

Conclusion

- The term advocacy, and in particular the impact and importance of independent advocacy, is not consistently understood by residents, relatives, care home managers and care home staff. A narrow view has emerged which sees it as synonymous with safeguarding, dispute resolution and complaints. There also appears to be a lack of training about advocacy services available for care home managers and staff. There is a notable lack of awareness amongst residents in relation to the availability of advocacy and, in particular, how and in what circumstances they might access it.
- Older people are not always supported at times of major decision-making and transitions. Independent advocacy is particularly important in certain circumstances of vulnerability including older people's entry into care homes (which is often preceded by a crisis such as bereavement, a period of ill health or a stay in hospital) or when facing major decisions and changes to their lives such as the threatened or impending closure of a care home.

- Some older people lack control over their living environment and choice in their everyday life. This is due to a misunderstanding of meaningful voice, choice and control and combined with a lack of independent advocacy can result in some older people withdrawing socially and emotionally. Sometimes compliance can be misinterpreted as positive acceptance when actually it represents resignation to a situation over which the older person has no control.
- There is a lack of consistent and comprehensive inspection and monitoring of independent advocacy provision. This has contributed to a general lack of awareness and understanding of independent advocacy. The role of CSSIW is crucial in supporting the profile and importance of advocacy within care homes and there is a need to raise awareness and provide training on advocacy for Inspectorate staff.
- The current provision of independent advocacy lacks consistency and a clear framework. There is currently no coherent and consistent approach to assessing need and planning for advocacy provision and funding. Commissioning contracts with care homes do not explicitly stipulate the arrangements care homes should have in place for independent advocacy.

This report contains a series of good practice recommendations to public bodies in Wales, which set down a benchmark for improving the access older people have to the independent support they need. These recommendations are intended and expected to lead to a step change in the way that advocacy is perceived and understood, and an increase in the consistency and quality of advocacy services across Wales which is recognised and valued by older people.

The intended outcomes of these recommendations are that:

- Care staff understand and promote the concept of voice, choice and control and the role of advocacy within this.
- There is increased awareness and understanding of advocacy, including the role and impact of independent advocacy, across Wales.

- Awareness of the role, and evidence of the use of, independent advocacy are embedded in regulation and inspection arrangements.
- There is a coherent and consistent approach to the commissioning contracting, provision and monitoring of effective independent advocacy services across Wales.

The overall intention of this work is that older people in key situations of vulnerability who are making critical decisions around moving in to or changing the social care setting are aware of, and have access to independent information, advice and advocacy, and through this are able to make the right decisions at that particular point in their life.

The Commission will play its part to ensure that over the next two years we make significant progress in achieving this aim in Wales.

Appendix 1: Definitions of Advocacy

Generic Advocacy

This type of advocacy is provided on a voluntary basis, most often by third sector organisations. There is currently no legal requirement to provide generic advocacy.

Statutory Advocacy

In certain circumstances, individuals have a legal right to access and be supported by an independent advocate.

Independent Mental Capacity Advocate (IMCA)

For those with Mental Capacity Issues under the Mental Capacity Act 2005, advocacy is provided in the form of an Independent Mental Capacity Advocate (IMCA).

An IMCA must be instructed and then consulted for people lacking capacity who have no-one else to support them (other than paid staff) whenever:

- An NHS body is proposing serious medical treatment.
- An NHS or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home.
- An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:
 - Care review.
 - Adult protection cases, whether or not family, friends or others are involved.

Additionally, in some circumstances, an IMCA must also be instructed to represent someone under the Deprivation of Liberty Safeguards (DoLS), as defined in the Mental Capacity Act 2005.

Deprivation of Liberty Safeguards (DoLS)

If all alternatives to providing care in the least restrictive way have been explored, a hospital or care home may believe it is necessary to deprive a person of their liberty in order to care for them safely.

Where this is the case, the Deprivation of Liberty Safeguards (DoLS) are used to ensure that an individual's loss of liberty is lawful. The safeguards:

- provide the person with a representative;
- allow a right of challenge to the Court of Protection against the unlawful deprivation of liberty;
- provide a right for deprivation of liberty to be reviewed and monitored regularly.

Independent Mental Health Advocate (IMHA)

An Independent Mental Health Advocate (IMHA) provides advocacy for those who are detained under the Mental Health Act 1983.

IMHAs can also provide advocacy support for people who are conditionally discharged, subject to guardianship or a Community Treatment Order (CTO).

Commissioner for Older People (Wales) Act Definition

Within the Commissioner for Older People (Wales) Act 2006 advocacy is defined as arrangements made by a person for making persons available: (a) to represent the views and wishes of relevant older people in Wales; or (b) to provide relevant older people in Wales with advice and support of a prescribed kind^{viii}.

Older People's Advocacy Alliance (OPAAL)

The OPAAL definition was developed with Action for Advocacy and over sixty national partner organisations, all part of the National Advocacy Forum for Older People in November 2008. It states that:

“Advocacy supports and enables older people who have difficulty representing their interests, to exercise their rights, express their views, explore and make informed choices. Independent Advocacy supports the person regardless of the demands and concerns of others. It challenges the causes and effects of injustice, oppression and abuse and upholds human rights.”

The legal and policy framework

The legal and policy frameworks relevant to advocacy are summarised in the following table:

Framework	Provision	Jurisdiction	Sponsor
Health and Social Care Act 2001	Legal right for NHS users to access independent complaints advocacy	England and Wales	Department of Health
Regulations and National Minimum Standards for Care Homes for Older People (2004)	Standard 8: Assistance to contact agents, e.g. advocates Standard 11: Assistance to access advocacy, where capacity is lacking	Wales	Welsh Assembly Government (WAG)
National Service Framework for Older People 2006	Standard 1: Independent citizen advocacy to be available, publicised and accessed Standard 10: Access to advocacy for those using mental health services	Wales	Welsh Assembly Government
Mental Capacity Act 2005 (MCA)	Legal right to advocacy (IMCA) in limited and prescribed situations	England and Wales	Department of Health, Ministry of Justice and Wag
Mental Health Act 1983, amended by the Mental Health Act 2007	Legal right to advocacy (IMHA) for those subject to compulsion	England and Wales	Department of Health and WAG
MCA 2005: Deprivation of Liberty Safeguards	Legal right to advocacy (IMCA) for those subject to the Safeguards	England and Wales	Department of Health, Ministry of Justice and Wag
Mental Health Measure (Wales) 2010	Legal right to advocacy (IMHA) for those in hospital informally or subject to compulsion	Wales	Welsh Assembly Government
Wales Interim Policy and Procedures for the Protection of Vulnerable Adults (2010)	Advocacy should be arranged to support vulnerable adults during the adult protection process	Wales	Wales Adult Protection Fora
Sustainable Social Services for Wales - A Framework for Action (2011)	A business case will be developed to introduce a comprehensive advocacy service for older people	Wales	Welsh Government

Appendix 2: United Nations (UN) Principles for Older Persons²

The UN encourages Governments to incorporate the following principles into their national programmes whenever possible:

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.

11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-Fulfillment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Appendix 3: Context for the Review

On-going Research

In addition to acknowledging the work already done to underpin this Review, there is also ongoing research and other initiatives that are directly relevant.

The National Assembly for Wales' Health and Social Care Committee Review into Residential Care for Older People

The National Assembly for Wales' Health and Social Care Committee

is undertaking an inquiry into residential care for older people. The Committee invited individuals and organisations to provide evidence to assist them in examining the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people, including:

- The process by which older people enter residential care and the availability and accessibility of alternative community-based services, including reablement services and domiciliary care.
- The capacity of the residential care sector to meet the demand for services from older people in terms of staffing resources, including the skills mix of staff and their access to training, the number of places and facilities and resource levels.
- The quality of residential care services and the experiences of service users and their families.
- The effectiveness of services at meeting the diversity of need amongst older people.
- The management of care home closures.
- The effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.
- New and emerging models of care provision.

It is widely acknowledged that there are gaps in knowledge with regard to the diversity of older people's experiences. The Commission is aware that there is ongoing work that is beginning to address some of these under-researched areas.

Provision of inclusive and anti-discriminatory services to older lesbian, gay, bisexual-identifying (LGB) people in residential care environments in Wales

This 2 year study, funded by the National Institute for Social Care and Health Research, commenced in April 2011. It seeks to examine the translation and implementation of Welsh policy at a local level, specifically within the policy and practices of residential care environments for older people who identify as lesbian, gay and bisexual (LGB). Older LGB residents' sexual health and social needs are often overlooked or not recognised in policy and practice. The objectives of this study include an exploration of how older LGB people are included

and supported in care environments in Wales. Care environments will include Extra-Care, residential care settings and nursing homes, including elderly mentally infirm (EMI) settings.

The study will first seek to determine to what extent older LGB residents' needs are included in Inspection Reports on care homes. Secondly, how care staff view LGB residents and what good practice is in place for promoting their rights and interests will be examined, through established attitudinal measures on sexual practices and perceptions of older people. Thirdly, policy makers and interest groups will participate in focus groups to look at how older LGB residents are included in policy. Finally, the views and experiences of older LGB people (aged 50 and over) will be obtained through semi-structured interviews about their hopes and expectations for future residential care.

The findings will inform service providers about how they can provide inclusive and equal care to LGB residents. This information will help develop staff training and assist care environments in providing anti-discriminatory services, in line with the Equality Act 2010. The outcomes of this study will also help assess the standard of care provided in respecting and promoting the sexual lives of residents and meeting the relationship and support needs of LGB-identifying residents.

'In their own words': Voices of African-Caribbean and Black Welsh men and women

Over the decades, research in the area of dignity and age has grown in both the UK and internationally. Although the body of research evidence has helped significantly to refine the concept of dignity and to broaden our understanding of older people's experiences and expectations of care, few studies have sought to examine the concept of dignity and perceptions of dignified care, as linked to social identity and racialisation, to develop an understanding of the possible impact this has on enhancing or damaging a care encounter. This research, prepared by Ms Liz Folkes and Dr Roiyah Saltus on behalf of the Wales Ethnicity Research Collaboration (WERC), sought to address such gaps in Wales.

The study revealed that social markers such as ethnicity and cultural identity shaped participants' understanding of what dignity

means and also had an impact on how they felt they would be treated while receiving care. A key message is that attention to these elements is important, as is the need to develop an understanding of the possible impact such factors may have on enhancing or damaging the experience of receiving care. The anxiety around external sources of support and care was voiced, by some, in terms linked to their personal identity and not being treated with care and with dignity because of their ethnic or cultural background.

Missing Voices: A review of independent professional advocacy services for looked after children and young people, care leavers and children in need in Wales

The Children's Commissioner for Wales carried out this review of independent professional advocacy service arrangements in Wales in 2011. It found that independent professional advocacy was being provided in all 22 Local Authorities. Some of Wales' most vulnerable children and young people, however, remain unaware of their entitlement to have an independent professional advocate to represent their views. Looked after children, care leavers and children in need in

Wales, who want the support and advice of an independent professional advocate to help them have their voice heard, are being badly let down.

Whilst many do receive an excellent service from independent professional advocates, there are others who are missing out. National and local structures are supposed to be in place to ensure that all these children and young people can access independent professional advocacy services and benefit from them. The review has a number of key findings including:

- Children and young people who have not had contact with an independent professional advocate are often not aware what 'advocacy' means.
- Professionals who work with vulnerable children and young people do not always recognise the benefits of independent professional advocacy and do not consider access as an automatic entitlement of the children and young people they work with.
- There is a lack of clarity and consistency about the way in which independent professional advocacy services are commissioned in Wales. Current reliance on short-term contracts is undermining stability of provision and the development of robust services.

- There is no annual or systematic monitoring, inspection or regulation of independent professional advocacy services for looked after children, care leavers or children in need in Wales.

Legal and Policy Frameworks Relevant to Advocacy

The legal and policy framework for independent advocacy has changed significantly over the past 10 years. Dunning's initial scoping study (2010) reflected how recent developments in policy had occurred incoherently in Wales, with a more substantial evidence base developing in England. The Sustainable Social Services for Wales White Paper and a pledge made by the Welsh Government, however, provide a timely opportunity to investigate the business case for an independent advocacy service for older people in Wales. Additionally, the Social Services (Wales) Bill offers a unique opportunity to provide the Welsh Government with regulation-making powers to help develop a more coherent and comprehensive advocacy service throughout Wales.

Appendix 4: Methodology

This study was conducted between September 2011 and February 2012. It used mixed methods including (i) semi-structured face-to-face interviews with older residents, relatives, care home managers and care home staff (ii) semi-structured telephone interviews with relatives, (iii) focus groups with CSSIW Inspectors and independent advocacy providers and (iv) documentary analysis of information obtained from Local Authorities, Local Health Boards and Local Authority and independent care home managers with regard to existing arrangements for advocacy for older people in care homes.

A small, yet representative, sample of care homes from across Wales was selected for this study that reflected the diverse geographical and cultural context of Wales. The data for this Review was collected directly by staff of the Older People's Commissioner for Wales to ensure meaningful engagement with older people and to hear and understand their views and experiences of entering and living in a care home.

This study is unique in the use of the Powers of Entry and Review available to the Older People's Commissioner for Wales, which resulted in unprecedented access to care homes compared to other similar studies.

Obtaining Information

In September 2011, we wrote to regulated bodies, services and persons (who may be subject to the Review), informing them of our intention to conduct a Review of advocacy arrangements for older people in care homes in Wales. These included all 22 Local Authorities, 7 Local Health Boards (where joint commissioning arrangements may exist) in Wales, the Care and Social Services Inspectorate for Wales (CSSIW), the Deputy Minister for Social Services and Children and all registered care homes for older people in Wales.

In October 2011, we issued a further letter requiring information about advocacy arrangements from all 22 Local Authorities and 7 Local Health Boards. We also contacted 143 care homes made up of a selection of 5 care homes per Local Authority area and 33 care homes that were identified through the Commission's Information and Enquiries team. CSSIW inspection reports were also utilised in desktop research to inform the selection of care homes. This ensured that all categories of care were included (e.g. mental health/dementia) and that we gathered information from homes run by Local Authorities in addition to the private, voluntary and independent sectors.

Selecting the Local Authority Areas

Five Local Authority areas were selected that, as far as reasonably possible, represented the diverse cultural and demographic context of Wales, reflected in terms of the following:

- Likely proportion of Welsh speakers;
- Rural / urban / former industrial / inner city settings;
- Care homes under the threat or in the process of closure;
- Likely proportion of care home residents without family or friends nearby;
- Likely proportion of self-funders.

Selecting the Care Homes

We selected 16 care homes for inclusion. We wrote to each of the care homes advising them of their inclusion in the study and of our power to enter the care home to conduct the Review. A member of the research team followed up these letters with telephone calls and liaised with the care home providers and/or managers to make arrangements for the visits.

Prior to the visits taking place, the care home providers and managers were requested to ensure that all residents, relatives and care staff at the home were made aware of the visit and asked if they wished to take part. Participant information sheets were then sent to the home for distribution. The research

team asked to be informed in advance if any assistive equipment, such as a hearing loop or interpretation services were required. A number of the research team were fluent Welsh speakers and undertook the majority of interviews in care homes located in areas where Welsh was the language of choice.

All care home providers and managers allowed the research team to enter their care home. As part of the visits, the research team visited 2 specialist care homes for older people with advanced dementia. Although it was understood that there may be little or no participation from the older residents, it was considered important to explore advocacy arrangements for older people who were unable to speak for themselves. Within these care homes, interviews were conducted with care home managers, staff and relatives. Additionally, 3 of the care homes selected were in the process or under threat of closure.

Ethics

Throughout the research process, the study adhered to the Social Research Association (SRA) and the British Society of Gerontology (BSG) ethical codes of practice. Our ethics policy set out the guiding principles of the study and how they should be applied.

The Commission's POVA policy, which places a duty on Commission staff to report any incident relating to the abuse of an older person, was adhered to at all times during the visits.

It was anticipated that frail and/or cognitively impaired older residents would present particular challenges and the ability of participants to understand the purpose of the Review and make decisions about their participation in the interviews would require careful consideration and assessment. Older residents were given participant information sheets in advance of the visits and encouraged to discuss the study with family, friends and staff and to ask questions that could be passed on to members of the research team. The research team operated a policy of not excluding older residents displaying mild to moderate dementia with communicative ability, or those with a visual or hearing impairment. The research team relied initially on information from the care home staff as to who had sufficient capacity to understand and consent to participate in the research. The research team, however, were keen to engage with the quieter voices in the care home and spent time talking and interacting with other older residents in addition to those signposted by care home managers. The research team applied the two-stage test of capacity (Mental Capacity Act 2005) to make their own judgement as to whether a participant was able to make an informed decision to take part.

Before interviews took place, written consent was obtained from each participant. Participants were advised that they were able to withdraw from the interview at any time and refuse for their data to be used in the research. Information they had supplied would then be deleted. No objections were raised during any part of the study.

Interviews

Interviews with older residents were used to establish whether, and to what extent, they were aware of the availability of independent advocacy and if they understood how and in what circumstances they might access it. Interviews with relatives and care home managers and staff were important in exploring how advocacy is more widely understood and whether its importance within care homes is recognised. The research team also recorded their observations whilst in the care home, such as the general appearance of the physical environment (including atmosphere, ambience and odour), physical appearance of the older residents (including alertness and where they were sat), physical interaction with staff, and availability and accessibility of information relating to advocacy arrangements within the care home.

Within each of the 16 care homes, the research team aimed to conduct up to 5 in-depth interviews with older residents, 2 interviews with relatives, 1 interview with the care home manager and up to 3 interviews with care home staff.

Interviews with older residents covered topics in relation to how they felt their opinion and views were valued within the home such as: how they were supported to make day-to-day and important decisions; who supported them to make these decisions; and to what extent they were aware of the availability of independent advocacy and how and in what circumstances they might access it. Interviews with relatives sought to explore their understanding of advocacy: how important they viewed it within the care home environment and the ways in which they supported their relatives to make decisions.

Interviews with care home providers and managers also sought to explore their understanding of advocacy generally and to what extent arrangements in place within the home were effective in supporting the older residents' autonomy and decision-making.

Interviews also covered the provision of training for managers and staff and processes of determining how and in what circumstances older residents are supported to access independent advocacy services. Interviews with care staff covered their understanding of advocacy and their role in supporting the older resident to make decisions within the home.

Interviewers made notes during the interview and participant responses to open-ended questions were audio-recorded. The voice files from the interviews were transcribed and the manuscripts were imported into specialised software for analysis.

Sample and Response Rates

The research team interviewed 46 older residents. There were anticipated variations in the expected and achieved response rates due to differences between care homes in terms of size (number of residents living at the care home), physical health, mental capacity and willingness of the older residents to participate in the interview. Older residents were initially identified and approached to take part in the study by the care home manager. Older residents were also recruited on the day after meeting and talking with the research team and agreeing to participate. As previously noted, 2 of the care homes visited were specialist care homes for older people who had advanced dementia. Subsequently, no older residents were interviewed as the research team observed and concluded that there was insufficient individual capacity to consent to the interview or understand the purpose of the visit.

In total, 22 relatives were interviewed, 10 in person during the research team's visits to the care homes and a further 12 over the telephone at a later date. Relatives were typically informed of the visits and approached to take part by the care home manager. Some relatives were also recruited on the day of the research team's visit and agreed to be interviewed either in person or at a later date over the telephone. The research team interviewed 13 care home managers and 26 care home staff.

Focus Groups

Focus groups were held with CSSIW Inspectors and independent advocacy providers to test the initial findings of the study and obtain their perspectives on the provision and monitoring of advocacy in care homes. Three focus groups were held: 2 for advocacy providers (1 in South Wales and 1 in North Wales) and 1 for CSSIW Inspectors, with representatives of the 4 regional CSSIW Inspectorates.

Focus groups with CSSIW Inspectors sought to: validate early findings; establish challenges and opportunities linked to the inspection process; obtain inspectors' views on the current situation in care homes with

regard to advocacy support for older people; and determine whether modernised inspection processes and outcome-focussed inspections are helpful in understanding control and advocacy within care homes.

Focus groups with advocacy providers sought to establish whether there was a shared definition of advocacy amongst providers. Also discussed were the existing arrangements and independence of advocacy schemes, the accessibility, availability and take up of services, as well as commissioning, inspection and good practice examples.

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