NICE National Institute for
Health and Care Excellence

Resource impact summary report

Resource impact
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This guideline covers advocacy for people using health and social care services in all adult settings (including for young people under 18 if they are using adult services).

Local authorities, health authorities, NHS trusts, and health and social care providers must arrange for independent advocacy services to be provided to everyone legally entitled to advocacy (including young people who are using adult services) with person-centered advocacy, as part of their legal duty. This must be offered according to the relevant legislation as described in the section on legal right to advocacy in the guideline.

Many of the recommendations in the guideline reinforce the statutory duty and do not need any additional resources to implement in areas that are compliant with statutory duties.

There will be a resource impact where there is current non-compliance with statutory duties. There may also be a resource impact from updated recommendations relating to offering advocacy to people not covered by legal entitlement, increased access to independent mental health advocates, and training for health and social care practitioners who work with advocates. Where a change is required to current practice, this may require additional resources to implement, which may be significant at a local level.

Experts from the committee highlighted that if advocacy is effective in representing people's needs and helps people navigate a complex service system, this has the potential to lead to the provision of the right services at the right time that match individuals' needs, which can lead to better outcomes and more efficient use of resources.

Because of variability in data reporting and lack of robust data on the annual number of people who require services, current practice and the variation across organisations and services, the size of the resource impact should be determined at a local level.

There may be a resource impact in the following areas:

- Offering advocacy to people not covered by the legal entitlement (recommendation 1.2.1). This covers a wider group of people than those already being assessed for non-statutory advocacy and would include many people who currently live in the community. This is potentially more costly; however, it is likely to prevent needs escalating to a point at which people meet the threshold for statutory provision. So, providing non-statutory advocacy often does not represent entirely new costs, but a shift to earlier provision where there is a lower level of need (less time is needed than statutory advocacy), and the potential of future savings. People not covered by the legal entitlement include those who have a disability or are in a situation where they feel vulnerable and unable to speak up. It can include Community Mental Health Advocacy, Learning Disability Advocacy, Advocacy for Carers and/or Parents' (Child Protection) Advocacy. Advocacy relating to specific groups such as LGBTQ people, vulnerable refugees and asylum seekers, people experiencing housing problems and young adults leaving social care.
- Making access to independent mental health advocates (IMHA) opt-out rather than opt-in (recommendation 1.4.7). Opt-out is when people are referred for an IMHA automatically unless they object; whereas opt-in is where there is no automatic referral, access to an IMHA is given by request. Providers of IMHA are usually mental health charities. There is likely to be a resource impact in both the short and long term as more provision would be needed if people are aware of their right to access IMHA. This has been subject to estimation in the government's draft mental health bill: impact assessment (2022), which estimates an additional annual average cost across all local authorities (if moving from an assumed 50% to 85% provision) to be between £31 million and £33 million from 2028/29. This is dependent on a number of variables, including the current level of support provided which varies across the country.
- Training and skills for health and social care practitioners who work with advocates (recommendations 1.10.1 to 1.10.5) will lead to better access to advocacy and should also lead to better outcomes such as lower risk of needs escalating.
- Where there is non-compliance with legal duties. The resource differences between the amount of advocacy commissioned and the number of people needing support would be challenging to estimate. Implementing the recommendations on monitoring services and collecting data for quality improvement (recommendations 1.11.1 to 1.11.18) would allow local assessment of resource impact.

Implementing the guideline will lead to improved access to advocacy services. There are many resource benefits. These may help mitigate any additional costs, and in the long run, improve the quality of care that people receive.

These include:

- lower downstream costs from avoiding costly medical interventions such as unplanned hospital admissions
- preventing duplicate or inappropriate referrals to the NHS and the need for residential care
- improved quality of life by addressing needs more fully and earlier, ensuring services are more person centered and there is effective support, and preventing escalation. The resource benefits here are likely to offset any additional costs in the long term.

Advocacy services are commissioned by integrated care systems and local authorities. Providers are social care services (independent providers of advocacy services) and charities.