City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 5th of March 2020

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Subject:

Advocacy Services across the Bradford District

Summary statement:

This report provides an update on the Council and CCG's jointly commissioned Independent Advocacy, Self and Group Advocacy, Volunteering and Capacity Building services

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Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

1.1 This report provides an update on the Council and CCG's jointly commissioned Advocacy Services across the Bradford District.

2. BACKGROUND

2.1 On 21st of March 2019 the Health and Social Care Overview and Scrutiny Committee, in line with Standing Order 4.7.1, considered the report on the outcome of the joint commissioning by the Council and the CCGs of Independent Advocacy, Self and Group Advocacy, Volunteering and Capacity Building services.

2.2 It was resolved at the above committee that a report on performance information and outcomes, and consideration of demand for services including the cultural competency and diversity of the services was to be submitted to the Committee in 2020.

2.3 This report therefore sets out to provide updates on the;

- **Independent Statutory and Non-Statutory Advocacy** service contract. This is being delivered by Voiceability and provides for several different types of advocacy support to meet the Council's statutory obligations under the Mental Capacity Act 2005, the Mental Health Act 2007, the Care Act 2014, Deprivation of Liberty Safeguards (2015), Safeguarding and issue-based professional Advocacy. A description of the services Voiceability provide as well as the different types of Advocacy is available in Appendix 1*.Please note that due to the coming year- end, not all information for 2019-2020 is available. Where this is the case 2018-19 data has been used.*
- **Self and Group Advocacy, Volunteering and Capacity** Building service contract. This is being delivered by Equality Together and provides support to improve outcomes for individuals and groups who wish to represent their own or shared interests to obtain the care and support they need. Equality Together also subcontract with People First Keighley and Craven, Bradford People First and now Age UK who were added in late 2019. A description of the services Equality Together provide as well as the different types of advocacy is available in Appendix 1.

3. REPORT ISSUES

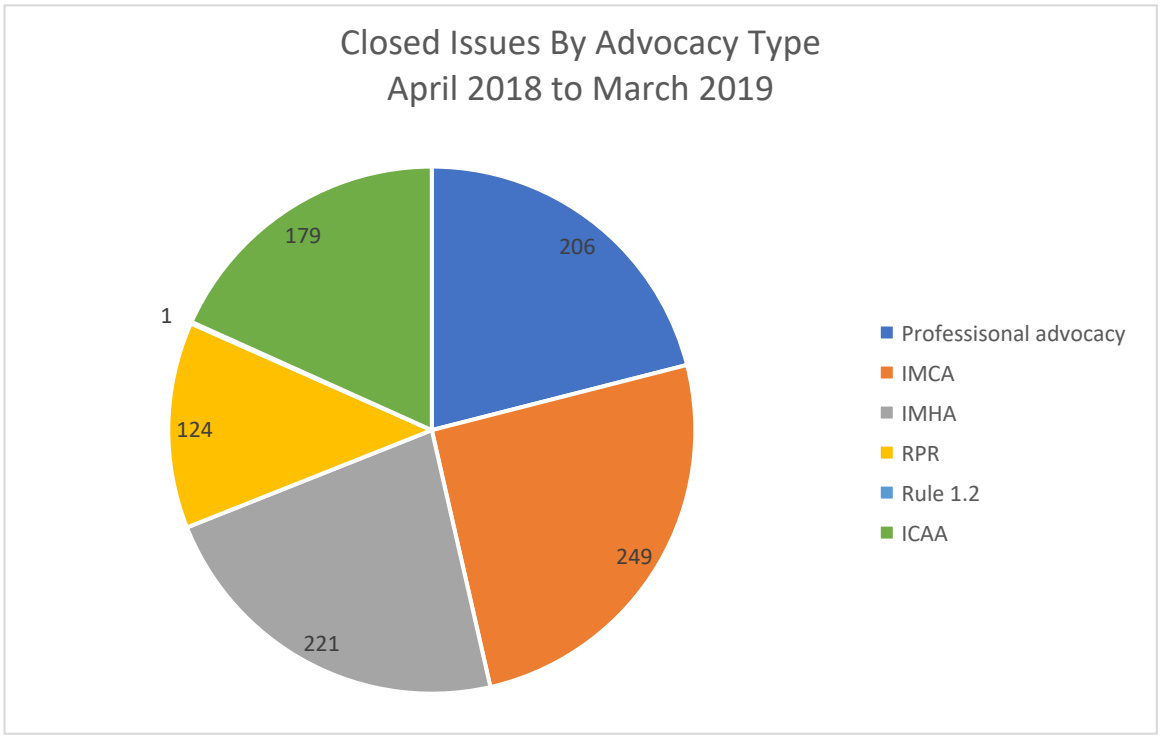
3.1 Performance - Independent Statutory and Non-Statutory Advocacy

3.1.1 Overall, the service provided by VoiceAbility is performing well with good outcomes for people and positive feedback from operational staff. Fuller details of performance are contained in APPENDIX 2, with a summary below.

3.1.2 The service is essential due to the number of statutory duties it has to meet under the legislation referred to above, and commissioners feel confident that the move to a unified service with a single gateway, using consolidated Council and CCG funding, gives much greater assurance that the Council is meeting its obligations.

3.1.3 The chart below shows the type of cases taken on over 2018- 2019. This shows that the large majority of cases taken on are where there is a statutory duty. Professional advocacy includes areas such as family or housing issues and are only seen if there is sufficient capacity. Tables 2 and 4 in Appendix 2 of this report provides a further breakdown of the types of issues referred in and taken on.

Closed issues information 01/04/18 to 31/03/19



3.1.4 In terms of outcomes, VoiceAbility report that of the 1,364 referrals received (Table 1) which involved providing advocacy support on 1,392 issues (Table 2), 980 were successfully handled to conclusion (Table 4).

3.1.5 In terms of support delivered, this was slightly lower than projected demand (see 3.1.8). However, we believe this to be the short term impact of the changed service delivery model and change of service provider. More recently, VoiceAbility have recruited new staff and retrained trained existing staff and are now operating to closer to a full staff team.

3.1.6 The current service model allows people to be triaged quickly, so that they can be prioritised and seen accordingly. The service operates a short waiting list, with 74% of all referrals become open cases with advocates assigned within two weeks, of the remainder a further 17% are assigned an advocate within six weeks of referral. The majority of these waiting six weeks are when there is not a statutory need. A quick turnaround also means that problems are less likely to escalate and the waiting list is regularly reviewed to ensure that the nature of the issue has not changed.

3.1.7 Cases are dealt with efficiently, this allows more people to be seen. The below indicates the average time advocates spend on cases by type of advocacy. VoiceAbility also have in place processes to review and close cases appropriately so that new referrals can be picked up.

Closed Referrals - Average Time Recorded	**Average of Recorded Time (mins)**	**Average of Recorded Time (hh:mm)**
Care Act	514	08:34
IMCA	421	07:01
IMHA	282	04:42
Professional Advocacy	781	09:44
RPR	519	08:39
Rule 1.2 representative (3a representative)	230	03:50
Grand Total	**408**	**06:48**

3.1.8 The service responds flexibly to meet the demands of the district. Since the contract has been in operation, the type of referrals received has differed from the indicative amounts predicted, and the following table shows indicative number of referrals over a year, against the actual number received during this financial year (10 months).

Advocacy Type	**Indicative Numbers (1 year)**	**Actual Advocacy Referrals from Apr 19 to Feb 20 (10 months)**
IMHA	318	134
Professional Advocacy		128
DOLS - Paid RPR	240	260
Safeguarding	240	20 alerts 68 Safeguarding Support
IMCA Advocate	130	227
Re-X	65	11
Litigation Friend	200	
Care Act	220	164
TOTAL	**1413**	**1140**

3.1.9 The service has been able to meet unexpected demands through putting in place a different type of operating model to previously- this has more staff trained up in more than one area of advocacy, so the service can react flexibly. Therefore the provider can respond to fluctuating levels of demand across the district and support people where it is needed most.

3.1.10 The new contract supports this approach as it requires the organisation to deliver an overall amount of hours as a service, rather than a target against each area of advocacy, as long as statutory needs are prioritised. An explanation of the difference in actuals against predicted can be found in Appendix 3

3.1.11 The introduction of a single pathway means that people are much less likely to fall in between different services, and internal referrals can be made if necessary. This is important as often people need support with secondary issues that are not always evident on presentation. Where the advocate is trained up in one area of law, they may support with more than one issue.

Partnership Working

3.1.12 Anecdotal feedback from practitioners, including the DoLS Team and Social Workers is that the standard of work being provided by Advocates has much improved since VoiceAbility took over the contract. This includes an improved working relationship, with advocacy now functioning as an intrinsic part of the Mutli-disciplinary Team on the Assessment and Treatment Units (ATUs). The DoLS team report they now have a lot more information and are more assured that people who are deprived of their liberty are now being properly represented.

3.1.13 The role of the service can (and should) mean that advocates still challenge professionals and practice, and a case study, supplied by VoiceAbility, illustrating an Independent Mental Health Advocacy case can be found in Appendix 4

Safeguarding Adults Board

3.1.14 As noted in a SAB report, IMCA plays an important role in keeping adults safe directly when there are specific Safeguarding concerns, but also through ensuring a deprivation of liberty is lawful and appropriate or that people have support around their long-term accommodation and medical treatment.

3.1.15 It was also noted that the service is coping well with demand, but that the introduction of the new Liberty Safeguards (which replace the current DoLS) was likely to have a large impact on demand, but was yet unknown. Bradford however has been very involved in the development in this work, and is at the forefront of this nationally in terms of preparation due to its relationship with Voiceability and a strong DoLS Team. More information on this can be found at section 3.4.1.

Recruitment

3.1.16 Following the transfer of previous staff teams, VoiceAbility invested heavily in training up the current team. The next step was then review their staffing base and identified where there are gaps, such as where there are skills and/ or language shortages, followed by a drive to recruit more staff that are reflective of the district through targeted recruitment. This has included sharing adverts for prospective new staff with organisations that support or work with cultural groups and BME groups, and using links in Adult Services such as the Safeguarding Adults Team, social worker teams, Mental

Health staff teams and clinical teams for IMCA . This has resulted in an increase of people from more diverse backgrounds applying for the positions and the employment of a new member who can speak Punjabi, Urdu and Hindi. .

3.1.17 Staff at Voiceability can now communicate in a range of languages and formats including:

BSL, Makaton, Talking mats, BLISS and PECS

Points of reference/intensive interaction

Punjabi, Urdu, Hindi, with translators and interpreters where appropriate

English, Sign Supported English, Paget Gorman

3.1.18 There are still challenges in recruitment and VoiceAbility are committed to further increasing the diversity of their staff base.

Referrals

3.1.19 It should be noted that the service is largely reliant on referrals from other professionals, rather than self-referral, in order to meet eligibility criteria (this enables the Council to focus its resources on meeting its statutory duties). To ensure that they are receiving referrals from all areas, VoiceAbility have built up a good relationship with staff, for example on Mental Health Units, and undertake advocacy awareness raising to refresh with people how to access the advocacy service and expectations regarding when they should, ideally, be instructed. This aims to increase the number of referrals received as well as people's understanding of advocacy.

3.1.19 Referrals for statutory advocacy support are generally linked to DoLS or similar issues which to a large degree explain the figures reported on ethnicity of referrals by Voiceability. Information taken from the Council's SALT report shows the ethnicity of clients in residential and care settings. A broad analysis of these statics suggests that the majority of people in these settings, and from which a significant proportion of statutory advocacy referrals derive, are White British with only 9% from BAME communities. (Appendix 2). Therefore, referrals received are representative of the care home population. See also section 3.4 Going forward

3.1.20 Whilst it is difficult to compare the diversity of clients that have had cases opened by VoiceAbility to that of the previous providers', broad analysis suggests that overall the service is reaching the same levels of service delivery to BAME communities as before – previously 82% of clients accessing advocacy support were White British and only 18% of clients were from BAME communities (Appendix 2, Chart 6).

3.1.21 To increase the penetration of statutory and non-statutory services to BAME communities VoiceAbility have started holding 'hub' advice sessions with cultural and faith groups and making better links with LGBT groups locally to raise awareness of the service and how to access if appropriate. (See also 3.1.10 and 3.1.13)

3.1.22 More information on the background (diversity) of cases received can be found at Appendix 2.

Capacity Building

3.1.23 VoiceAbility are starting to deliver work more sessional outreach in different locations. This has the dual benefit of being able to deliver more advice to people through cutting down on travel time, but also increase the number and diversity of the referral received and raises their profile with organisations in the community. A couple of these have taken place with plans for roll-out being developed for 2020

3.2 Performance - Self and Group Advocacy, Volunteering and Capacity

3.2.1 As noted in the previous Advocacy report to OSC, it is not possible to produce similar demand projections for Self and Group Advocacy, due to the less formal nature of the support provided. Instead revised performance indicators were established for year one of Self and Group Advocacy service delivery from which baseline demand and performance data would be produced.

3.2.2 Performance reports for Self and Group Advocacy, Volunteering and Capacity Building Support by nature reflect a more static client group. People the service support and develop as self and group advocates often continue to be involved with the service for some time. Examples of service impact in supporting local forums, training and advocating on specific issues through awareness sessions are provided in **APPENDIX 4.**

3.2.3 It should also be noted that demand for the service and the nature of the work it takes on can be reliant on the type of referral received. Clients on the Self and Group Advocacy, Volunteering and Capacity Building service are not dependent on referral from or confirmation of eligibility by Council staff. The provider is free to accept all clients self-referred or referred clients subject to capacity considerations.

Recruitment

3.2.4 The advocacy services provide support by staff and also through the use of experts with lived experience and service users. The services are working to ensure that their staff and experts with lived experience are reflective of the communities they are working with and making extra steps to recruit and engage with people from communities with protected characteristics, including people from BAME and LGBTQ communities and people who have long term conditions including mental health issues or are carers. This is also supported by effective partnership working and networking.

Capacity Building

3.2.5 The four delivery partner organisations look at “Capacity Building” in four ways: -

a) As an “Expert with Lived Experience” and “Self-Advocate Volunteer”
b) As a “Service User/Client”
c) As a delivery organisation
d) Organisations and agencies supporting or working with vulnerable people

3.2.6 Expert with Lived Experience and Self Advocate Volunteer: Over the past twelve months we have invested in our approach and dedicated training programmes for

volunteer self-advocates or as we describe them “Experts with Lived Experience”. *Experts with Lived Experience are people who have personal experience either as an individual through a long term health condition, disability or through facing disabling barriers of using or caring for someone who uses all areas within the health and social care systems, who in turn can provide “Voice” or support and enable others in the aim to live “Healthy Happy and at Home” and to be active and involved within the community.* We introduced an accredited Training Programme via CERTA either at Level Two or Three for “Experts with Lived Experience” which has seven dedicated learning objectives based over a nine-week programme, details in Appendix 4

3.2.7 Service User or Client: This is provided through either dedicated one-to-one support or through group advocacy sessions the individual (service user/client) develops:

- Confidence and Self esteem
- Communication
- Understanding and awareness of the system and the community in which they reside
- Reduced isolation and loneliness
- Prioritising of issues and concerns
- Action planning
- Individual choice and control
- Voice
- Improved mental wellbeing

3.2.8 Delivery Organisation: Each partner organisation regularly reviews its operational framework to support the needs of the individual and groups/forums through a “People Centred Approach” which we serve, that has resulted in one-to-one appointments and group sessions operating at various times through the week including evenings/weekends delivered either on site or at other facilities/locations around the district. There is an ongoing commitment to increase the knowledge, skills, understanding and awareness of our teams in relation to the health and social care system to provide “Voice” or to enable and support others to live “Healthy, Happy and at Home” plus active and involved in their community. Comprehensive training is provided, including in-house training for all staff and volunteers. Regular recruitment campaigns are taking place to increase the amount of “Experts with Lived Experience” and “Self-Advocates” to support our pool of volunteers across all areas of service delivery.

3.2.9 Organisations & Agencies supporting or working with vulnerable people is delivered through partnership working, networking, engagement events and forums with organisations and agencies from both the statutory and voluntary sectors, the opportunity to provide “Voice” combined greater understanding and awareness of the issues and concerns facing our service users/clients.

3.3 Cultural Needs

3.3.1 Equality Together actively engage and support both individuals and groups from across all communities of interest and have been able to recruit both paid staff and volunteers that truly reflect the diversity of the district in which we live and operate within plus have the need “Lived Experience” as defined. Our staff are able to converse and support clients throughout the majority of South Asian Languages, including Urdu, Punjabi

(Mirpuri/Pahari), Punjabi, Hindko, Gujarati, and Hindi, and where we are unable to provide in-house support, we engage with other locally based organisations that can provide interpreters primarily in relation to European Languages. Staff and volunteers are from wide diverse backgrounds, and have in-depth cultural knowledge. Individuals are connected to supporters who have cultural understanding (disability and ethnicity) and where appropriate, individuals are paired with the appropriate gendered worker. The service is fortunate to have internally staff that specialise with BSL and are able to provide information and support in accessible formats.

3.3.2 We recognise that BAME communities can experience additional barriers to access and when combined with other factors such as mental health, lead to further isolation. The CCGs have commissioned community engagement and development work with BAME communities who experience mental health difficulties. We will use the outcomes from this work to inform service improvements and developments with our advocacy providers and statutory services.

3.4 Going Forward and Future Demand

Introduction of the Legal Protection Safeguards

3.4.1 In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards (LPS). The target date for implementation is spring 2020. Prior to then, a revised Mental Capacity Act Code of Practice will be published, which aims to bring clarity to some outstanding questions about how LPS will work in practice.

3.4.2 The amendment bill will;

- Widening the scope of people covered to include people aged 16.
- Include supported living, shared lives, domestic settings and children's residential homes as well as hospitals and care homes already covered by DoLS.
- Expand role of the Council as Responsible Body.

3.4.3 Whilst it remains uncertain what the full impact of these changes will have on demand for Statutory and Non-Statutory Advocacy support it is clear there will be an increased demand for Independent Mental Capacity Advocate's (IMCA).

3.4.4 In Bradford, the MCA Lead and DoLS Manager have been heavily involved from the start, working with the Department of Health's committee to draft the LPS Code of Practice, with VoiceAbility inputting from an advocacy perspective. Locally, we have taken numerous steps to prepare for this including raising awareness with social workers across adults and children's services, care homes, self-advocacy groups as well as the creation of a small implementation team. This steering group also comprises of multi-agency heads of service comprising of the 3 hospitals trusts in Bradford (AGH, BRI CMHT) as well as the CCG and Voiceability. This and other work is captured in an LPS action plan which the DoLS Team holds.

3.4.5 In terms of demand the Council and VoiceAbility have started to gather information such as expected number of LPS cases, where referrals will come from, where training needs to be targeted, who should manage referrals etc. They have also working

towards having all their advocates IMCA trained to meet the potential demand.

3.4.6 Having this information early and through being heavily involved at a national level, has allowed Bradford to prepare for LPS as far as possible at this stage. Consequently we are well placed to take mitigating actions that will minimise any impact caused by LPS.

Culturally Appropriate Advocacy

3.4.7 Very recently the department have been approached by researchers at the Institute for Mental Health at the University of Birmingham who researching current approaches that Councils and CCG's have adopted in terms of commissioning culturally appropriate Independent Mental Health Advocacy with regard to the Code of Practice, existing regulations and the Public Sector Equality Duty placed on LA's. From this a best practice model will be developed and piloted. We are supporting this by reviewing the questionnaire for Commissioners which is to go out nationally to LAs and CCGS, and then involvement in a Bradford focus group which will follow this. The work with the University of Birmingham will scope and evaluate the efficacy of our current provision and we will work together to develop policy and understanding for commissioning culturally appropriate advocacy. The scoping work has commenced and we will hope to see this work complete in time to inform the next contracting round.

3.4.8 Commissioners wish to work with providers to ensure that services are reaching people in Bradford and are representative of the make-up of the district. We acknowledge that the statistics provided in Graphs 3-6 are not statistically significant and we will continue to work with VoiceAbility to improve this in order to make a better comparison against population subgroups eg people on ATU, Care homes.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The contract will continue to be funded at the current budget levels however, resources will need to be reviewed once more information is gathered regarding the impact of the LPS as described in 3.4.5

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The governance structure of this work will sit within the Health and Wellbeing Department and will report to Departmental Management Team (DMT), to the CCG's Joint Clinical Commissioning Board and to the Integrated Commissioning Board and the Health and Wellbeing Board where both the Council and CCG's are represented.

6. LEGAL APPRAISAL

6.1 There are no legal issues arising out of this Report in addition to the statutory references made within the body of the Report or detailed in the previous legal appraisal set out in the Report dated 21 March 2019 regarding commissioning of services.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 The Advocacy services provided through these contracts are designed to support some

of the most vulnerable residents in Bradford District communities. As such they are an important part of the approach to equality and diversity as the Council and CCGs through this service seek to empower citizens.

7.1.2 The on-going monitoring of the contract will provide information on any changes and ensure they are addressed.

7.2 SUSTAINABILITY IMPLICATIONS

7.2.1 None.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 The commissioned service providers are required to support the Council's commitment to reduce CO2 emissions through the contracting arrangements it enters into with the Council.

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1 There are no community safety implications arising from this report.

7.5 HUMAN RIGHTS ACT

7.5.1 The implementation of the Council's and CCGs duties under the Care Act 2014 must be discharged in keeping with the positive obligations incumbent of the Council and NHS to uphold and safeguard people's human rights in keeping with the European Convention on Human Rights and statutory principles of the Mental capacity Act 2005 Code of Practice.

7.5.2 In implementing the Care Act 2014 must safeguard peoples Human Rights whether or not the person has capacity to consent.

7.5.3 The Human Rights Act 1998 provides a legal basis for concepts fundamental to the well-being of older people and others who are in need of Home Support. The Act provides a legal framework for service providers to abide by and to empower service users to demand that they be treated with respect for their dignity.

7.6 TRADE UNION

7.6.1 Not applicable.

7.7 WARD IMPLICATIONS

7.7.1 There are no direct implications in respect of any specific Ward.

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

7.8.1 Not applicable

7.9 IMPLICATIONS FOR CORPORATE PARENTING

7.9.1 None.

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.10.1 There may be a need for partner agencies to share data however this would only be with the express permission of the individual affected in the full knowledge of why and what it would be used for. GDPR principles relating to any individuals data and rights under the Data Protection Act 2018 will be respected.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 None.

9. OPTIONS

9.1 There are no options associated with this report. Its contents are for information only.

10. RECOMMENDATIONS

10.1 That the content of the report be noted.

11. APPENDICES

Appendix 1: Statutory and Non Statutory Advocacy Services Overview

Appendix 2: Statutory and Non Statutory Advocacy Services 2018-19 Performance Summary

Appendix 3: Statutory and Non Statutory Advocacy Services – Predicted against Actual

Appendix 4: Statutory and Non Statutory Advocacy Services Case Studies

Appendix 5: Self and Group Advocacy, Capacity Building and Volunteering Services

Appendix 6: Self and Group Advocacy, Capacity Building and Volunteering Services 2018-19 Performance Summary

Appendix 7: Self and Group Advocacy, Capacity Building and Volunteering Services Case Study

12. BACKGROUND DOCUMENTS

None

APPENDIX 1

Statutory and Non Statutory Advocacy Services

The service provided by Voiceability provides a single gateway for the provision of statutory and non-statutory advocacy services that can be accessed by health and social care professionals, as well as self-referrals.

The requirement of the contractor is to ensure the Council and the NHS meets its statutory requirements in relation to the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 1983 (amended 2007).

The service also accepts referrals for non-statutory advocacy where it has capacity to do so once statutory advocacy obligations are met.

The key objective of the statutory advocacy services is to provide the statutory advocacy services to any eligible people in accordance with the three principal statues and all associated regulations and code of practice:

- The Care Act 2014
- The Metal Capacity Act 2005, including the Deprivation of Liberty Safeguards (2009)
- The Mental Health Act 1983 (amended in 2007)
- The Equality Act 2010
- The Health and Social Care Act 2012

Set out in the table below is the various advocacy service roles that are required in relation to statutory advocacy services:

Independent Mental Health Advocacy (IMHA) – Mental Health Act 1983 (amended 2007)

This is an independent advocate who is trained to support people to understand their rights under the Mental Health Act 1983 (amended 2007) and will participate as necessary in decisions about the individual's care and treatment.

Deprivation of Liberty Safeguards and Paid relevant person's representative (DoLS – Paid RPR) – Mental Capacity Act (MCA) 2005

Where there is a Standard Authorisation of a deprivation of an individual's liberty, the local authority must appoint a relevant person's representative (RPR) to represent the person who has been deprived of their liberty.

The role of the RPR is to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, independent of the commissioners and providers of the services they are receiving.

Safeguarding – Care Act 2014

An independent advocate is appointed to support and represent the person for the purpose of assisting their involvement in a Safeguarding enquiry or Safeguarding Adults Review. This will only happen in situations where the following two conditions are met; the person has substantial difficulty in being involved and if there is not an appropriate individual available to support them.

Independent Mental Capacity Advocate (IMCA) – Mental Capacity Act 2005

IMCAs are a legal protection for people who lack the capacity to make specific important decisions. These include making decisions about where they live and about serious medical treatment options. IMCAs are usually instructed to represent people when there is not a family member or friend available, or who is able, to represent the person.

Rule 1.2 Representatives (Re-X) – The Court of Protection Rules 2017

A 1.2 Representative is a person who is able to consider whether, from the perspective of an individuals' best interests (A 1.2 representative can be but not always an advocate), they agree or do not agree that the Court should authorise the individual's package of care, which would result in a deprivation of the individual's liberty.

Litigation Friend – The Court of Protection Rules 2007

A 'litigation friend' is a suitable, willing and able person appointed by the court to represent a 'protected party' (a litigation friend can be is not always an advocate). The litigation friend must act in the protected party's best interests and can give instructions on the behalf of an adult who lacks the mental capacity to conduct their own court case.

Care Act – Care Act 2014

Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, supporting them in weighing up their options, and assist them in making their own decisions. The service is commissioned to promote awareness and understanding of statutory advocacy services to those people in receipt of service, their carers, voluntary and community organisations, health and social care professionals.

Equality Act – Equality Act 2010
Local authorities and CCGs must consciously consider the need to do the things set out in the general equality duty: eliminate discrimination, advance equality of opportunity and foster good relations and ensure contracts with providers are designed in such a way as to meet the advocacy needs of people who share protected characteristics.

Health and Social Care Act – Health and Social Care Act 2012
Public sector organisations must provide support to people who want to make a complaint about the NHS, and need some support to do this. Support may range from receiving a self-help pack, information and options, to support from an advocate, depending on needs.

The service also provides advice and support around statutory advocacy issues to the general public and health and social care professionals.

The role of the service is also to develop good working relationships with health and social care organisations, wider advice/advocacy organsiations and the voluntary and community sector.

APPENDIX 2

Statutory Advocacy Performance Summary April 2018 – March 2019

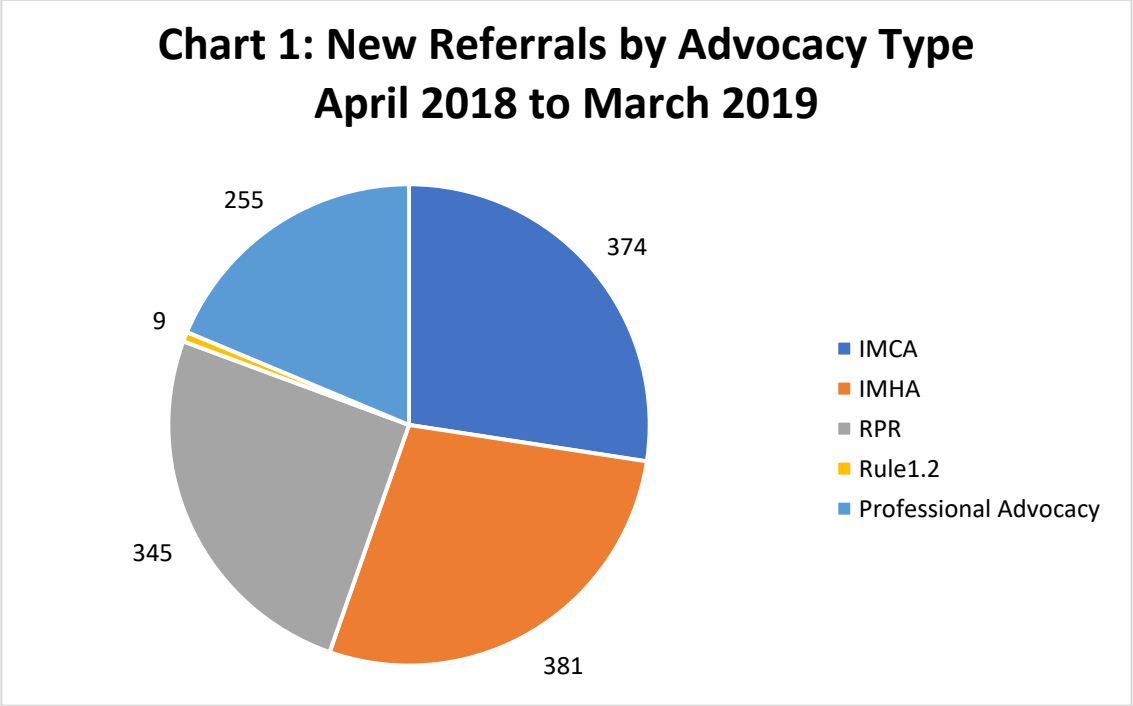


Table 1: Support Need of New Referrals April 2018 – March 2019

Not Recorded	85
Acquired Brain Injury	18
ASD	11
Carers	3
Dementia	273
Eating Disorder	2
Learning Disability	351
Mental Ill Health	532
Neurological Condition	4
Older Person	7
Physical Disability	14
Physical Ill Health	29
Prefer not to say	2
Profound and Multiple Learning Disabilities	2
Sensory Impairment	14
Stroke	13
Substance Misuse	3
Victim of Abuse	1
Grand Total	**1364**

Table 2: Issues Information 01/04/18 to 31/03/19

Advocacy support requested for the following issues over the year:

Accessing professional support	126
Accommodation (IMCA)	83
Appeal	1
Assessment	70
B1 – 39a Urgent and Standard Authorisation	148
B3 – 39c Relevant Person without Peron's Representative	3
B4 Relevant Person requested support	1
B5 Persons Rep requested support	2
B6 – 39d Relevant Person will benefit	4
B7 – 39d Relevant Person's Representative will benefit	9
Building ability to self-manage	2
Building confidence	1
Care Planning and Care Plans	44
Care Review (IMCA)	23
Caring Responsibilities	6
Challenge a decision / assessment	6
Complaint about co-patient	1
Complaint about staff	4
Concerns about Provider	1
CPA	17
CTO	10
CTR	1
Discharge and Aftercare	12
Employment	1
Family and Other Relationships	6
Financial	12
Guardianship	1
Health service – access to	2
Health Services not meeting need	1
Health Services Withdrawal	1
Housing	1
Housing and Accommodation	4
Identifying Issues	5
Information & Advice	13
Legal	5
Leisure	1
Medication	3
MHA contest section	4
MHA Rights	96
MHA Section 17 Leave	1
Placement	1
Relationship with Professional	1
Review	28

Rule 1.2 representative	5
Safeguarding Children and Young People – Support	1
Safeguarding Children and Young People – Support for Parents	20
Safeguarding Support	47
Safeguarding Vulnerable Adults – Alert	24
Safeguarding Vulnerable Adults – Support	6
Safeguarding Vulnerable Adults (IMCA)	34
Serious Medical Treatment (IMCA)	70
Social Care Services – Not Meeting Need	3
Support during Standard Authorisation	260
Support Planning	86
Tribunal	1
Ward Round	10
Total Issues	1392

Table 3: Capacity Information 01/04/18 to 31/03/19

Did Partner have Capacity for the issue requested support for:

Not Recorded	22
Does Not Have Capacity	691
Fluctuating Capacity	173
Has Capacity	443
Total	1392

Closed issues information 01/04/18 to 31/03/19

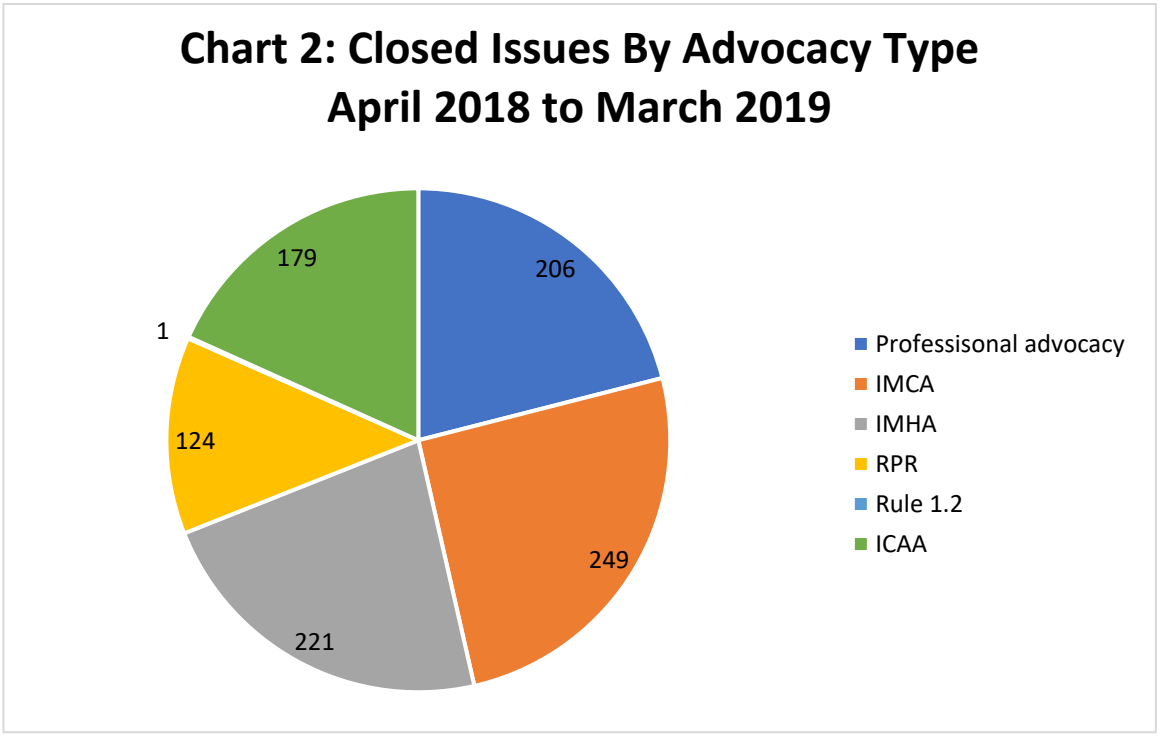


Table 4: Closed Issues Information

Accessing professional support	116
Accommodation (IMCA)	74
Appeal	1
Assessment	50
B1 – 39a Urgent and Standard Authorisation	128
B2 – 39A Standard Authorisation	14
B3 – 39c Relevant Person without Peron's Representative	3
B4 Relevant Person requested support	1
B5 Persons Rep requested support	2
B6 – 39d Relevant Person will benefit	2
B7 – 39d Relevant Person's Representative will benefit	6
Building ability to self-manage	2
Building confidence	1
Care Planning and Care Plans	40
Care Review (IMCA)	17
Caring Responsibilities	5
Challenge a decision / assessment	5
Complaint about co-patient	1
Complaint about staff	2
Concerns about Provider	1
CPA	7
CTO	6
Discharge and Aftercare	10
Employment	1
Family and Other Relationships	1
Financial	10
Guardianship	1
Health service – access to	2
Health Services not meeting need	1
Health Services Withdrawal	1
Housing and Accommodation	2
Identifying Issues	4
Information & Advice	9
Legal	4
Leisure	1
Medication	2
MHA contest section	2
MHA Rights	85
Placement	1
Review	20
Safeguarding Children and Young People – Support	1
Safeguarding Children and Young People – Support for Parents	14

Safeguarding Support	36
Safeguarding Vulnerable Adults – Alert	15
Safeguarding Vulnerable Adults – Support	4
Safeguarding Vulnerable Adults (IMCA)	25
Serious Medical Treatment (IMCA)	59
Social Care Services – Not Meeting Need	2
Support during Standard Authorisation	113
Support Planning	59
Tribunal	1
Ward Round	10
Total Closed Issues	980

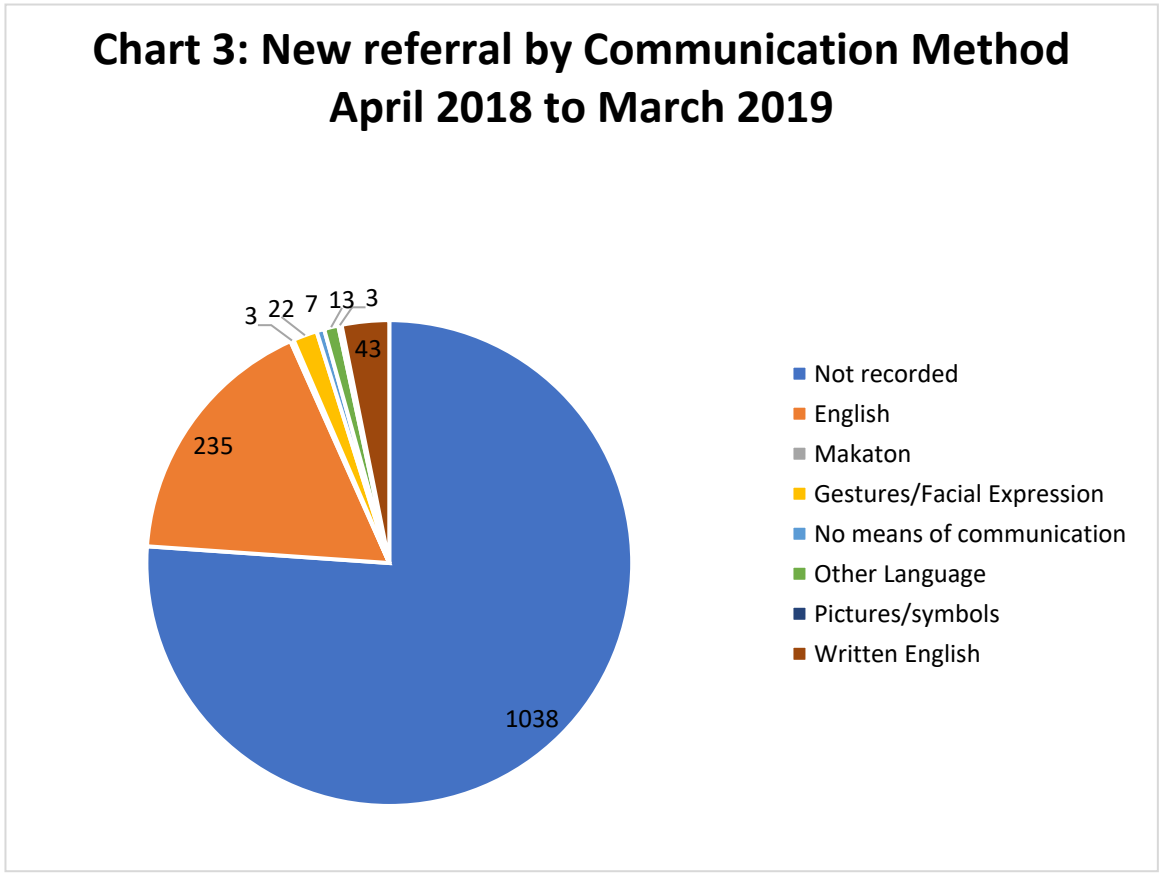
Table 5: Capacity to instruct to Closed Issues or not?

Not Recorded	14
Does Not Have Capacity	476
Fluctuating Capacity	135
Has Capacity	355

Table 6: Closed Issue Outcome

Completely Achieved	538
Not Achieved	240
Partly Achieved	124
Partner supported to access appropriate service to resolve issue	33
Referral subject to data transfer	10
Unknown Outcome, despite attempts to contact Partner	35

Breakdown of referrals by communication method and characteristics



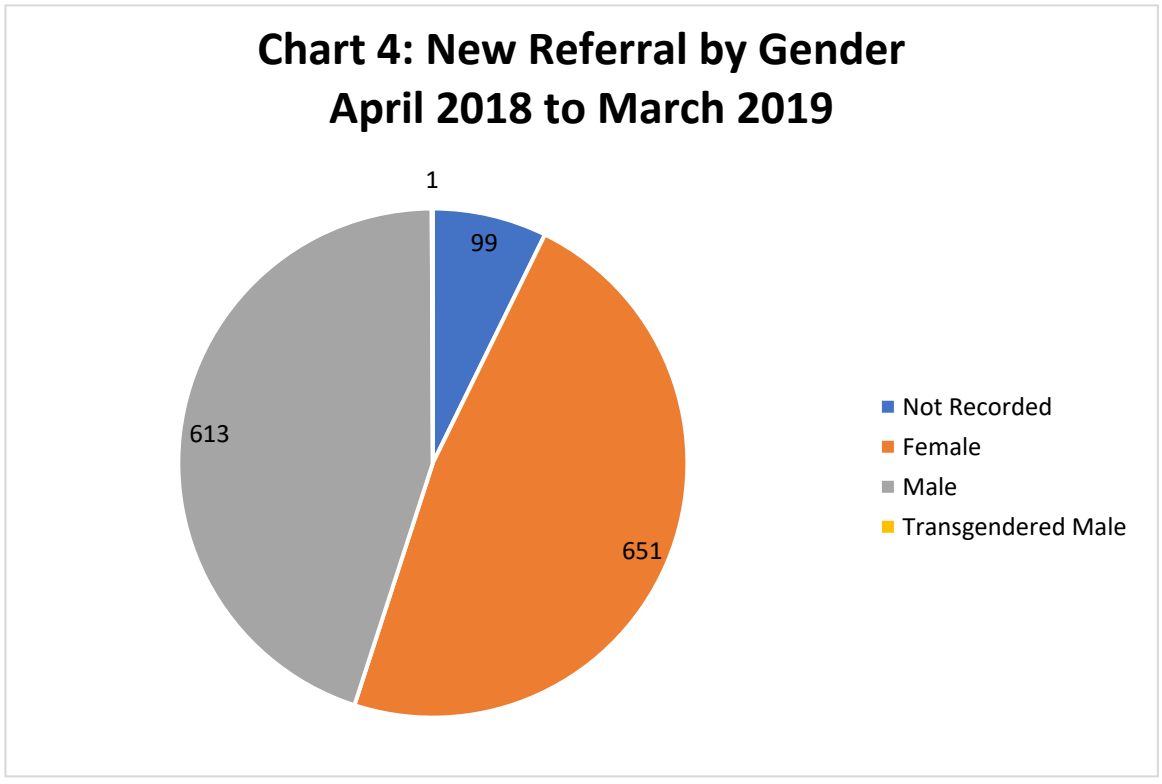


Chart 5: New Referrals by Age
April 2018 to March 2019

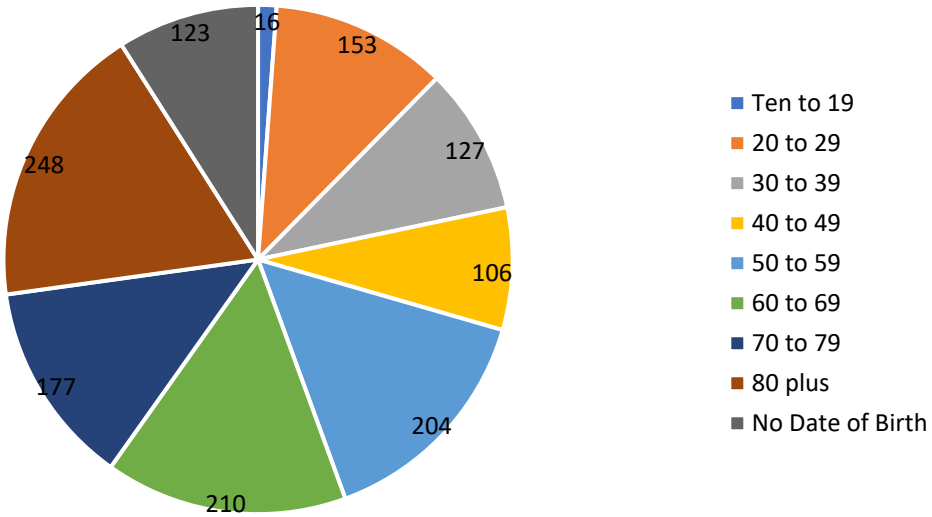


Chart 6: New Referrals by Ethnicity
April 2018 to March 2019

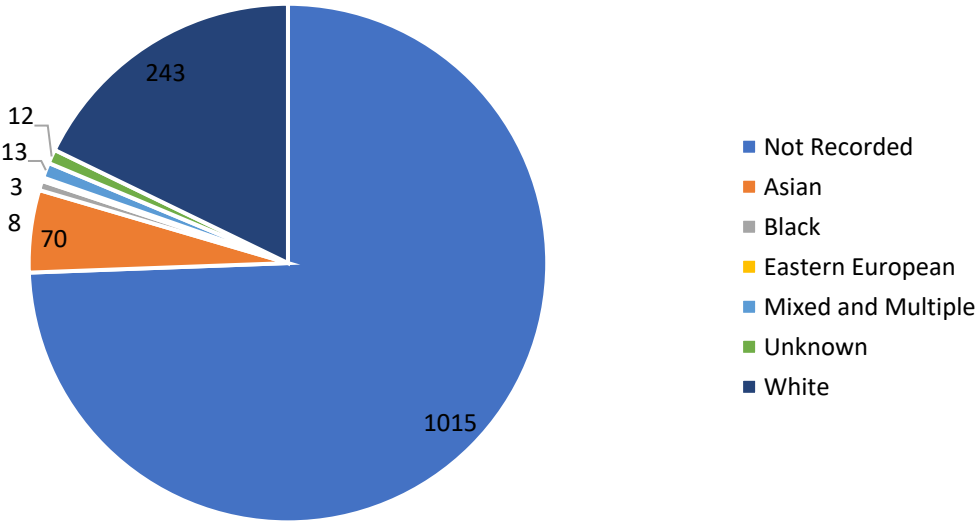


Table 7:
The following table taken from the Council's SALT report shows the ethnicity of clients in residential and care settings.

Ethnicity	Long term support Female clients		Long term support Male clients		
	Nursing	Residential	Nursing	Residential	Totals
White English / Welsh / Scottish / Northern Irish / British	189	521	103	300	1113
Irish	3	10	0	10	23
Gypsy or Irish Traveller	0	0	0	0	0
Any other White background	12	24	4	6	46
White and Black Caribbean	2	3	0	2	7
White and Black African	0	0	0	0	0
White and Asian	0	1	0	2	3
Any other mixed / multiple ethnic background	0	0	0	0	0
Indian	3	5	3	6	17
Pakistani	1	5	5	14	25
Bangladeshi	0	0	1	1	2
Chinese	0	1	0	1	2
Any other Asian background	0	0	0	0	0
African	2	0	1	1	4
Caribbean	2	5	3	3	13
Any other Black / African / Caribbean background	1	0	0	1	2
Arab	0	0	0	0	0
Other	3	1	2	1	7
Refused	0	0	0	0	0
Undeclared / Not known	85	201	56	106	448

A broad analysis of these statics as indicated in Table 9 below suggests that the majority of people in these settings and from which a significant proportion of statutory advocacy referrals derive are White British with only 9% from BAME communities.

Table 8:

White English / Welsh / Scottish / Northern Irish / British	65%
All Others	9%
Undeclared / Not known	26%

APPENDIX 3 -Difference in actuals against predicted

A comparison of projected demand against referrals received shows that

- demand for Independent Mental Health Advocacy (IMHA), Deprivation of Liberty (DoLS), Independent Mental Capacity Advocacy (IMCA) and Independent Care Act Advocacy (ICAA) was higher than predicted
- demand for Litigation Friend, Safeguarding, Re-X and Professional or Non-Statutory Advocacy support were lower than predicted.

The difference in numbers predicted and received can be explained as the original estimates were calculated by pulling together the performance data from across the 5 previous grant-funded projects and from referral sources and comparing with national and regional benchmarking. Due to the inconsistency in the way previous grant funded services had been monitored demand projection figures were always considered 'indicative' and flexible. In addition to this, the team were aware that there was likely to be an increase in referrals to people needing support under DoLS legislation, but the impact of that was yet to be seen.

In terms of Safeguarding, (see table above) the reduction in the numbers of cases recorded can be accounted for as a result of changes in the way categories of cases are now recorded. Many cases previously recorded simply as safeguarding cases but involve support of an IMCA are now actually recorded as IMCA cases.

APPENDIX 4 Statutory Advocacy Case Studies

Case Study 1: Independent Care Act Advocate

KH is a young Muslim man diagnosed with Autistic Spectrum Disorder.
Following admittance to hospital under the Mental Health Act KH was referred for an advocate for a Care Act assessment on discharge. The advocate pursued attempts to use section 117 aftercare funding for adaptations to the family home and contacted the assistant director of social services to escalate this. However as part of the assessment it was identified that a residential placement with overnight stays at weekends at the family home would be the most appropriate plan for KH.

The advocate visited, with KH, a proposed placement. Although this seemed at first to be a good fit for his needs on further investigation by the advocate it was established that there would be difficulties in ensuring he was able to attend mosque for Friday prayers and with providing a halal diet. Although these were not insurmountable KH wished to look at alternative placements and one was identified which was more able to meet his needs. After a visit by KH and his advocate, he moved in and he appears settled.

Case Study 2: Independent Mental Health Advocate

–

The advocate was assigned a partner with LD, Cerebral Palsy and dysexecutive syndrome about a year ago. P was placed on an acute ward and intensive care ward as the ATU declined to take her after a number of incidents on the ward. P can be very wary of others and chooses who they are prepared to work with.

Initially the advocate felt out of their depth having never engaged with client with Cerebral Palsy and LD before joining VoiceAbility. The assigned advocate's background up to this point was purely Mental Health. Understanding this client was a challenge for the advocate but with time and patience they have been able to adjust their listening skills and now understand P's every word.

She has grown to trust and confide in her Advocate to such an extent that she will now share information with the advocate and no one else. The advantage of coming from a place of non-judgement combined with a pro-service user has allowed the advocate to be the conduit for her deepest held feelings and wishes.

The journey has been quite something. The advocate has supported P to contact CQC, senior managers and others in a bid to find appropriate accommodation for herself. Services argue that because of her complex needs and mobility issues (P can crawl on her knees but generally uses electric wheelchair to move around) finding a place that hits all of her needs has been thus far nigh on impossible.

Her advocate has supported and has applied consistent pressure on services to address the issue of housing for P. We have had numerous meetings and assessments before an investigation was triggered.

The advocate supported to request another fresh assessment in order to challenge the S37/41 which resulted in the assessor concluding that the section was not appropriate at all, that the risks being fielded were grossly exaggerated and that once accommodation has been found the section has to be lifted and allow P her full liberties again. (Section only in place to allow for duty of hospital accommodation till proper long term placement found.) P now has extended leave to go into Bradford, go shopping, hairdressers etc.

The advocate is currently supporting P to look at 3 possible accommodation options, one of which is very local and with a Disabled Facilities Grant should make the property accessible for P. Hopefully we are finally looking at a happy ending to a long and arduous road for P.

Case Study 3: Independent Mental Capacity Advocate

In April 2019 Social Work colleagues working with a female client identified that in order for her to fully engage in work with her she would need the support of a female, Mirpuri Punjabi speaking advocate. It was clear from the outset that it would be difficult to source these specific needs, Mirpuri Punjabi is a regional Punjabi dialect quite rare in itself.

Following discussions with Voiceability about the clients very specific needs Voiceability set about trying to source a Mirpuri Punjabi speaking advocate from other Voiceability teams in the region. Here again this drew a blank.

Voiceability's Bradford office Manager then contacted a number of other advocacy service providers in the region with the view to sourcing a Mirpuri Punjabi speaking advocate. Peter contacted the following agencies;

- Advonet Leeds
- Oldham Advocacy Together Hub
- Advocacy Together Hub Rochdale
- Cloverleaf, Oldham
- Stockport Advocacy
- Touchstone Kirklees
- Leeds Touchstone
- Rochdale Advocacy Together
- Manchester Advocacy Hub
- Bolton Advocacy Hub
- Blackburn with Darwen Advocacy Hub
- Advocacy Focus
- Tameside, Oldham and Glossop Mind
- Barnsley Rethink Advocacy

Unfortunately a female Mirpuri Punjabi speaking advocate could not be sourced so consideration was given to use of a female advocate and female interpreter. A female Mirpuri Punjabi speaking interpreter was successfully sourced by Voiceability and a female advocate from their staff team allocated the case. This proved to be a satisfactory arrangement acceptable to the client.

APPENDIX 5

Self and Group Advocacy, Capacity Building and Volunteering Services

The Council and CCGs have commissioned Equality Together to deliver the above advocacy services. The Council and the NHS are required to:

> "Consider the person's own strengths and capabilities and what support might be available from their wider support network or within the community to help in considering what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve".

The service is open to any resident in the Bradford District by direct referral from a range of health and wellbeing agencies e.g. GPs, hospitals, other NHS agencies, Community Mental Health workers, Social Workers, etc., and through self-referral. The service is for all persons requiring support to express and/or represent their own interests and obtain the care and support they need.

Self and group advocacy refers to a range of measures which may support a person to express and/or represent their own interests and obtain care and support. The service has developed an infrastructure of volunteer peer supporters who work across local communities, supporting people who are in receipt of health and social care services.

The key aims and objectives of the service are to:

- Improve outcomes for Service Users and their Carers who are in need of Self and Group Advocacy;
- Improve awareness and understanding of Self and Group Advocacy concepts amongst service users, Carers, professionals and health and wellbeing partners across the public, private and voluntary and community sector.
- Ensure sufficiency of supply of Self and Group Advocacy and contribute to developing self-advocate capacity and infrastructure.
- Provide a contact point and relevant information for people who need Self and Group Advocacy, their Carers, friends and family members.
- Promote awareness campaigning opportunities and projects aimed at increasing the understanding of issues faced by people with learning disabilities, for example Healthy Living, Hate Crime, and self care
- Provide or commission appropriate training for volunteers within Bradford to ensure sufficiency of supply of volunteer peer support.
- Provide advice and support around Self and Group Advocacy, Capacity Building and Volunteering to the general public and health and social care professionals.
- Develop good working relationships with health and social care organisations strategic partnerships, wider advice / advocacy organisations and the voluntary & community sector.

APPENDIX 6

Self and Group Advocacy, Volunteering and Capacity Building 2018-19 Performance Summary

Table 10: Average Number's per Quarter by Activity 2019-18

Self-advocates engaged with the service	181
Attending awareness raising activities	271
Training sessions completed	87
Local forums attended and supported	178
Number of people made contact with through newsletters, social media etc.	9,015

Chart 7: Referral by Gender

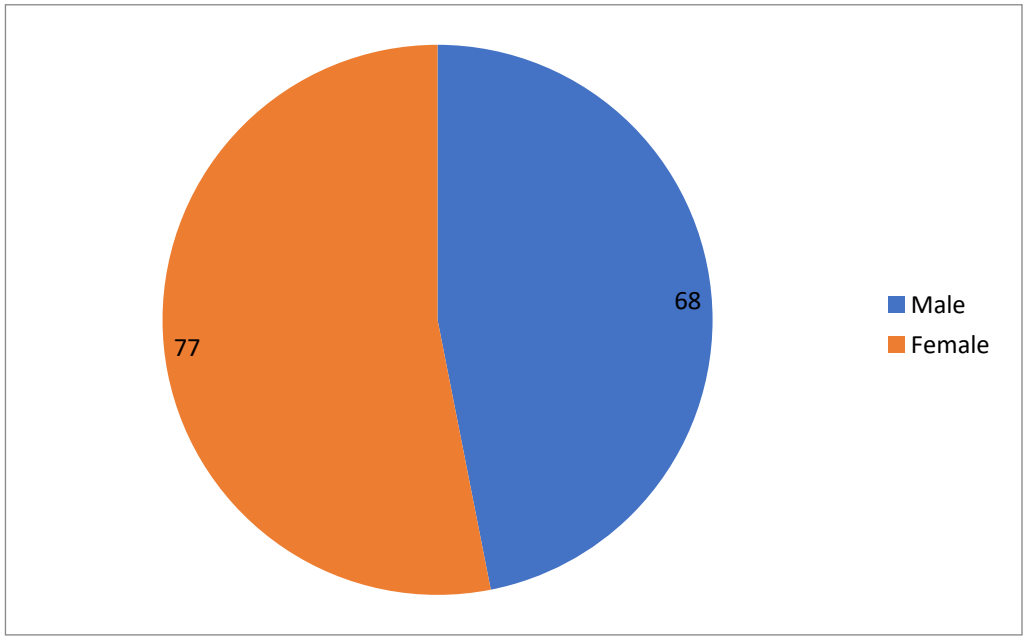


Chart 8: Referral by Age

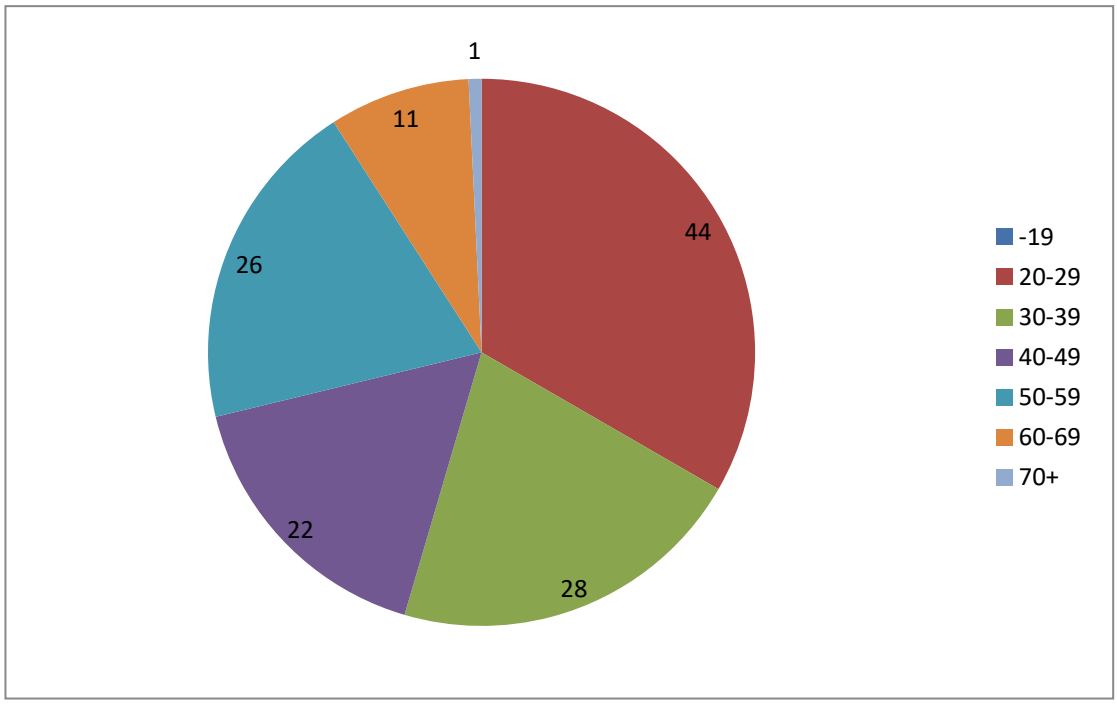
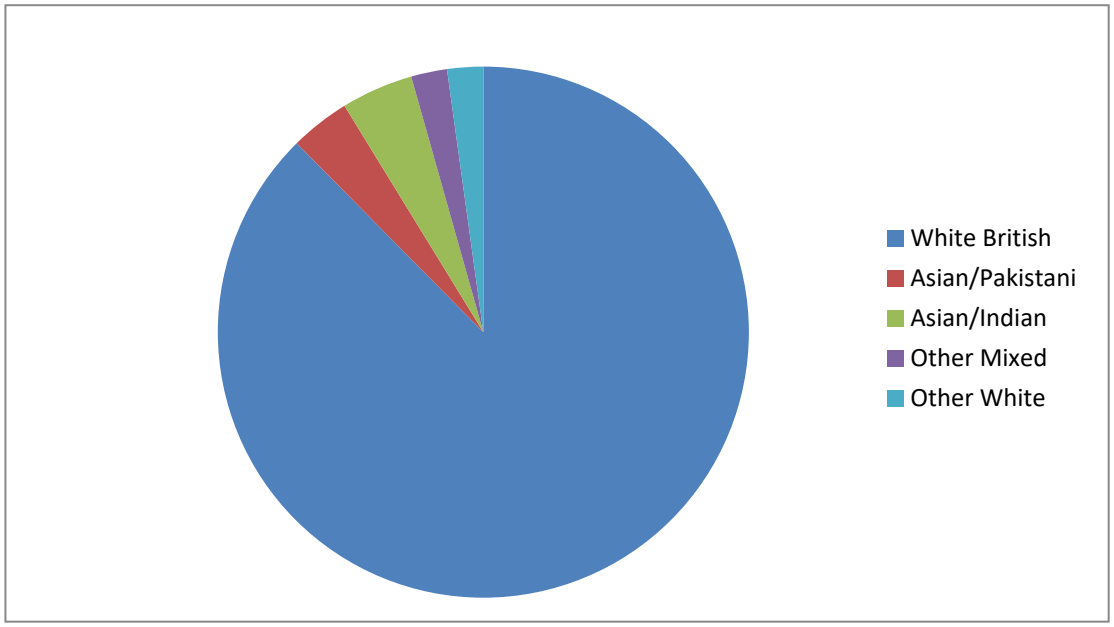


Chart 9: Referral by Ethnicity



Appendix 7:

Self and Group Advocacy, Capacity Building and Volunteering Services Case Study

Case Study 1: Added Value

Equality Together: Working with the Disable People Forum to develop a quality improvement approach to support future advocacy activity of the forum.

Equality Together: Working with the Action to Information Action Group supporting the groups work to promote and implement the Accessible Information Standards in the statutory and voluntary sector.

Bradford People First; Working with Electoral Services to improve the voting experience of people with learning disabilities. Helped to create a voting passport and quick guide to voting to help people take part in elections. Currently in the process of creating a learning disability awareness pack for polling station staff.

People First Keighley and Craven: Attended a national conference on 'Preventing Deaths of People with Learning Disabilities advocating for people with learning disabilities from Bradford District.

Case Study 2: Capacity Building

From an individual's perspective: -

"Self-Advocacy" is about taking control of decisions about yourself and telling others what you want.

As four organisations, part of our advocacy work is to support individuals to "Self Advocate". Along with running one to one sessions, we also run a number of focused self-advocacy groups, where people like you can meet and work to resolve the issues that you all face.

For example:
A client with learning disabilities, our organisations will build a relationship with the client, developing their understanding and confidence that in turn will empower them to make informed choices and decisions to "Self Advocate" what they want.

"Self-Advocacy" is about: -

- Taking control of decisions
- That are made by you
- Telling others what you want

Most people "Self Advocate" every day and take it for granted, that they can.

Learning to "Self Advocate" is part a process; we aim to support and enable you to feel confident enough to tell others what you want.