

HAMPSHIRE COUNTY COUNCIL**Decision Report**

Decision Maker:	Executive Member for Adult Social Care and Public Health
Date:	27 January 2015
Title:	Advocacy Services
Reference:	6351
Report From:	Director of Adult Services

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1. Executive Summary

1.1. The purpose of this paper is to request permission to take up a one year extension, plus a two month additional contract through a Single Tender, for Mental Health Advocacy, Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and Paid Representative, with effect from 1 February 2015.

Additionally, permission is requested to go to tender and award a twelve month contract for Care Act Advocacy, a new requirement of the Care Act 2014, with effect from 1 April 2015 using an accelerated restricted process.

1.2. This paper seeks to

- give information on the current contract, its sources of finance and performance
- give information on new duties in relation to advocacy under the Care Act 2014
- outline short term contract and tendering arrangements for Care Act Advocacy including prediction of demand and financial impact
- outline the next steps for the commissioning of statutory and non-statutory advocacy from April 2016.

2. Contextual information

2.1. This report covers short and long-term plans that will provide access to Independent Advocacy for people as determined by the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 (MCA) and the Care Act 2014 and general advocacy across all care groups.

2.2. Current advocacy commissioning and new requirements are detailed below.

2.3. Mental Health Advocacy

2.3.1. Hampshire County Council currently contracts with Solent Mind to provide general mental health advocacy, Independent Mental Health Advocacy (IMHA) (under the Mental Health Act), Independent Mental Capacity Advocacy (IMCA) and Paid Representative (under the Mental Capacity Act).

2.3.2. The current mental health advocacy contract runs from 1 February 2013 to 31 January 2015, with the option to extend for a further twelve months. In order to develop long term plans to cover all types of advocacy within a single contract, there will be a need to take up the twelve month extension and commission a further two months' contract through the Single Tender Approach to give an end date of 31 March 2016 in line with Care Act Advocacy.

2.3.3. The service specification states in clause 3.9 that "The service will meet the legal requirements for advocacy set out in the MHA and MCA and any subsequent legislation". This clause will enable the provider to meet the requirements of the Care Act for people with mental health needs without any further contract variation. See Appendix 1 for the service specification.

2.4. Advocacy for people with a learning disability

2.4.1. People with a learning disability have had access to advocacy provided by Hampshire Advocacy Regional Group (HARG) and Choices through annual Adult Services grants, which run to 31 March 2015.

2.5. Other advocacy

2.5.1. There is very limited access to advocacy for older people (an annual grant covering older people living in Winchester) or those involved in safeguarding and no access to advocacy for people with a physical disability at present.

2.6. Care Act 2014

2.6.1. From 1 April 2015, under the Care Act, the Council will become responsible for the arrangement of an Independent Advocate in certain circumstances. If a service user or carer has substantial difficulties in being fully involved in the processes listed below and they do not have another appropriate person available to support them, they would be entitled to an Independent Advocate to facilitate their involvement in:

- accessing information and advice
- assessment
- care planning
- review of care plans
- safeguarding

2.6.2. The Care Act uses the same wording to describe the areas where a person might have difficulties as the MCA:

- understanding information
- retaining information
- using and weighing information

- communicating their wishes and feelings
- 2.6.3. The legislation applies to any potential service user or carer seeking information or advice and any service user or carer involved in the above processes (section 2.5.1). This includes young people in transition from Children's Services and young carers. In Hampshire, advocacy provision for young people in transition will be the responsibility of Adult Services commissioning but advocacy for young carers will sit within contracts commissioned by Children's Services.
- 2.6.4. Care Act Advocacy is applicable to people living in the community, in hospital or care homes, and those in prison who are involved in the above processes.
- 2.6.5. Independent Advocates must have a 'suitable level of experience' which could include experience of providing advocacy or working with people who have substantial difficulties due to the nature of their illness or disability. After appointment they would be expected to work towards the National Qualification in Independent Advocacy (level 3) City & Guilds qualification, which normally lasts for two years.
- 2.6.6. Independent Advocates must not be working for the local authority or for an organisation that is commissioned to carry out the local authority's processes, nor can they be providing care to the person in a paid capacity. This might restrict the providers who will be available to provide the advocacy service.
- 2.6.7. Independent Advocates would have the same powers to access records and the person's family as an IMCA should the person lack capacity to give consent.
- 2.6.8. Independent Advocates must challenge the local authority if they have concerns about how the authority has acted, what decision has been made or outcome proposed. The local authority must take into account any representations made by an Independent Advocate and provide a written response to any report.
- 2.6.9. The local authority will be responsible for ensuring awareness of the Advocacy Service, possibly in conjunction with the provider.
- 2.6.10 Some people will also be entitled to an IMCA for specific issues and will continue to use that service, but the Care Act widens the access of people lacking capacity to advocacy.
- 2.6.11. As this is a new requirement and advocacy has not been accessible to all care groups in the past, it is difficult to determine demand for the service. The single year contract will give an indication of the level of demand.
- 2.6.12. Permission is therefore sought to tender for Care Act Advocacy for one year. There would be a maximum value to the contract but it would be paid on an activity basis.

3. Finance for 2015-16

3.1. Mental Health advocacy

3.1.1. This service is commissioned on an activity basis with a maximum financial limit. In year 1, there was a saving of £30,192. To the end of October 2014, the £325,000 budget for the contract is £5,421 underspent but demand is increasing. The contract has a maximum value and is separated into the four elements which have different funding streams. When the costs reach within 10% of the total value, a meeting is triggered to determine actions, which could include limiting access to general mental health advocacy or seeking additional funding from either the Clinical Commissioning Groups (CCGs) or HCC budgets.

Type of advocacy	Funding per annum (max)	Source	Total funding for length of contract (max) 1.2.13 – 31.3.16	Length of contract
General mental health advocacy	£107,244	Mental Health Commissioning budget	£339,606	1.2.15 – 31.1.16 + 1.2.16 – 31.3.16
General mental health advocacy	£59,756	CCGs through S256	£189,227	1.2.15 – 31.1.16 + 1.2.16 – 31.3.16
IMHA	£25,000	CCGs through S256	£79,167	1.2.15 – 31.1.16 + 1.2.16 – 31.3.16
IMCA	£109,000	MCA budget	£345,167	1.2.15 – 31.1.16 + 1.2.16 – 31.3.16
Paid Representative	£24,000	MCA budget	£76,000	1.2.15 – 31.1.16 + 1.2.16 – 31.3.16
Total	£325,000		£959,167	

3.1.2. The general mental health non-statutory advocacy which does not require an advocacy qualification is costed at £13.29 per hour. The statutory advocacy (IMHA, IMCA and Paid Representative) which requires qualifications is costed at £25.71 per hour.

3.2. Advocacy for people with a learning disability

3.2.1. Two bids have been submitted for Adult Services grants for 2015-16 for services relating to advocacy. It is proposed to remove that funding from the grant pot and use it to contract for Care Act advocacy for people meeting the eligibility criteria, except those with mental health problems, who are already covered in the other contract.

Organisation bidding	2014-15 grant award	2015-16 proposed funding with 6% reduction from 2014-15
Hampshire Advocacy Regional Group (HARG)	£51,700	£48,598
HARG	£214,320	£201,461
Total	£266,020	£250,059

3.2.2. It is proposed to add £50,000 from the Care Act funding to the above values, giving a maximum total of £300,059 for one year. It will be let on the same activity basis as the mental health contract, with the same hourly rates for non-statutory and statutory advocacy.

4. Performance

- 4.1. It has not been possible to compare all the mental health data against previous contracts, as some were based on hours delivered rather than referrals. Actual figures available are shown in Appendix 2 but there has been a rise in the statutory IMHA and IMCA referrals, as was requested of the provider, a considerable rise recently in the number of Deprivation of Liberty Safeguards referrals since the Supreme Court Judgement and a rise in general mental health advocacy.
- 4.2. By far the biggest issues that people have used advocates' support for during the contract life are benefits and finance followed by care and treatment. See Appendix 2 for full details.
- 4.3. The provider submits quarterly data and regular contract monitoring meetings take place.
- 4.4. As with the mental health contract, there will be separate reporting of Care Act Advocacy and any general advocacy that takes place. It is not known if there will be any national reporting of Care Act data, as there is for IMCA data, but it will be possible to submit if required. As it will be a developmental contract there will be close monitoring. This will give a clearer picture of potential demand for advocacy and enable more accurate determination of the budget and any potential savings or pressures from 2016 onwards.

5. Consultation

- 5.1. There has been no consultation on the mental health advocacy as that is still under contract.
- 5.2. Relating to Care Act advocacy, a workshop for voluntary sector organisations currently delivering advocacy or advocacy-type support and some Adult Services staff, including Community Development Workers, was held on 23 September 2014 which asked delegates the following questions:
 - What should advocacy look like?
 - What does Hampshire County Council need to do to improve people's participation in our processes?

- How can Hampshire County Council improve access to information and advice?

The outputs from providers will be incorporated into future service specifications but have also informed other Care Act workstreams, such as the Social Care Practice Manual and information and advice. Suggestions have also informed the recommended future approach to advocacy commissioning that is outlined in Section 8. See Appendix 3 for the workshop outputs.

6. Equalities Impact Assessment

- 6.1. A full Equalities Impact Assessment has been undertaken – see Integral Appendix B. The key findings are that the Care Act advocacy will have a positive equality impact in that it will make advocacy available to some people in specific care groups who do not currently have any access; older people and people with physical disabilities. The most vulnerable of people who are involved in safeguarding will also have access to advocacy to give them a voice.
- 6.2. It is for the Executive Member as decision maker to have due regard to the need to: eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act and advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7. Legal

- 7.1. A request for a Single Tender Approval is a request to waiver the Council's Standing Orders and depart from usual practice. As such it may only be used in exceptional circumstances with appropriate approval.

8. Future direction

- 8.1. It is proposed to develop a different type of advocacy contract that will be tendered through the EU tendering process in 2015 with a view to commencement on 1 April 2016.
- 8.2. That contract will cover IMHA, IMCA and Care Act statutory advocacy and general advocacy and would receive funding from Adult Services mental health budget, former learning disability grant funding, Care Act funding (if necessary), CCG funding and NHS England funding for IMHA in Hampshire mental health secure hospitals. If this approach is approved, a Section 256 agreement will need to be put in place to transfer funds from NHS England.
- 8.3. The approach is based on the model that Surrey County Council successfully operate whereby an organisation (which could be a consortium, a prime bidder and sub-contractors or a single organisation) would be commissioned to organise advocacy, arranging the appropriate advocate for the issue. The organisation would be required to report on the usage of the various funding streams and the data for each type of advocacy.
- 8.4. The proposed approach would ensure greater independence of the advocate from the local authority and would offer a single point of contact for referrers.

It was suggested by providers at the workshop in September as a model worth considering.

9. Recommendations

- 9.1. That the Executive Member for Adult Social Care and Public Health gives approval to take up the one year extension to the mental health, IMHA, IMCA and Paid Representative contract to commence on 1 February 2015 with a value of up to £325,000.
- 9.2. That the Executive Member for Adult Social Care and Public Health gives approval to put in place a contract for mental health, IMHA, IMCA and Paid Representative for a maximum of two months to commence on 1 February 2016, using the Single Tender Approach with the current provider, with a value of up to £54,167 and a total contract value of up to £959,167.
- 9.3. That the Executive Member for Adult Social Care and Public Health gives approval to go out to tender and award a contract for Care Act Advocacy for a maximum of up to one year to commence on 1 April 2015 using an accelerated restricted process, with an annual and total contract value of up to £300,059.
- 9.4. That the Executive Member for Adult Social Care and Public Health gives approval to the future direction for commissioning statutory and non-statutory advocacy services with effect from 1 April 2016.

CORPORATE OR LEGAL INFORMATION:**Links to the Corporate Strategy**

Hampshire safer and more secure for all:	Yes
Maximising well-being:	Yes
Enhancing our quality of place:	No

Other Significant Links

Links to previous Member decisions:		
<u>Title</u> Grants to Voluntary Organisations 2015-16	<u>Reference</u> 6333	<u>Date</u> 27 January 2015
Direct links to specific legislation or Government Directives		
<u>Title</u> Mental Health Act Mental Capacity Act Care Act		<u>Date</u> 1983, as amended 2007 2005 2014

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

<u>Document</u>	<u>Location</u>
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;
- b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;
- c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionately low.

1.2. Equalities Impact Assessment:

From 1 April 2015 there will be a statutory duty for staff to identify service users and carers who have substantial difficulty in being involved in any of the following local authority processes unless they have another person who is appropriate and available to support them:

- accessing information and advice
- assessment
- care planning
- review of care plans
- safeguarding

This could apply to any adult and older person, any carer, young people in transition from Children's Services to Adult Services and young carers (advocacy for young carers is being dealt with under separate contracting arrangements in Children's Services).

This will extend the provision of advocacy to older people and those with a physical disability who currently do not have access to any advocacy.

In order to be able to support people to express their wishes and feelings or represent their views, advocates will need to spend time with them and build up an understanding. This is very likely to take place in people's homes so will benefit those who live in rural areas and who have difficulty travelling.

It will support those at greatest need who have difficulty in understanding information, retaining that information, using and weighing that information and in expressing their wishes and feelings.

It will be provided free of charge and regardless of gender, sexual orientation, race or marital status providing a person meets the statutory eligibility.

Eligibility is determined by legislation which will have a positive impact, ensuring a service where none had previously existed.

<http://www3.hants.gov.uk/as-equality-ia-archive.htm>

The link to the EIA on mental health advocacy is

<http://www3.hants.gov.uk/eia-mental-health-advocacy.htm>.

The link to the EIA on IMCA and Paid Representative is

<http://www3.hants.gov.uk/eia-tender-imca.htm>, both undertaken prior to tendering of the joint service in 2011.

2. Impact on Crime and Disorder:

- 2.1. This service is expected to have a positive impact on crime and disorder as it will support people to express their wishes and feelings.
- 2.2. It will be accessible to people in HMP Winchester who meet the legislative eligibility.

3. Climate Change:

- a) How does the proposal impact on our carbon footprint/energy consumption?

Both the mental health advocacy service and the Care Act advocacy service will be demand led and it is not possible to predict from where and when demand will come. There are timescales built into the mental health advocacy contract and some elements require qualified advocates which will determine who undertakes the work. Activity under the Care Act will be dependent on when particular local authority processes occur and will also require qualified advocates in time, which will determine who undertakes the work. This will make it difficult for providers to ensure that staff are allocated to cases with a view to reducing travel distances and frequency.

- b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term strategy in order to address this.

The contracts will be monitored to ensure that where possible, regard to given to minimising the carbon footprint.

**SERVICE SPECIFICATION
GENERAL MENTAL HEALTH ADVOCACY, INDEPENDENT
MENTAL HEALTH ADVOCACY (IMHA), INDEPENDENT MENTAL
CAPACITY ADVOCACY (IMCA) AND PAID RELEVANT PERSON'S
REPRESENTATIVES (Paid RPR)**

1 Introduction

1.1 The first part of the service specification applies to all types of advocacy; specific requirements relating to each type are shown under the relevant advocacy sections.

1.2 The Council believe that high quality, accessible services are important to the health, well being and independence of people living in the Hampshire area. These services should address need, be efficient and effective and produce good value for money. Within services there should be diversity and choice for service users.

1.3 No person will be unlawfully denied access to a service on the sole grounds of their age, race, gender, disability, sexuality, marital status, ethnicity or religion; some services may be designed for a specific group of people who may have difficulty in accessing general services.

1.4 To ensure that people have a greater influence over services which they access and decisions which affect their lives, they need to feel empowered and supported.

1.5 The provision of a general advocacy service for people with mental health needs is a key component in ensuring that people receive high quality services that meet their individual needs and in supporting them to take greater control over their lives.

1.6 IMHA services specifically support people detained under the Mental Health Act 1983, as amended 2007 (MHA 1983) to understand and exercise their rights.

1.7 IMCA services, as determined by the Mental Capacity Act 2005 (MCA 2005), provide non-instructed advocacy for people whose mental capacity is impaired and who need to make specified decisions.

1.8 Mental health advocacy services have been commissioned from the voluntary sector in Hampshire for many years, the last contract running from April 2009 to 30 September 2012. IMHA services have been commissioned on a spot purchase basis by NHS Hampshire (PCT) since its inception in 2009.

1.9 The IMCA service was first commissioned by Hampshire County Council (the Council) in April 2007 and the Paid RPR service in April 2009. The contracts will cease on 30 September 2012.

1.10 The Council and the PCT have decided that better value and quality can be achieved by commissioning a single service covering all aspects of advocacy as listed above. This would also enable a single point of entry for

people in need of advocacy services and greater consistency in the service provider and advocate.

1.11 The Council reserves the right to make modifications to this specification in the light of legislative, strategic or financial changes.

2 Strategic Context

2.1 The 2007 amendment to the MHA 1983 placed a duty on the appropriate authority to make arrangements for help to be provided by independent mental health advocates (IMHAs) for “qualifying patients”.

2.2 The MCA 2005 gave the first statutory framework for people who lack capacity to make decisions for themselves or who wish to make preparations for a time when they may lack capacity. This was further strengthened in 2009 with the introduction of Deprivation of Liberty Safeguards (DOLS) to give specific protections to people living in hospitals and care homes.

2.3 The Government’s mental health strategy ‘No health without mental health’ 2011 recognises the importance of advocacy in helping *“people with mental health problems and their families and carers so that they can make decisions and choices about local services.”*

2.4 The Joint Hampshire Mental Health Commissioning Strategy commits to commissioning advocacy services to enable and support people and to ensure provision of high quality care.

2.5 Stakeholders attending multi-agency events to develop and comment on the Joint Hampshire Mental Health Commissioning Strategy considered advocacy services to be amongst the most valued services.

2.6 Service users across the County used their experiences to help draw up the principles, aims and outcomes of the advocacy service specification.

3 Service Principles

3.1 The service will be independent and free.

3.2 The service will put the needs, wishes and views of the client and their service first.

3.3 The service will represent their client’s view or support their client in their chosen course of action unless this action puts the person, the Advocate, IMHA, IMCA, Paid RPR or others at risk, or the action is illegal.

3.4 The service will safeguard the rights of their clients, both rights under mental health and mental capacity policy and law and rights as citizens.

3.5 The service will respect the confidentiality of their client, disclosing information only with their permission or in their best interests, in line with the statutory framework within which they are working. The exception to disclosure of information would be in the event of the safety of their client or others being at risk.

3.6 The service will involve service users to ensure a high quality service and

continued development.

3.7 The service will respond positively to the needs of diverse individuals, including cultural, religious, language, gender, sexuality, disability, age and communication needs, with information on the service made available in such a way that promotes equality of access to and quality of service across all people eligible for the service. It must recognise that individuals' needs can change over time and respond accordingly.

3.8 The service will respond to reasonable requests from clients about the gender of the advocate/representative appointed and will appoint an alternative advocate/representative should a client feel unable to work with their advocate/representative.

3.9 The service will meet the legal requirements for advocacy set out in the MHA 1983 and MCA 2005 and any subsequent legislation.

3.10 The service will ensure that all paid staff and volunteers, except those in training or on probation, have attained the necessary competencies and qualifications to provide advocacy in line with legislative requirements for each role.

3.11 The service will work in partnership with other agencies when required.

3.12 The service will keep abreast of local and national changes in provision of mental health and other relevant services and respond accordingly.

3.13 The service will meet the Council's corporate priorities of:

- making Hampshire safer and more secure for all
- maximising wellbeing
- enhancing our quality of life.
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4 Policies and Procedures

4.1 The service will comply at all times with statutory requirements.

4.2 As not all "qualifying patients" will be able to instruct IMHA services and in order to provide IMCA services, the service provider will have in place policies that address the delivery of non-instructed advocacy.

5 Service Monitoring

5.1 The service provider shall record the following data and make such information available to the service purchasers on a quarterly basis or upon request:

- gender, age and ethnicity of service users by type of advocacy
- number of referrals per type of advocacy and source by postcode
- number of people the service is working with in quarter by postcode
- referrals not accepted/unable to provide advocate by postcode
- dates of referral, start and end of work
- hours delivered per case
- outcome of work
- number of staff and volunteers and hours worked
- vacancies, starters and leavers and sickness levels
- details of qualifications and experience of staff

- CRB checks and date
- training undertaken and delivered
- service user/referrer feedback
- compliments and complaints
- budget statement

5.2 Meetings to discuss contract issues or service development can be requested by Commissioners or the Service Provider and will occur on an annual basis as a minimum.

GENERAL MENTAL HEALTH ADVOCACY (GMHA)

6 Service Aims and Objectives

6.1 To assist their clients in speaking for themselves and securing their rights.

6.2 To empower their clients to take charge of their own lives and to develop the skills, confidence and knowledge to be able to better address future issues and problems for themselves.

6.3 To assist their clients to find information and to understand their situation.

6.4 To assist their clients to access appropriate services.

6.5 To assist their clients to express their views and concerns.

6.6 To assist their clients to negotiate and resolve conflict.

6.7 To signpost people to other services when appropriate e.g. CAB, supporting them to access such services as required.

6.8 To inform Commissioners and Providers of issues of quality and gaps in services.

7 Service Operation

7.1 The advocacy service is for people over the age of 18 who experience a mental health problem which will be primarily, but not exclusively, for those people who are currently using or eligible to use secondary mental health services and any Hampshire County Council commissioned mental health services.

7.2 The service will be accessible to people living in the community in Hampshire and those in mental health in-patient units and residential services who were normally resident in Hampshire.

7.3 The service will promote itself to service users in a range of mental health settings and community settings and in a range of languages and formats as required.

7.4 The service will be available to any person with mental health needs who is subject to a safeguarding intervention.

7.5 The service will be available to people in receipt of Self Directed Support (SDS).

7.6 The service will provide a pool of qualified male and female paid advocates

and volunteers to cover the whole of Hampshire.

7.7 Referrals will be directly by service users and, with the consent of the service user, by others on their behalf e.g. family members or professionals.

7.8 The advocacy service will be available during office hours, every weekday, except public holidays. The Provider may make the service available at other times, as required. Arrangements will be in place to ensure continuity of service, for example, during annual leave, staff training, staff sickness and staff turnover.

7.9 The service will respond within 5 working days of receipt of a referral, ensuring arrangements are in place to receive referrals out of normal working hours. The Provider will ensure it has the means to prioritise urgent referrals, within reason.

7.10 The service will agree goal specific work with their clients.

8 Service Monitoring

8.1 The service provider shall record the following additional data and make such information available to the service purchasers on a quarterly basis or upon request:

- number of people on waiting list
- length of time on waiting list

9 Outcomes

- service user concern or issue resolved
- service user feels more empowered to deal with issues themselves in future
- service user feels their voice now heard through changes in system or practice
- service user accesses information to make informed choices
- service user knows their rights better
- service user feels they are treated more fairly
- service user has access to services as a result of advocacy intervention
- service quality improved as a result of advocacy intervention
- gap in services addressed as a result of advocacy intervention.

INDEPENDENT MENTAL HEALTH ADVOCACY (IMHA)

10 Scope of the service

10.1 Eligibility

- People who are detained under the MHA 1983 – except in certain emergency situations (see exclusions) – including those subject to a Supervised Community Treatment Order (SCTO) or Guardianship and those on leave of absence from hospital
- Conditionally discharged restricted patients
- Informal patients who are discussing the possibility of certain types of treatment e.g. neurosurgery for mental disorder and ECT (Electro-Convulsive Therapy) for person under 18 (Sections 57 and 58A)
- Informal patients in CAMHS in transition, to be used in clinical reviews, transition planning, care planning and client experience evaluations.

10.2 Geography

- People meeting the eligibility criteria who live in the geographical

boundaries of Hampshire County Council and are detained within the geographical boundaries of NHS Hampshire.

- People meeting the eligibility criteria who are placed in services outside the area but commissioned by NHS Hampshire.

10.3 Exclusion criteria

- People detained on the basis of emergency application (Section 4) until the second medical recommendation is received
- People detained under the holding powers in Section 5
- People detained in a place of safety under Section 135 or 136
- People detained in private hospitals in Hampshire, but previously living outside Hampshire with a GP outside Hampshire. To access the service, the hospital will need to seek permission and funding from the responsible PCT.

11 Service Aims and Objectives

11.1 To help people obtain information in order to understand the following:

- their rights under the MHA 1983
- the rights which other people (e.g. Nearest Relative) have in relation to them
- the parts of the MHA 1983 which apply to them
- any conditions or restrictions to which they are subject
- any medical treatment that they are receiving or might be given and the reasons for that treatment
- the legal authority for providing that treatment and the safeguards and other requirements of the MHA 1983 which apply to that treatment.

11.2 To help people to exercise their rights, which can include representing them and speaking on their behalf.

11.3 To support people in a range of other ways to ensure they can participate in the decisions that are being made about their care and treatment.

11.4 The involvement of an IMHA does not affect a person's right (or that of their Nearest Relative) to seek advice from a lawyer.

11.5 To work with providers to agree an IMHA Protocol for Engagement within 6 months of the commencement date of the service.

12 Service Operation

12.1 Response to referrals for the IMHA service will be dealt with within 3 working days. The IMHA service is not expected to provide a 24 hour, 7 days a week response to requests, or react to emergency calls.

13 Service Monitoring

13.1 The service provider shall record the following additional data and make such information available to the service purchasers on a quarterly basis or upon request:

- nature of detention and issue by ethnicity
- identification of an advance decision and its consideration in the decision-making process
- any disputes about decisions made by IMHAs and whether complaints process was engaged
- patient feedback

14 Outcomes

14.1 All “qualifying patients” to receive effective and timely advocacy which ensures that their needs and aspirations are listened to and acted on.

14.2 Any quality and service delivery issues relating to care and treatment of people subject to the MHA 1983 are addressed.

14.3 Number of IMHA reports where the referrers judged that the reports made a difference to the outcome.

INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

&

PAID RELEVANT PERSON’S REPRESENTATIVE SERVICE (PAID RPR)

As these services are very similar the service aims, objectives, operation, monitoring and outcomes have been listed together, however, please note that these two services are very distinct and will be carried out independently of each other.

15 Service Aims and Objectives

15.1 To represent the views of service users whose mental capacity is impaired and who have no appropriate relative or close friend to be consulted with.

15.2 To assist in seeking resolutions that maintain the best interests of the service users.

15.3 To provide reports, based on consultation with the person and interested parties, to assist decision makers and Best Interests Assessors to undertake their responsibilities in line with the MCA 2005.

15.4 To assist unpaid RPRs to undertake their roles within the DOLS scheme (Section 39D).

15.5 To exercise the safeguards within the DOLS scheme, being:

- o requesting DOLS reviews when appropriate
- o requesting DOLS reviews when it is apparent that the ‘detained resident’ would want this to be requested
- o using the formal complaints system of the Managing Authority of Supervisory Body when appropriate
- o using the formal complaints system of the Managing Authority of Supervisory Body when it is apparent that the ‘detained resident’ would want this to be used
- o making applications to the Court of Protection when appropriate
- o making applications to the Court of Protection when it is apparent that the ‘detained resident’ would want this application to be made.

15.6 To inform the MCA Development Manager or DOLS Administration Team at Hampshire County Council regarding general issues or specific case issues.

16 Service Operation

16.1 The service must be for a wide variety of service users, including people with a learning disability, dementia, mental health problem, acquired brain injury and physical health condition that affects their capacity.

16.2 Referrals will be received from staff in both Hampshire County Council and its health partners.

IMCA

- o from doctors and nurses providing serious medical treatment
- o from social workers arranging hospital discharges
- o from social workers and care managers planning long-term moves for people with learning disabilities, dementia or other conditions.

DOLS IMCA

- o from any Supervisory Body responsible for a person subject to a DOLS application or Standard Authorisation, where that person is accommodated in Hampshire.

Paid RPR

- o from the Supervisory Body (Hampshire County Council on its own behalf and that of NHS Hampshire) via the DOLS Administrator.

16.3 The service will be available during office hours, every weekday, except public holidays. Arrangements will be in place to ensure continuity of service, for example, during annual leave, staff training, staff sickness and staff turnover.

16.4 The IMCA service will make initial response to the referral within 1 working day, ensuring arrangements are in place to receive referrals out of normal working hours.

16.5 It is anticipated that the Provider will spend an average of 12 hours per IMHA referral, which would include face-to-face contact, travel, reports, administration and consultation with others.

16.6 The Paid RPR service will meet each newly referred person face-to-face within 2 weeks of referral and will visit each person on average for 1 hour of face-to-face contact every 2 weeks whilst the appointment lasts. It is not anticipated that this would exceed 40 hours of visiting and travelling per annum.

16.7 The service will work in partnership with other statutory, independent or voluntary services and staff, including hospital discharge staff, doctors, nurses, social workers, care managers and managers of care homes.

16.8 The service will assist staff and managers in other services, who are likely to refer their patients and service users, to understand the roles of the IMCA and Paid RPR and know how and when to access the service.

16.9 The service provider will send out questionnaires to referrers to determine whether IMCA reports were judged to be in time for the decision maker to consider and to have made a difference to the outcome.

17 Service Monitoring

17.1 The service provider will record the following additional data and make such information available to the service purchaser on a quarterly basis or upon request:

- number of IMCA reports which the referrer judged to be in time for the decision maker to consider, with outcomes
- number of IMCA reports which the referrer judged to have made a difference to the outcome, with details of outcomes
- number of cases needing formal representation of the person, for example, requesting a DOLS review, using complaints procedure, application to the Court of Protection, with outcomes.
- number of face to face meetings between each “detained resident” and the Paid RPR.

18 Outcomes

18.1 Views expressed by IMCAs on behalf of people who lack mental capacity are made in a manner that safeguards their rights, dignity, privacy and respects them and their individuality.

18.2 Wherever possible the clients and their families, if appropriate, are involved in the representation of their own views and wishes.

18.3 Reasoning for views expressed in protecting people’s best interest are clearly and appropriately demonstrated.

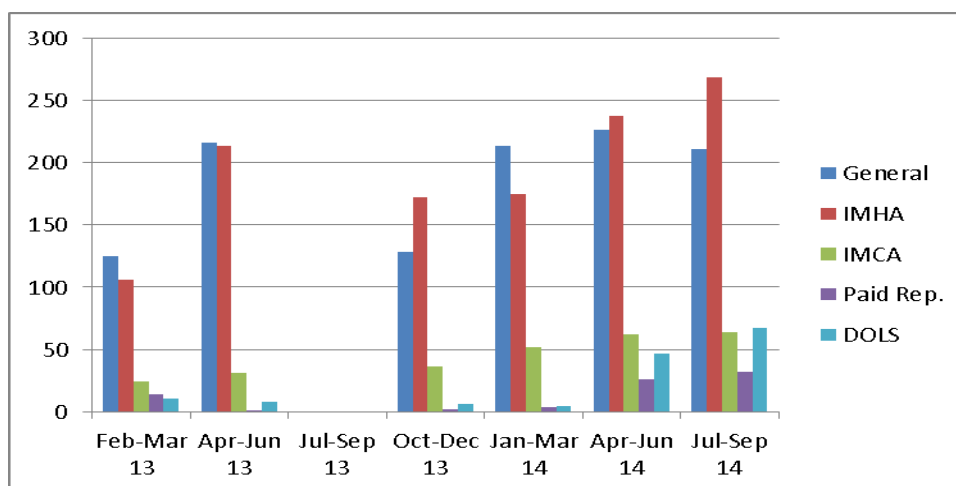
18.4 Statutory safeguards of the DOLS scheme are exercised appropriately ensuring that people's Article 5 human rights are upheld.

18.5 IMCA reports are developed and produced in a format and timescale to support best interests decision making.

**Performance Data from Mental Health, IMHA, IMCA
and Paid Representative Contract with Solent Mind**

Combined Advocacy Referrals 2013-2014

Type Advocacy	Feb-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14
General Advocacy	125	216	data missing	128	213	226	211
IMHA	106	213	data missing	172	175	237	268
IMCA	24	31	data missing	36	52	62	64
Paid Rep.	14	1	data missing	2	4	26	32
DOLS	11	8	data missing	6	5	47	67



Note: There were problems with data collection in period July to September 2013 and a change in Manager so data is not currently available for this period.

Prior to the letting of the combined contract to Solent Mind, there was an Adult Services' contract for general mental health advocacy, a separate contract for IMCA and Paid RPR and spot purchasing arrangements by PCTs for IMHA. Data is available and shown below for the

Mental Health Advocacy Referrals 2009-2011

	April 2009 – March 2010	April 2010 to March 2011
Quarter 1	178	253
Quarter 2	183	306
Quarter 3	297	260
Quarter 4	140	247

IMCA & Paid RPR Referrals 2009-2011

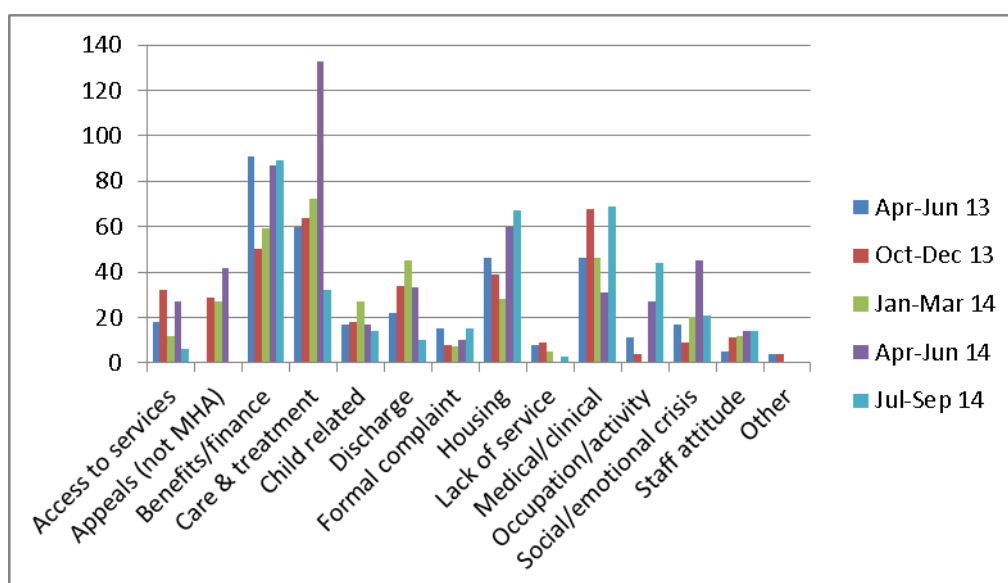
	April 2009 - March 2010	April 2010 – March 2011
IMCA	105	140
Paid RPR	9	12

IMHA Hours

IMHA Hours 2010-11	2,000
IMHA Hours May – Oct 2014	2,759.6

Issues raised 2013-14

Issues	Apr-Jun 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Total
Access to services	18	32	12	27	6	95
Appeals (not MHA)	0	29	27	42	0	98
Benefits/finance	91	50	59	87	89	376
Care & treatment	60	64	72	133	32	361
Child related	17	18	27	17	14	93
Discharge	22	34	45	33	10	144
Formal complaint	15	8	7	10	15	55
Housing	46	39	28	60	67	240
Lack of service	8	9	5	0	3	25
Medical/clinical	46	68	46	31	69	260
Occupation/activity	11	4	0	27	44	86
Social/emotional crisis	17	9	20	45	21	112
Staff attitude	5	11	12	14	14	56
Other	4	4	0	0	0	8
Total	360	379	360	526	384	2009



Care Act Advocacy Workshop 23.9.2014

1. What should advocacy look like?

Suggestions

- Capability for VS in Hants to provide appropriate, high quality advocacy already exists (and can be expanded if necessary)
- Advocacy may come from a diverse range of professionals / agencies to benefit need. Might depend on agencies resources re: NVQ III
- (use) knowledge, experience and skill specific to SU group
- Need to ensure specialisms factored in
- Allow to tap into local groups / specialist groups
- Make allowance for integration with hard-to-reach groups (comm. assocs, kinship groups etc)
- Need to ensure consistent level of quality and access to all areas within the county and for all impairment groups

-
- Need local knowledge
 - Ensure the service is based in local communities

-
- Contract one organisation to link local advocacy groups together, provide training and manage referrals from ASD
 - Need to build capacity in specialist organisations (especially small organisation) e.g. Umbrella Organisation

^

Specialists / Local Services

- Surrey model – SCC pay – org commissions services
- Outsourcing (not sure what was meant by this)
- Consortium approach
- Consortia? If A,B,C &D come together and A provides a process could A signpost to B without a conflict of interests?
- Use of pilot to test models and training and numbers
- As we have a statutory duty to provide this... does it have to be a contract? Can it be grant funded?
- Mix of contracts and grants
- Grant funded agreement to a large number of organisations
- Would a framework approach provide enough business for each organisation?
- Service level agreement framework to enable spot purchases
County wide contract? Zones across the county? Specialist advocacy for different Groups e.g. learning disability? Older people? Foreign Language
- Build in feedback mechanism / review of processes as part of procurement / ongoing contract monitoring

-
- Accessibility for training and cost on small agencies
 - HARG offers training > certified
 - Skills for care funding to support learning

- Support around training – especially small organisation
- NVQ training to be accessible for people with learning needs

- Need to understand demand
- What is the eligibility for deciding someone needs advocacy?
 - o Ensure consistent approach.
 - o Ensure people understand advocacy available.
 - o Self-referral.
 - o PD and sensory IMP – limited
 - o OP – patchy
 - o LD – Better
- What is eligible for advocacy support – Autism?

- What does advocacy service look like?
 - o Level of advocacy required.
 - o Individual by individual basis.
 - o Need to promote independence.
 - o Ensure people’s wishes are understood
- Links with other funding stream to maintain other activity e.g. HIOWCE...

- Bi-lingual advocates – can both advocate and translate – someone knowledgeable about the system but also about a person’s culture

- Sharing information where more than one advocacy service is involved

Issues

- Better LA processes will not lead to a reduced need for independent advocacy

- Requirement for level 3 qualifications would preclude use of volunteers. (Time, cost supervision)
- Concern that LA believes that volunteers are a “cheaper option” – sufficient funding will not be made available

- BUT financial resources appear not to be made available or sufficient
- Ongoing financial commitment required (not spot purchase!) to enable VS to prepare for reliable service – then if necessary spot purchase to “top-up”
- Recognition of cost, time and capacity of agencies who advocate
- What funding will actually be available? What’s the current investment? What’s the level of demand?

- If a service is commissioned how can it stay independent?

- Who will choose advocate? Individual?

- Advocacy for people in prison

- Transition who advocates for the young person? Whether parents are the most appropriate person? Advocates need specialist skills to handle the child and the parent

- Value for money comes from orgs doing the non-statutory aspects of advocacy e.g. linking people with MPs etc. Would this be lost through a contracted approach?

- How do we decide if a family member is suitable to be an advocate

- Specialist organisations v advocacy organisations

- Self-identifying as “user” or “carer” isn’t natural for people

2. What do HCC need to do to improve people’s participation in our processes?

- Invite people to their own meetings
- Consult them on time/venue for meetings and listen and act on it
- Create meaningful partnerships with service users
- Ask them who they would like with them (and not be restrictive on numbers)
- Allow them time to prepare (and support them to do so)
- Empower service users by providing choice and decision making opportunities
- Involve service users in planning
- Treat everyone as an individual not a “diagnosis”
- Don’t decide the outcome of the meeting before the meeting
- Allow enough time for meetings (flexibility) – to work at client’s pace
- Don’t keep clients waiting – and do what you say you will do – on time
- Encourage and facilitate clients to develop their own plan (or if not possible families/friends/representatives)
- Ensure practitioners involve family members and carers to make a balanced judgement based on what everyone is saying
- Developing relationship with advocate and client
- Location – come to the person
- Improving ability of care manager to communicate especially initially
- Sensitivity to other cultures and attitudes to care and being cared for
- Make it clear what is happening and the various stages “this is your assessment etc” and clarify timescales
- Sometimes information needs to be provided more than once in order to be understood
- Access to information is really important, before and after assessments
- Better information
- Remove barriers erected through the use of words and language
- Understanding of rights prior to assessment
- Person centred plans actually linked to assessment
- Practitioners need to ensure people “genuinely understand” the information being shared

- Preparation in advance would help people to get their needs understood
- Not being 'passed around' services and having to repeat yourself
- First response should be appropriate response – not blindly refer/signpost to pass-the-buck
- Taking service user perspective into account
- Embrace good communication skills
- This is for everyone – changing the culture of the care manager

- Advocacy takes the pressure off the care manager
- Independent support to interpret and understand options
- The best practitioners involve advocates to address power imbalance
- Power dynamic – people find it tricky to say no to professionals

- Improve information about direct payments and the way this is presented to people

- Work with other services

3. How can HCC improve access to information and advice?

- More upfront information and advice would delay need for higher level care and support
- Awareness of eligibility criteria prior to referrals
- Clarify the offer of advice/advocacy and where this is appropriate
- Pre self-assessment tool
- Awareness of rights and entitlements
- Information in the right place
- Awareness of what's free and what's chargeable
- Awareness and understanding of rights and responsibilities
- Need providers to be aware of where information and advice is in order to signpost
- Information sheet for agencies to pass on/signpost
- Need information not just about services but about assessment process, financial assessments and example questions etc
- Access to information is really important, before and after assessments
- Provide straightforward information – easy for everyone to understand

- Do we know enough about where people go for information?
- Where are the information hubs?
- Local information hubs - better care sites - contact and call centres
- Phone – no automated systems – real person answering who can talk and listen not just pass on to someone else – training for staff needed
- Reliable sources of information
- Multi-pronged attack or approach! Different information sources for different people
- GPs more aware of social needs and signpost to wider support

- Use existing areas of contacts – GPs, libraries, community centres, CAB, housing, churches
 - Roadshows/surgeries – face to face
 - Information and advice at trigger points e.g. undertakers, hospital
 - Good links with communities and voluntary services for example wellbeing centres and different cultural groups to make all aware of what is on offer. Need to be aware of different cultures and their 'health behaviours
 - Consider 'outreach' work around information and advice. Wellbeing workers to attend groups/wellbeing centres
 - Voluntary sector also need good links with each other and authorities to know quickly who to contact and signpost for information and advice
 - Ensure all voluntary sector agencies and professional partners know what is available re: marketing and communication
 - Drop-ins, coffee mornings
 - Information at food banks
 - Peer advice and information
-
- Can't rely on digital/on-line
 - Do not assume everyone has access to internet/phone
 - Issues with online information – not all can access or find
 - Authority needs to make website and information easy to access and navigate
 - Social media (website etc) but not exclusively
-
- Understanding terminology
 - Remove barriers erected through the use of words and language
-
- Link between children's and adults more smooth re: information
 - Need to link with local offer
-
- SHIP wide work to look at how best to provide information and advice
-
- How do we reach those who are isolated and need support but not in 'system' so may not access information and advice
-
- Empowering non H&SC professionals to offer advice and support i.e. cultural leaders, peers, community groups
-
- Translation
 - Information specific re: sensory impairment for example
-
- Effective information sharing between agencies
-
- No postcode lottery – closer cooperation between neighbouring authorities

**Potential funding sources for proposed commissioned service
from April 2016**

Type of Advocacy	Funding source	Amount	Potential for savings	Statutory or non-statutory	Comment
IMHA	CCG	£25K	No	Statutory	Needs confirmation of funding and S256 beyond 31.3.17 Needs additional funding from LA to meet increased demand
	NHS England	£51K	No		Needs S256 with effect from 1.4.16
IMCA	AS MCA budget	£109K	Unlikely	Statutory	Difficult to determine demand
Paid Representative	AS MCA budget	£24K	Unlikely	Statutory	Difficult to determine demand
Care Act	AS previous grant funding + Care Act funding	£250K + £50K	6% savings made for 2015-16	Statutory	Demand not yet known
General	AS Mental Health Commissioning budget	£107K	Unlikely	Non-statutory	Additional funding needs to be put into IMHA
	CCG	£60K	No		Needs confirmation of funding and S256 beyond 31.3.17