ITEM 4

NORTH YORKSHIRE COUNTY COUNCIL

Care and Independence Overview and Scrutiny Committee

28 September 2017

Independent Advocacy

1.0 Purpose of Report

1.1 The purpose of the report is to provide an overview of the Independent Advocacy service that the Council has a statutory duty to provide, including how the service was commissioned, how the service is monitored and a summary of advocacy activity.

2.0 Background

2.1 The Care Act 2014 requires local authorities to involve people in assessment, care planning and reviews. The new legislation widens the eligibility for advocacy to include individuals who would experience substantial difficulty in being involved with care and support 'process' or safeguarding, or Safeguarding Adults Review (SAR); and does not have an appropriate individual to support them. Where someone is unable to fully participate in these conversations and has no one to help them, local authorities will arrange for an independent Advocate.

2.2 Advocates provide an independent support to people, who through vulnerability or lack of capacity need support to help them make a decision, or express what they want to say, or someone to act on their behalf and represent their best interests. This is if there is no family of friend who can undertake this.

2.3 The Care Act sets out what is required of an independent advocate:

a) A suitable level of appropriate experience
b) Appropriate training and qualification, e.g. working towards the National Qualification in Independent Advocacy (level 3) within one year of being appointed and to achieve it in a reasonable amount of time
c) Competency in the task
d) Integrity and good character
e) Ability to work independently of the local authority or body carrying out the assessment, support planning or review on the local authority's behalf.
f) Arrangements for supervision

2.4 Other Statutes that place the duty of the provision of advocacy, called Independent Mental Capacity Advocates (IMCA) or Independent Mental Health Advocates (IMHA) on Local Authorities are:

a) Mental Health Act 1983 (amended 2007)

b) Mental Capacity Act 2005 and;
c) Health & Social Care Act 2012
d) Equality Act 2010

2.5 There are specific requirements for advocates where someone may be deprived of their liberty, and where they do not have the capacity to make a particular decision about their health and care, or living arrangements and have no close family or friend able to act on their behalf, through for example Lasting Power of Attorney.

2.6 This more specialist advocacy could include decisions on, for example, where someone should live, whether they should undergo a particular treatment, whether they need some restrictions placed on their day to day movements to ensure their safety.

2.7 Local authorities can also provide discretionary advocacy for people who do not necessarily fall into the Care Act or more specialist advocacy requirements.

3.0 How the Advocacy Service was commissioned

3.1 A commissioning exercise was undertaken and completed in February 2016 to select a new provider of advocacy services from April 2016. The invitation to tender sought one county wide provider, with the ability for consortia to bid, or for a Lead Provider to sub-contract. This optimises value for money, by minimising management and overhead costs, and supports operational quality for people receiving the service. Provider staff will undergo the same training and development and work to the same policies and procedures and allows flexibility in the response to both specialist and discretionary work.

3.2 The selected provider (Total Advocacy), provides Care Act, the more specialist IMCA and IMHA and some discretionary advocacy. As the demand for each element of the service going forward was not known, indicative percentages were given for each element which can flex depending on demand.

3.3 The commissioning exercise followed good practice outlined in “Commissioning for Better Outcomes” and included contacting other local authorities for best practice examples, reviewing other specifications, undertaking engagement (see below) etc.

3.4 From the 9th – 30th November 2015, the Council undertook an engagement programme with potential users, carers and professionals to inform the procurement. This was via face to face discussion, 138 responses to an online survey, presentation and conversation with discussion groups and attendance at forums with people who use HAS services and professionals supporting customers.

3.5 The online survey responses and face to face discussions highlighted awareness of advocacy as their top ranking issue. This was closely followed by expectations, which are linked to awareness, availability of information and

advice regarding what advocacy services can assist with. As a result of this strengthened communication, advice and information requirements were written into the specification.

3.6 A session was held in November 2015 with professionals and providers to map the customer journey from initial contact through to delivery for people who may need advocacy support. This identified examples of how organisations could more efficiently adapt and use current systems and protocols. Examples were: training needed at initial contact with NYCC customer contact centre and additional training delivered to support understanding of whether an advocacy issue and how to identify one; ensuring Living Well teams have advocacy information, identifying areas of low usage and the successful provider working with those communities to raise profile of advocacy.

3.7 The selection of the provider was a robust process involving a number of Officers from NYCC and CCG's assessing their response to a series of questions, a presentation and providing evidence that they are a soundly governed and financially secure organisation. The provider also had to provide assurance that they have an externally verified quality assurance process.

4.0 How the service is monitored

4.1 Quarterly performance monitoring and practice meetings are held with the provider.

4.2 This is in order to:

- review monitoring activity completed by the provider on a quarterly basis
- allow any issues to be raised from either the Council or the provider that is affecting service delivery
- consider any new requirements e.g. changes in legislation

4.3 The provider produces a quarterly report which summarises the position and provides case studies. Appendix 1 summarises the performance monitoring for 2016/17. The level of detail allows the Council to scrutinise the service and highlight any issues that need to be further explored.

4.4 Examples of this include:

- in the Harrogate area, the level of referrals for Care Act advocacy appeared low compared to the level of population in that area. As a result of this, awareness raising was carried out with Care and Support staff in that area. The figures from last year show an in increase of three referrals in Quarter 1 of 20916/17 to 11 in Quarter 4.

- looking at the analysis of the primary needs of people with independent advocacy support, people with learning disabilities comprise nearly half. As the numbers of people with dementia increase, one would expect an

increase in numbers of people with dementia requiring support. Having this level of detail, will allow us to monitor the position going forward.

5.0 Demand for Services

5.1 Overall, almost 1.500 referrals for independent advocacy were made in 2016/17 and the caseload of the service increased from 469 to 711.

5.2 The demand for Care Act advocacy has not as yet increased as much as was expected before the legislation was enacted.

5.3 Specialist advocacy continues to increase and comprised 60% of the advocacy activity in 2016/17. This has increased steadily since 2012/13 and is in line with a doubling of Deprivation of Liberty (DoLS) assessments, with a need for both one off assessments and longer term advocacy support. Much of this increase has been caused by the Cheshire West judgement in the High Court in 2013, which clarified, and extended the circumstances under which a Deprivation of Liberty Safeguard should be considered to include those occasions where it has been assumed that someone is not objecting to the safeguards put in place.

5.4 25% of referrals for advocacy was for the non-statutory or discretionary independent advocacy. As the demand for Care Act advocacy has not been as high as expected, this has allowed the flexibility to provide more for this.

6.0 Recommendations

6.1 The Care and Independence Overview and Scrutiny Committee is recommended to note the information in this report.

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19 September 2017
Background Documents Nil

APPENDIX 1

Total Advocacy

Summary Monitoring Report for 2016/17 (full year)

Care Act Advocacy

- 181 new referrals during 2016/17 – 12% of total referrals to the Total Advocacy service.
- Caseload of 95 at 31.3.17 – 13% of total caseload.
- 14% of total advocacy hours provided during 2016/17 - below the indicative target of 20% but this has enabled some flexibility within the contract as there are a high number of non-statutory referrals. Comparison with Quarter 3 does show a 35% increase in advocacy hours provided in Quarter 4.
- Highest percentage of referrals are in Scarborough (33%) and Hambleton (20%). 3 referrals were for individuals placed out of County – Total Advocacy provided the advocate.
- 100 referrals (45%) were for advocacy support through the Needs Assessment Process. This represents 0.77% of the total 12,977 Needs Assessments completed by NYCC during 2016/17.
- 62 referrals (28%) were for advocacy support through the care and support review process. This represents 0.39% of the total 15,797 reviews completed by NYCC during 2016/17.
- 36 referrals (16%) were for advocacy support through Safeguarding. During the period April to December 16, 2.29% of the 1,137 Safeguarding concerns that progressed to Safeguarding enquiry received advocacy support.
- 95 referrals (49%) were in respect of individuals that were recorded as having a Learning Disability as their primary need.

IMCA/RPR

- 606 new referrals during 2016/17 – 42% of total referrals to the Total Advocacy service. Of the total IMCA referrals 195 (32%) were for a Paid RPR
- Caseload of 396 as at 31.3.17 – 56% of total caseload.
- 46% of total advocacy hours provided during 2016/17 – in line with the indicative target
- Highest percentage of referrals are in Scarborough (34%) and Harrogate (29%)
- Highest number of referrals – 195 (32%) related to advocacy support as Paid RPR. 164 (27%) related to a change in accommodation.

IMHA

- 216 new referrals during 2016/17 – 15% of total referrals to the Total Advocacy service.
- Caseload of 77 as at 31.3.17 – 11% of total caseload
- 15% of total advocacy hours provided during 2016/17– in line with the indicative target.
- Highest percentage of referrals are from Cross Lane, Scarborough (48%)
- Highest number of referrals – 140 (65%) related to advocacy support for people detained under Section 2 of the Mental Health Act.

Non-Statutory Advocacy

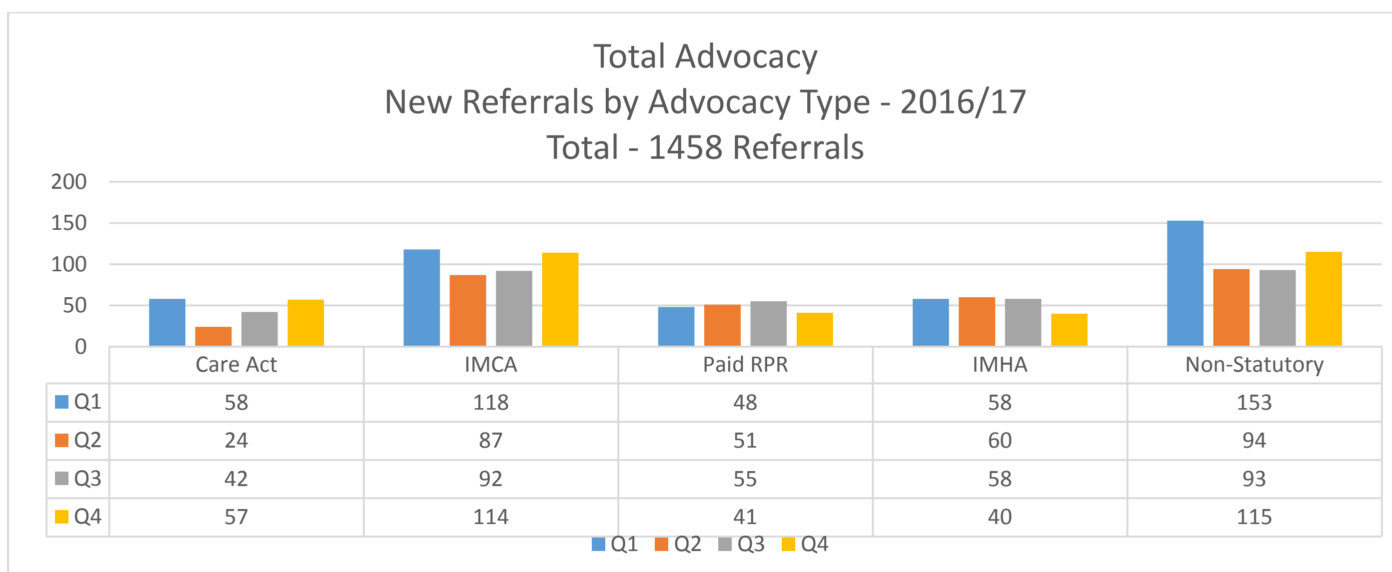
- 455 new referrals during 2016/17 – 31% of total referrals to the Total Advocacy service.
- Caseload of 143 as at 31.3.17 – 20% of total caseload
- 25% of total advocacy hours provided during 2016/17– higher than the indicative target, however the lower demand for Care Act Advocacy has provided some flexibility within the contract.
- Highest percentage of referrals are in Scarborough (34%)
- Highest percentage of referrals are from Health and Adult Services (37%) with self-referrals the next highest (23%)
- Highest number of referrals related to people requiring support with housing – 87 (20%) or to access other services – 86 (20%)

Advocacy Hours

- Overall Advocacy hours provided during 2016-17 are slightly below the indicative annual target however this appears to be due to the lower demand for Care Act Advocacy as hours provided for IMHA/IMCA/RPR and Non-Statutory advocacy are above indicative targets.

Detailed analysis and charts

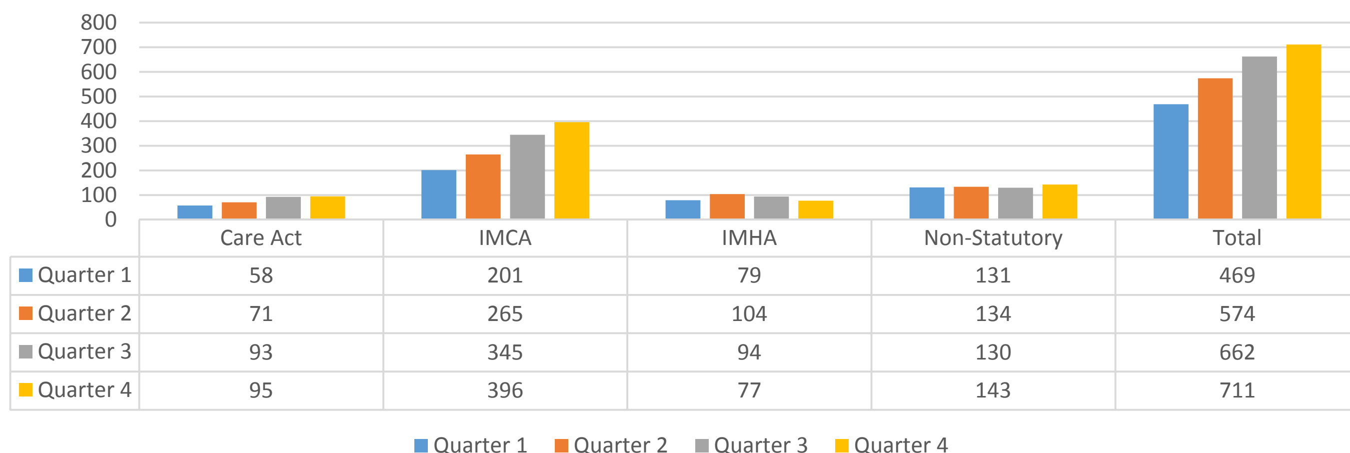
Total Advocacy - New Referrals by Advocacy Type - 2016/17						
	Q1	Q2	Q3	Q4	**Total**	**% of total referrals**
Care Act	58	24	42	57	**181**	**12%**
IMCA	118	87	92	114	**411**	**28%**
Paid RPR	48	51	55	41	**195**	**13%**
IMHA	58	60	58	40	**216**	**15%**
Non-Statutory	153	94	93	115	**455**	**31%**
Total	**435**	**316**	**340**	**367**	**1458**	



Caseload at end of each quarter - 2016/17								
	Quarter 1	% of Total	Quarter 2	% of Total	Quarter 3	% of Total	Quarter 4	% of Total
Care Act	58	12%	71	12%	93	14%	95	13%
IMCA	201	43%	265	46%	345	52%	396	56%
IMHA	79	17%	104	18%	94	14%	77	11%
Non-Statutory	131	28%	134	23%	130	20%	143	20%
Total	**469**		**574**		**662**		**711**	

APPENDIX 1

Total Advocacy
Caseload by Advocacy type at end of each Quarter 2016/17



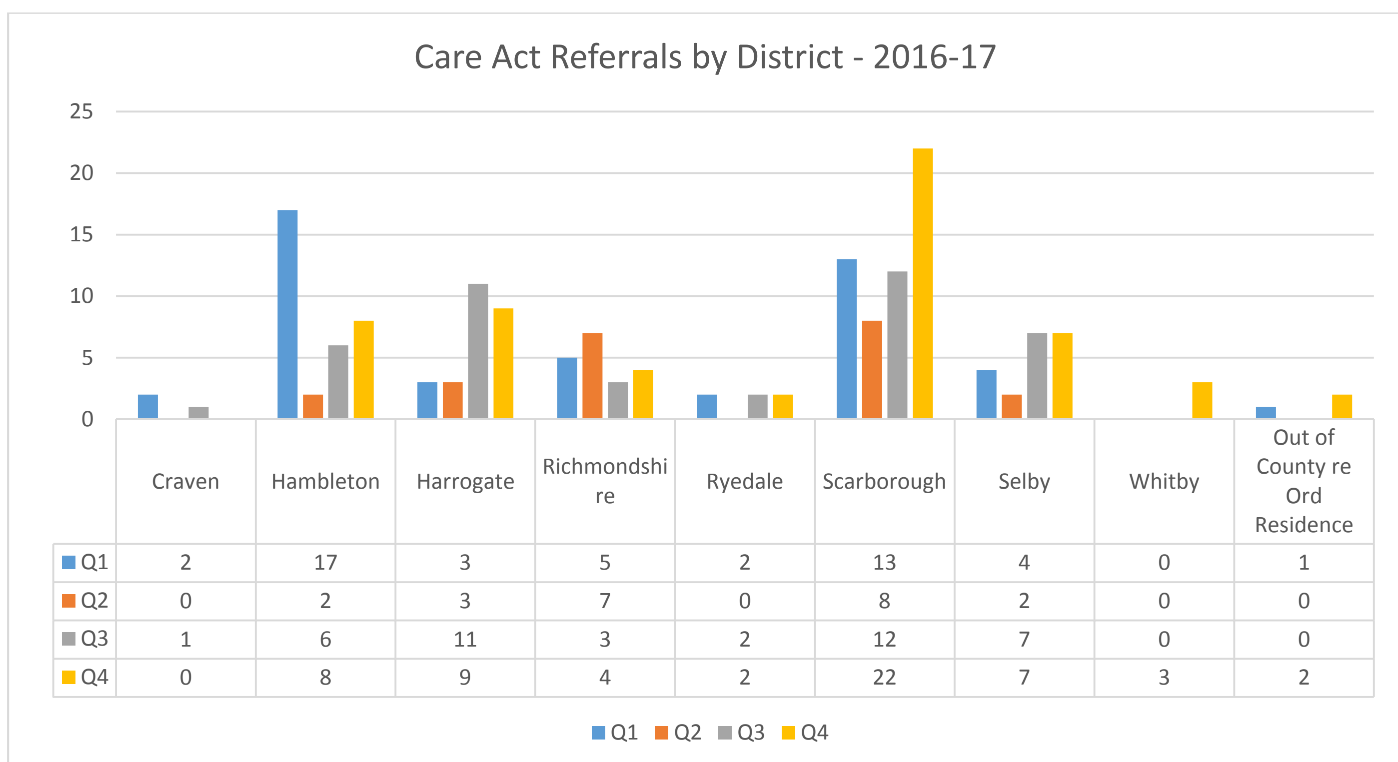
	Care Act	IMCA	IMHA	Non-Statutory	Total
Quarter 1	58	201	79	131	469
Quarter 2	71	265	104	134	574
Quarter 3	93	345	94	130	662
Quarter 4	95	396	77	143	711

Total Advocacy - Number of Individuals worked with over the months April 2016 to March 2017												
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Care Act	55	58	53	49	50	43	50	55	56	61	59	81
IMCA	222	221	217	195	217	210	221	260	198	Not recorded		236
IMHA	77	77	90	70	62	63	72	60	82	53	65	55
Non-Statutory	107	132	150	126	136	115	126	126	110	130	85	112
Total	**461**	**488**	**510**	**440**	**465**	**431**	**469**	**501**	**446**	**244**	**209**	**484**

Advocacy hours provided by Advocacy type									
	Target 2016/17			Actual 2016/17					
Advocacy type	Indicative annual activity %	Indicative annual activity by hours	Indicative quarterly activity by hours	Hours provided Q1	Hours provided Q2	Hours provided Q3	Hours provided Q4	Total Hours provided 2016/17	% of total hours provided
IMHA	60%	13,797	3,449.25	709	925	933	776	3,343	15%
IMCA				1,658	1,575	1720	1884	6,837	30%
RPR				604	962	1047	1022	3,635	16%
Total IMHA/IMCA/RPR				**2,971**	**3,462**	**3,700**	**3,682**	**13,815**	**61%**
Care Act	20%	4,599	1,149.75	688	708	752	1013	3,161	14%
Non-Statutory	20%	4,599	1,149.75	1,270	1,645	1214	1400	5,529	25%
Total		**22,995**	**5,748.75**	**4,929**	**5,815**	**5,666**	**6,095**	**22,505**	

Referrals by District 2016/17						
District	**Care Act**		**IMCA**		**Non-Statutory**	
	Referrals	**% of Total**	**Referrals**	**% of Total**	**Referrals**	**% of Total**
Craven	3	2%	9	2%	20	5%
Hambleton	33	20%	46	10%	59	14%
Harrogate	26	15%	138	29%	67	16%
Richmondshire	19	11%	24	5%	36	9%

Ryedale	6	4%	19	4%	21	5%
Scarborough	55	33%	159	34%	142	34%
Selby	20	12%	37	8%	36	9%
Whitby	3	2%	40	8%	38	9%
Out of County re Ord Residence	3	2%	0	0%	0	0%
Total	168		472		419	



Note re referrals by District – 28 referrals in Q1 and 2 referrals in Q2 were not captured by district split due to transition period from previous contracts and staff training on recording system.

IMHA Referrals by Location - 2016/17		
Location	**Referrals**	**% of Total**
Cross Lane, Scarborough	103	48%
Friarage Hospital, Northallerton	24	11%
Harrogate Hospital, Harrogate	56	26%
The Orchards, Ripon	2	1%
Springwood, Malton	3	1%
Worsley Court, Selby	20	9%
Community	6	3%
Total	**214**	

Care Act Referrals by Advocacy Support provided - 2016/17						
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**% of Total**
Needs Assessment	41	10	22	27	100	45%
Preparation of care/support plan	7	5	6	6	24	11%
Review of care/support plan	18	7	16	21	62	28%
Safeguarding	14	6	6	10	36	16%

Change of accommodation exception	1	0	0	0	1	0%
Total	81	28	50	64	223	

Non-Statutory Advocacy - 2016/17						
Advocacy support provided	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**% of Total**
Access to health services	8	0	0	0	8	2%
Access to mental health services	9	0	0	0	9	2%
Access to other services	60	5	17	4	86	20%
Care and Support Planning	16	0	0	0	16	4%
Care Reviews	12	0	0	0	12	3%
Child protection	5	0	0	0	5	1%
Complaints	35	6	9	6	56	13%
Finance/access to financial information	21	9	4	5	39	9%
Housing	60	6	15	6	87	20%
Support at meetings	3	0	2	0	5	1%
Needs Assessment	9	3	0	2	14	3%
Best Interest Meeting	5	2	0	1	8	2%
Review Meeting	5	1	8	2	16	4%
Care Package	9	1	2	4	16	4%
Family Issues	5	4	3	8	20	5%
Support to speak with social worker	6	5	6	10	27	6%
Safeguarding	2	0	0	0	2	0%
Physical Health Issues	2	5	8	0	15	3%
Total	**272**	**47**	**74**	**48**	**441**	

IMCA Referrals by Decision Making Area 2016/17						
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	% of Total
Change of Accommodation	41	38	40	45	164	27%
Serious Medical Treatment	13	12	15	25	65	11%
DoLS 39A	18	12	13	12	55	9%
DoLS 39C	11	0	4	2	17	3%
DoLS 39D	5	3	0	1	9	1%
Care Review	4	2	8	12	26	4%
Safeguarding	26	20	12	17	75	12%
Paid RPR	48	51	55	41	195	32%
Total	**166**	**138**	**147**	**155**	**606**	

IMHA Referrals by Mental Health Section 2016/17						
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	% of Total
Section 2	41	32	40	27	140	65%
Section 3	16	21	17	12	66	31%

Community Treatment Order	1	7	0	1	9	4%
Total	**58**	**60**	**57**	**40**	**215**	

Referrals by Primary Need - 2016/17						
Primary Need	**Care Act**		**IMCA**		**Non-Statutory**	
	Referrals	**% of Total**	**Referrals**	**% of Total**	**Referrals**	**% of Total**
Learning Disability	95	49%	120	20%	113	22%
Autism Spectrum Disorder	6	3%	0	0%	4	1%
Acquired brain injury	5	3%	23	4%	6	1%
Physical Impairment	14	7%	30	5%	88	17%
Sensory Impairment	2	1%	4	1%	9	2%
Mental Health condition	20	10%	67	11%	103	20%
Fraility / Older Person	3	2%	14	2%	60	12%
Hearing Impairment	0	0%	0	0%	1	0%
Visually Impaired	0	0%	1	0%	3	1%
Dementia	32	16%	312	51%	20	4%
Long term ill health	8	4%	4	1%	22	4%
Carer	0	0%	0	0%	31	6%
Other	9	5%	31	5%	45	9%
Total	**194**		**606**		**505**	

Referral Source re Care Act and Non-Statutory Advocacy - 2016/17				
Referral Source	**Care Act**		**Non-Statutory**	
	Referrals	**% of Total**	**Referrals**	**% of Total**
Health & Adult Services	157	80%	188	37%
Primary health service	0	0%	2	0%
Secondary health service	19	10%	46	9%
Self	0	0%	114	23%
Voluntary agency	0	0%	7	1%
Advocacy Provider	21	11%	54	11%
Housing	0	0%	1	0%
Other	0	0%	92	18%
Total	**197**		**504**	

Referral Source	**IMCA**	
	Referrals	**% of Total**
NYCC	482	80%
NHS	124	20%
Total	**606**	

Referral Source re IMHA - 2016/17		
Referral Source	**Referrals**	**% of Total**
MHA Office	73	34%
Ward Staff	112	52%
Self	23	11%
Advocate	7	3%

Total	**215**	