Service Specification for Independent Health and Social Care Advocacy - Adults

Index

General Requirements - Independent Health and Social Care Advocacy

1 Service Overview

Advocacy in Bath and North East Somerset

1.1 Definition

Independent advocacy helps people to understand their rights and choices, have those rights upheld, make decisions and have their views, wishes and needs heard. The national Advocacy Code of Practice defines advocacy as: “taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice. Non-instructed advocacy takes place when a person lacks the capacity to instruct an advocate. The non-instructed advocate seeks to uphold the person’s rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person’s unique preferences and perspectives”.

The Care Act statutory guidance further defines it as *"supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need"*. Advocacy can take several forms depending on the individual's ability and capacity to instruct an advocate.

2 Background

2.1 The population of Bath and North East Somerset (B&NES) was estimated to be around 188,678 in mid-2017 and like most areas in the UK is ageing. B&NES covers an area of 135.2 square miles and is a mixture of urban and rural communities, with a significant student population at the two universities.

2.2 B&NES is an area that has generally good health and low crime; however, there is significant variation across the district, with the most deprived communities experiencing a range of inequalities and poorer life outcomes. In the 2011 Census, 16% of B&NES residents reported that their day to day activities were limited through a long-term illness or disability and 10% of the population stated that they spent a substantial portion of their time caring for a friend or relative.

2.3 More information about B&NES can be found here: https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics.

2.4 The re-commissioning of independent advocacy services for adults enables us to commission arrangements to meet a range of statutory duties including the Care Act 2014; Health & Social Care Act 2012, Mental Health Act 2007, Mental Capacity Act 2005, Public Services (Social Value) Act 2012 as well as the local prevention, early intervention and personalisation agendas.

3 Aims and Principles

Aims

3.1 The aim of all advocacy services is to enable people to be in control of their lives, by ensuring that their rights are upheld and that their views, wishes and needs are heard, respected and acted upon.

3.2 The aim of this contract is to commission co-ordinated, personalised and empowering advocacy services that will ensure that the rights, wishes and interests of the people that they advocate on behalf of are promoted in a way that is non-judgemental and respectful. It will support recipients to be involved in and have influence over their health, care and support needs.

It will, therefore, represent the interests of an individual and empower and enable them where appropriate to:

3.2.1 clarify and express their views and concerns;
3.2.2 access information and services;
3.2.3 defend and promote their rights and responsibilities;
3.2.4 explore choices and options;
3.2.5 negotiate and resolve issues;
3.2.6 exercise choice and control over their lives;
3.2.7 and maximise their independence irrespective of their levels of need, now or in the future.

3.3 It will provide services that:

3.3.1 are of high quality;
3.3.2 are effective and efficient;
3.3.3 are sensitive and appropriate and designed so that they are inclusive of anyone who would be eligible for services and their carers;
3.3.4 collaborate efficiently and effectively with partners;
3.3.5 offer value for money for the public purse; and that
3.3.6 respond to changes in local needs and national legislation

3.4 The organisation(s) delivering this contract will be required to operate the services within a constantly changing environment of financial austerity and changing legislation, in particular in relation to Liberty Protection Safeguards, meaning that patterns of delivery and volumes may need to change during the term of the proposed contract. As a result, the Provider must keep up to date with these changes and adopt working practices that are flexible enough to meet future requirements and demands.

3.5 The Council will regularly review the volumes delivered under the contract and reserves the right to vary the commissioned volumes. For the avoidance of doubt, this variation may result in increased volumes, decreased volumes or a redistribution of hours between the 5 service elements.

3.6 The Provider will need to demonstrate a commitment to partnership working as this is key to the successful and safe delivery of these services. The Provider will work closely with the Council so that the duties are met efficiently, as well as working collaboratively, effectively and flexibly with partners involved in the commissioning and delivery of services so as to make best use of increasingly tight resources.

3.7 The funding available for the provision of these services and payment arrangements are set out in the Pricing Schedule. No funds may go towards any costs incurred which are not contract related. Any change in the statutory duties and/or funding arrangements will trigger a review of funding for this service. Any other changes in the funding will be agreed as part of the annual review process.

Principles

3.8 The services will be signed up to and implement the Advocacy Charter and work to a common set of principles, as described by the charter and the revised Code of Practice which are:

3.8.1 Clarity of purpose
3.8.2 Independence
3.8.3 Person Led
3.8.4 Empowerment
3.8.5 Equality & Diversity
3.8.6 Accessibility
3.8.7 Supporting advocates
3.8.8 Accountability
3.8.9 Safeguarding

3.9 Further information about these principles can be found in the Advocacy Code of Practice here: https://qualityadvocacy.org.uk/wp-content/uploads/2018/05/Code-of-Practice-1.pdf

3.10 The Provider will be independent and will:

3.10.1 ensure that commissioning and funding arrangements do not compromise provision of independent advocacy to clients;
3.10.2 have a statement of how it will demonstrate independence from providers and commissioners.
3.10.3 have a clear policy and process for identifying, registering and addressing conflicts of interest.

4 Service Usage

The following table sets out the requirements in terms of volumes. In certain specific circumstances, spot purchasing may be required, and bidders should indicate their spot purchase rates in the pricing schedule.

	Independent Care Act Advocacy	**Independent Social Care Complaints Advocacy**	**Independent Mental Health Advocacy**	**Independent Mental Capacity Advocacy**	**Independent Health Complaints Advocacy**
Hours	447	289	365	1041 (IMCA) 376 (IMCA DoLS) 1710 (RPR)	981

The Council will regularly review the volumes and reserves the right to vary these accordingly. For the avoidance of doubt, this variation may result in increased volumes, decreased volumes or a redistribution of hours between the 5 services.

5 Contract Objectives

5.1 The Provider shall ensure that the Services delivered are flexible, reflective, and evolve in response to changes in legislation, legal precedent, guidance, regulations, codes of practice and local experience. As a minimum, the core characteristics of this contract will be that the Services will be:

5.1.1 known, accessible and responsive,
5.1.2 professional,
5.1.3 independent
5.1.4 value for money and
5.1.5 making a positive difference

5.2 In order to provide a person centred service, the Provider will ensure a sufficient supply of suitably qualified and competent advocates who are independent of the NHS, the Council, and the organisations commissioned by them.

5.3 The Provider shall maximise opportunities for flexibility of service provision such that peaks and troughs can be absorbed according to changes in need and capacity.

5.4 The contract will provide a single point of access for requests for independent adult advocacy and related queries. It will manage the receipt and triage of referrals to all the advocacy services within this contract as well as tracking progress through the Service(s).

5.5 The Provider is responsible for ensuring the Council is informed of changes in service volumes that impact on the responsiveness or capacity of the Service.

6 Outcomes / Benefits

6.1 The Council is commissioning this contract in the context of its values as well as national policy. These services will help drive up the quality of local health and care services, resulting in improved experience, outcomes and benefits for the people who use them.

6.2 The Provider shall demonstrate successful delivery of the following outcomes across all the services in this contract for the people who use these services:

6.2.1 I have been able to communicate my views, feelings and aspirations about the issue(s) that I needed support with.
6.2.2 I felt heard, understood and taken seriously by the people making decisions about the issue(s) that affect my life.

6.2.3 I have been at the centre of all decisions about the issue(s) that affect my life, and have as much control as is possible over those decisions.
6.2.4 I have been treated with dignity and respect.
6.2.5 I have been able to build a trusting relationship with my advocate.
6.2.6 I felt my advocate understood what is important to me.
6.2.7 I have been able to communicate with my advocate directly.
6.2.8 I have access to up-to-date information about the advocacy service in a format that I can understand.
6.2.9 I have been given easy to understand information about confidentiality, safeguarding and consent to share my information.
6.2.10 I have been given easy to understand information on how to make a compliant to the advocacy service if I need to.
6.2.11 I have received personal and flexible advocacy support when I have needed it.
6.2.12 The information I have received has promoted my choices.
6.2.13 The advocacy service has helped me to understand my rights and to exercise them.
6.2.14 I was supported to access other services that could help me if it was appropriate.
6.2.15 I feel more confident about speaking up.
6.2.16 The advocacy support has made me feel more powerful and in control of my life.
6.2.17 I have been asked for my views about the advocacy service.
6.2.18 I have been given the choice to be involved directly in planning, and/or delivering and/or monitoring the advocacy service.

7 Interdependencies

7.1 There will be a seamless approach to service delivery across the independent advocacy roles delivered in this contract.

7.2 The five services delivered in this contract must work seamlessly together and have a transparent and pro-active approach to ensure clarity of information sharing. Their communications will be underpinned by appropriate agreements which are reviewed regularly, in the event that the services are delivered by different organisations through sub-contracting arrangements. The Commissioner will work with the successful provider to co-produce a simple SLA document that captures this information.

7.3 The Provider shall ensure that services are not duplicated and that individuals do not have to repeat their story to different advocates unnecessarily. The same advocate can provide support in more than one advocacy role, provided they are trained and qualified to do so. The Provider shall co-operate fully with other information and advice or advocacy providers to promote the best interests of people in Bath and North East Somerset.

7.4 Where it is necessary for more than one advocate to be involved in a Service User's case the Provider shall ensure that the advocates co-ordinate and work together to ensure the Service User's best interests and that a clear record of all activity is included on the particular case note.

7.5 There will be circumstances when a person is part of a social care 'process' but may not have access to an independent advocate under the Mental Capacity Act or the Mental Health Act. The duty under the Care Act will increase the availability of independent advocacy to them.

8 Eligibility

8.1 The specific eligibility requirements are set out in the individual service specifications.

8.2 Statutory duties for the local authorities within the Care Act (2014) have expanded and dove-tailed with current legislation including the Mental Capacity Act (2005) and the Mental Health Act (1983 as amended 2007). There are also anticipated changes for advocacy duties in relation to the Liberty Protection Safeguards, which are expected to come into force during the lifetime of this contract.

8.3 Self-help materials and sign posting will be offered to people not meeting the eligibility.

9 Outside the scope of this contract

9.1 The services delivered by this contract will not: make decisions or choices for people, provide a campaigning service, provide a befriending service, provide financial advice and advocacy or provide legal advice and advocacy.

9.2 No eligible individual shall be unreasonably excluded from accessing the specified services unless there are other more specific services available for their needs. If, in the event exclusion is unavoidable, the Provider shall notify the commissioner immediately.

9.3 The services are not intended to provide on-going advocacy for individuals other than as set out in this specification.

9.4 Advocacy should not be open-ended on any issue or used as a substitute for any other service.

9.5 Advocates shall not remain involved with individuals who cease to be eligible but shall facilitate signposting to other agencies who are able to offer appropriate support to the individual.

10 Social Value

10.1 The Public Service (Social Value) Act (2012) requires all public bodies to consider how they can improve the economic, social and environmental well-being of their local area through services they procure. The Provider must demonstrate they will work with commissioners and partners to ensure social value goals are delivered through this contract by promoting and enabling volunteering opportunities and building the capacity and confidence for people to use other forms of advocacy (when appropriate) such as supported self-advocacy, case advocacy, group advocacy, peer advocacy or citizen advocacy.

10.2 The Provider will contribute to the local employment market by taking on apprentices, interns or offering work experience or volunteering opportunities to local people wherever possible. It will develop strong links with partner organisations to offer project based volunteering opportunities whilst still ensuring continuity of advocacy for individuals.

10.3 The Provider will regularly review where it can provide added value, social value and innovation to improve the provision of the service in the short, medium and long term and to identify quick wins or invest to save strategies that it may wish the Council to consider.

10.4 The Provider will note the intention for the Council to address issues pertaining to 'Climate Change' and where it is within their gift and as supported by the commissioner promote practical ways of minimising the impact of.

11 Pathways, referrals and access

11.1 When mobilising this contract, the Provider will work with the Council to develop and implement appropriate pathways and processes through the services so that both the services and referrers are able to fulfil their respective duties in a timely manner for the benefit of the individual and manage capacity within the Services.

11.2 The pathways will:

- 11.2.1 enable the Provider to receive referrals from a range of sources including individuals, carers seeking an advocate, and health and social care staff referring individuals on their behalf;
- 11.2.2 minimise duplication and repetition;
- 11.2.3 enable the use of dual qualified advocates, provided they are trained and qualified to do so;
- 11.2.4 promote collaborative partnership working;
- 11.2.5 facilitate communication with other parties as individuals progress through the pathway; and
- 11.2.6 signpost to other services where they are more appropriate to meet the needs of individuals.

11.3 The contract will provide an effective single point of access for the public and professionals for all services in this contract. This will:

11.3.1 take telephone / email / letter / online enquiries (using an appropriate electronic form) and referrals as appropriate;

11.3.2 ensure appropriate level of information is obtained and recorded at first point of contact, using standardised forms. The service shall also ensure they collect details regarding any access or interpreting needs the person may have;

11.3.3 discuss appropriate options available for the individual based on their situation;

11.3.4 if appropriate allocate to the relevant independent advocacy service;

11.3.5 if the individual does not have eligible needs for services, provide self-help materials and signposting to relevant other resources within the local community;

11.3.6 track and ensure recording and monitoring of the individual's experience with Services.

11.4 The Provider will have a clear statement of purpose and a description of all the services it delivers.

11.5 The Provider will have a clear communications strategy, based on the specific characteristics of the local community.

11.6 The Provider must be responsive and able to manage daily activity, effectively minimising missed calls and limited service delivery.

11.7 Any provisions are additional to the right to have a Care Act assessment which is available to everyone regardless of their eligible needs.

11.8 Whilst the specific response times required will vary by service the Provider must acknowledge receipt of all referrals with the referrer within 2 hours of normal working hours. All delays in acceptance of referrals must be recorded and reported for discussion at contract review meetings.

11.9 The response times for each service are detailed in each individual Service Specifications and an overview provided in Appendix 2.

11.10 All referrals will be allocated an individual unique reference number, which will remain the identification for that individual across the services and must be used by all advocacy service providers working with that person.

11.11 The Provider shall notify the Commissioner immediately if service capacity is reached and a waiting list needed. In which case the Provider shall operate a prioritisation system, in agreement with the Commissioner.

11.12 The Provider will retain evidence of effective case management processes that include keeping both individuals in receipt of advocacy services and their referrers informed and engaged.

12 Range of support options

12.1 The Services will be delivered in a variety of formats designed to be accessible to all individuals, in terms of built physical environment, geographically across urban and rural communities and in mode of communication (e.g. audiotapes, easy read, large text etc.).

12.2 The service delivery shall be tailored to individual requirements.

12.3 The Provider shall make appropriate use of technology in a way that meets the needs of the individual as well as being efficient; this may include but is not to be limited to: web chat, email, telephone, face to face. The contract may provide one to one support in an individual's own home or offered at an accessible or appropriate venue, or attending hospital wards or residential settings. Advocates may accompany individuals to relevant meetings in order for the individual's voice to be heard.

12.4 The Service will facilitate self-advocacy by promoting self-help materials where appropriate.

12.5 The Provider will maintain a good understanding of, and be part of, the local landscape for information, signposting and complaints; and

12.6 The Provider will also share with commissioners the intelligence it collects to influence service improvements.

13 Liaison between professional parties

13.1 The Provider will put in place appropriate engagement protocols and information sharing agreements with the relevant organisations in order to deliver the service safely, securely and promptly.

13.2 The Provider will liaise proactively with the relevant organisations in order to facilitate resolution for the individual, ensuring a collaborative and timely approach and completed in a timely manner.

13.3 The Provider shall liaise with the provider of the children's advocacy contract(s) with regards to young people going through the transition process.

13.4 Post implementation of the Liberty Protection Safeguards, The Provider shall liaise with the provider of the children's advocacy contract(s) to develop a Memorandum of Understanding/Service Level Agreement under the guidance of the Commissioner.

14 Geographical coverage

14.1 The commissioned services are for people in Bath and North East Somerset except where stated to the contrary. Each specification will set

out specific requirements in relation to coverage and eligibility if appropriate.

14.2 The services must have an understanding of the geography of Bath and North East Somerset and the diverse communities living within it.

15 Location of service delivery

15.1 As far as is practical, appropriate and safe, independent advocates will work with people in private in order to determine how best to support or represent them. They will endeavour to meet in the most appropriate place of the person's choosing. Locations may include for example: hospitals, care homes and people's own homes.

15.2 The Provider will be responsible for providing office accommodation for the use of its Staff, which will include a secure storage area where case records may be safely stored.

16 Days and Hours of Operation

16.1 Details about the hours and days that the services must be available can be found in each individual service specification.

16.2 There shall be a central point to manage the referrals into the services that demonstrates knowledge of local geography and communities.

16.3 Information about the services must be available on-line 24 hours a day, 7 days a week. During maintenance and essential update periods Service Users shall be directed to alternative provision.

16.4 The Provider must ensure that entries on service directories such as Wellbeing Options are kept up to date and accurate.

16.5 The Provider shall meet the response times detailed in each of the individual Service Specifications.

16.6 The Commissioner reserves the right to request that a case be dealt with more urgently providing that is agreed between both parties.

16.7 In the event of the successful provider having questions/ queries about any aspect of the specification this shall be raised with commissioner through the contract management meetings/arrangements.

17 Accessibility

17.1 The Provider shall ensure that the Services will be provided free of charge regardless of any access needs of the person(s) seeking support.

17.2 The Provider will have arrangements in place to meet the access requirements of individuals using the Services. This means that the Provider will ensure that the Services delivered are appropriate to the individuals, including their protected characteristics. This includes ensuring that information is provided in a format most appropriate to their individual need and with the support of translators and/or interpreters where required.

17.3 The Provider shall arrange any such support that is needed and ensure that the support meets the relevant quality standards.

17.4 The Services provided under this contract will be compliant with the requirements of the NHS Accessible Information Standard[1].

17.5 Further information is available from: https://www.bathnes.gov.uk/services/your-council-and-democracy/equality-and-diversity/accessible-formats-directory).

18 Contingency planning

18.1 Arrangements must be in place to ensure continuity of service for example during annual leave and staff sickness, and to ensure the Service can respond within specified timescales.

18.2 Each Service will maintain an up to date business continuity plan and share this with the Commissioner.

19 Change in Provider

19.1 The Provider shall co-operate fully with the Council and CCG during the handover leading to the mobilisation and termination/expiry of the contract. This co-operation shall extend to full access of all documents, reports, summaries and any other information required to achieve an effective transition without disruption to routine operational requirements.

19.2 The Provider shall take all reasonable steps, as the incumbent, to ensure that the handover of operations to a new provider causes the least possible disruption and that such handover is done in the shortest most practical time agreed by all parties.

20 Service User Involvement and Feedback

20.1 The Provider shall involve the individual in the decision-making process as far as possible, depending on their capacity and capabilities and will ensure that the individuals they work with get the support they need to

[1] https://www.england.nhs.uk/ourwork/accessibleinfo/

communicate their needs and wishes. This will be evidenced through contract management and performance reporting, for example using case studies, reports and case file audits.

20.2 The Provider will routinely seek feedback from individuals who have used or are using the Services. The Provider will be required to show evidence of having taken account of individuals' views, particularly in respect of accessibility and impact for each Service. The Provider shall discuss with the Council the methods used to obtain this feedback.

20.3 The Provider shall endeavour to seek feedback, wherever possible from individuals using the Service and their referrers on the Outcomes identified in Section 6.

21 Compliments and Complaints

21.1 The Provider will routinely seek feedback from those using the Services and those referring individuals to it. The Provider will collect and use this feedback to review, develop and implement plans to improve the Service. The Provider will share this feedback and learning with the Council as part of the contract monitoring arrangements.

21.2 The Provider must have an easily understood, well-publicised and accessible procedure to enable individuals and their relatives or representative to make a complaint or compliment and for complaints to be investigated.

21.3 The majority of people who receive a service are extremely reluctant to complain, even for valid reasons; for fear that the Service may be taken away from them. The Provider is required to take positive action to enable individuals to use the complaints and compliments procedure.

21.4 The complaints procedure must include:

- 21.4.1 Date of complaint
- 21.4.2 Nature of the complaint
- 21.4.3 Action taken
- 21.4.4 Outcome of the complaint

21.5 A system must be in place to analyse and identify any pattern of complaints and compliments and the Provider shall share their findings with the Council.

21.6 There may be times when an advocate has concerns about how the Council has acted or what decision has been made or what outcome is

proposed. In this instance the advocate shall follow the Council's standard complaints procedure

21.7 The Provider will have clear and robust processes for raising concerns with commissioners, providers and regulators.

22 Partnership working

22.1 The Council and Provider will work together to mobilise this contract and to ensure that there is operational guidance available to referrers.

22.2 The Provider shall work closely with the Council to monitor the demand for the Service and maximise its' reach and scope for the benefit of individuals.

22.3 The Provider must assist staff and organisations who are likely to refer eligible individuals in understanding the role of the Service and how to access the Service.

22.4 The Provider must have a thorough knowledge and understanding of other services that can provide support and guidance.

22.5 The Provider will develop strong links, both formal and informal with local communities, customers, carers and those representing them in order to ensure that they are consulted, involved and engaged in the Provider's work plan on a regular basis.

22.6 The Provider will ensure representation at appropriate meetings and steering groups as agreed with the commissioner.

22.7 The Provider will ensure participation in regional and national networks as appropriate in order to develop contacts with similar projects and benefit from the learning and experience.

22.8 The Council will require the Provider's manager and relevant managers to meet on a regular basis to discuss operational issues and to raise issues on behalf of individuals.

23 Safeguarding

23.1 The Services will be delivered to promote and ensure safeguarding of all individuals to have a right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity.

23.2 The Provider will respect the confidentiality of the person requiring advocacy, disclosing information only with their permission or in the best interests if they lack capacity or competence, in the case of a child. The exception to disclosure of information would be in the event of the person

or others being at risk. To ensure that Commissioners can support the resolution of any issues we will work agree a practicable solution that achieves this but does not breach client confidentiality.

23.3 The Provider will comply with the procedures of the local multi agency board set out at https://www.safeguarding-bathnes.org.uk/ and amended from time to time. The Provider will actively work within the agreed inter-agency framework based on the guidance contained in the Care Act 2014 related to safeguarding and regularly review the policy, procedures and guidance.

23.4 The Care Act 2014 sets out a clear legal framework for how the Council and the Provider should protect adults with care and support needs at risk of abuse or neglect. The Provider and its Staff shall report to the Council any allegations of abuse or suspicions of abuse in respect of an adult at risk.

23.5 \Any concerns about such abuse shall be reported to the Council's Safeguarding team. On the occurrence of any serious accident or change in the condition of an individual which gives the Service cause for concern the Service must keep a record of all communications between parties in connection therewith. If and to the extent that an individual is in immediate danger or in need of medical attention the Provider shall immediately notify the appropriate emergency services.

24 Equality and diversity

24.1 The Provider must ensure that the Services are culturally sensitive and appropriate to the diverse needs of individuals and flexible enough to meet the requirements of different people. All statutory obligations must be met including the Human Rights Act and the Equality Act;

24.2 The Provider and Council shall at all times operate a policy of equality of opportunity and anti-discriminatory practice in employee recruitment and management and in the delivery of the contract and shall comply with all equality legislation.

24.3 The Provider must also recognise that an individual's needs may change over time and shall respond accordingly.

24.4 Where the Provider has cause to use Staff or suppliers not directly in its employment it will take reasonable steps to ensure that suppliers or subcontractors operate a policy of equality of opportunity and anti-discriminatory practice in recruitment and management and in the delivery of the contract, which is equal to policies agreed as part of the original contract, and shall comply with all equal opportunities legislation.

24.5 The Council is responsible for ensuring legal compliance with public sector equality duties; not only for the services that they provide directly, but also for the services that it commissions from others. The Council will

wish, therefore, to ensure that services genuinely meet the needs of people from diverse and vulnerable groups with effectiveness being measured by service quality and outcomes.

25 Resources

25.1 The Provider will ensure that they have the relevant technology infrastructure necessary to operate this Service including access to secure internet and e-mail accounts for all Staff, telephone facilities as well as software suitable to operate a service database.

26 Staffing

26.1 The Provider will provide an adequate number of Staff to fulfil the contract; and have an appropriate workforce which collectively has the specialist knowledge and skills to meet the particular needs of individuals including the wide range of needs that will present within protected characteristics.

26.2 The Provider shall:

26.2.1 provide sufficient skilled, trained qualified advocates who can work with young people and adults from different backgrounds and those with a range of complex needs, including challenging behaviour;

26.2.2 ensure all advocates are appropriately selected and checked in line with safe employment policy and procedures;

26.2.3 ensure advocates are given relevant training, and have the experience, skills and personal attributes commensurate with the responsibilities of the role and have access to ongoing training as appropriate; in accordance with legislative requirements.

26.2.4 make available to all advocates, effective and up-to-date policies on confidentiality, complaints, non-discriminatory practice, child protection and adult safeguarding.

26.2.5 ensure all advocates are provided with appropriate support and regular face-to-face supervision to ensure that they carry out their role professionally in a non-discriminatory manner;

26.2.6 provide Staff cover during periods of absence due to sickness, staff holidays or for other reasons to ensure the service is not interrupted;

26.2.7 appoint a suitably trained and qualified manager who shall have responsibility for the management and oversight of the whole service;

26.2.8 ensure that support staff develop consultation and communication skills in order to deliver some of the elements of this service;

26.2.9 actively promote volunteer/employment opportunities to ensure it has a sufficient number to meet demand within available resources and provide appropriate support and training;

26.2.10 ensure that all volunteers and Staff are accountable, supported and supervised and monitored regularly. The Provider must ensure that all volunteers and paid Staff have access to regular, high quality supervision on a one-to-one basis.

26.2.11 ensure that staff understand the Council's policy framework, statutory responsibilities, and current guidance from the Department of Health.;

26.3 It is expected that all independent advocates will have the relevant skills and competencies for the task and will be willing to undertake further training and development. This will include successfully completing the relevant modules of the National Advocacy Qualification for all relevant Staff as soon as possible and within one year of starting employment (making necessary adjustments for any maternity leave, long-term sickness or other similar absences). Documentary evidence of this may be requested by the Commissioner.

26.4 The Provider shall ensure that Advocates:

26.4.1 have appropriate experience for the relevant service, for example in non-instructed advocacy or in working with people with substantial difficulty in being involved in care and support/safeguarding processes;
26.4.2 have appropriate training and qualifications;
26.4.3 are competent to full the responsibilities of the role;
26.4.4 have integrity and are of good character; all independent advocates must have a satisfactory enhanced DBS screen. In the event of a query arising from the satisfactoriness of the DBS, the commissioner has the final say;
26.4.5 have sufficient regular supervision with an appropriate supervisor.

26.5 Advocates will NOT be:

26.5.1 employed or otherwise working for the NHS, Council or anybody to which the Council has delegated its assessment and planning functions;
26.5.2 involved in providing care or treatment in a paid or professional capacity for the cared for person or their carer when representing either person.

26.6 The Provider will ensure that advocates:

26.6.1 receive training in line with QPM Code of Practice and Charter from an appropriately qualified training provider in the advocacy field;
26.6.2 are able to offer or can easily access specialist knowledge, or skills that would allow them to support individuals with more complex needs, such as those with mental ill-health, those with learning disabilities, communication difficulties, sight or hearing impairment or Individuals for whom English is not their first language;
26.6.3 have access to translation and interpretation services;
26.6.4 are able to access professional medico-legal support as required;
26.6.5 have the capacity and expertise to support individuals in secure environments, such as secure accommodation; and
26.6.6 have undergone the necessary clearance checks, including enhanced Disclosure and Barring Service (DBS) checks. It will be a matter for the Provider to decide whether any formal entries which

appear on relevant checks will automatically act as a bar or disqualification to advocacy employment.

26.7 When recruiting and training Staff the Provider will ensure that it takes into account the range of communications skills required to meet the needs of the population, with the aim of ensuring that no one is excluded from accessing the Services.

26.8 It is recognised that the Provider may not be able to employ a sufficient number of advocates to meet the range of requests for advocacy from specific ethnic, religious and other groups. Therefore, it is expected that links will be built with other specialist advocacy services and local support groups within the locality to increase the choice of support that can be made available. Any such arrangements will be agreed with the Council.

26.9 The Provider will ensure the Service is delivered in a professional manner and will monitor the impact of significant absences and unfilled vacancies. The Provider will be responsible for all actions of its Staff, including volunteers. If the Provider decides to sub-contract any part of the Service they will have to demonstrate an equivalent level of rigour to those of its own Staff and those of the sub-contractor.

26.10 The Provider will provide advocates with skills in communicating in non-standard ways, for example people who have no spoken language and people with behaviour perceived to be challenging.

27 Supervision requirements

27.1 The Provider shall ensure the implementation of a robust employee training policy framework.

27.2 Induction, supervision and professional development are essential components of the service and contribute to ensuring quality and consistency of the provision.

27.3 Staff will receive a formal induction to the service which shall include how to access support and supervision.

27.4 Staff will have regular support and supervision, (including team working arrangements). Each advocate will receive regular individual management supervision with their line manager.

27.5 Each advocate will have a personal/professional development plan that is assessed, implemented, and evaluated annually.

27.6 Records will be maintained on the delivery of supervision and the generation of individual personal development plans. The Provider shall keep records about all advocacy awareness training sessions delivered, noting attendees. These records will form the basis for reports as

required.

28 Information Management

28.1 The Provider will have policies and procedures for making and maintaining records of engagements with individuals in line with the Council's retention schedule. The policies and procedures will detail standards for recording patient information, internal audit and quality monitoring, storage, cataloguing, archiving, and destruction. There will be a procedure for handling and storage of third-party information.

28.2 The Provider's record keeping shall focus on enabling quantitative and qualitative analysis, and on producing a record which is open and accessible. It is expected that the Provider will produce and operate a policy that accommodates these requirements and reflects that, in limited circumstances, the disclosure of these case records may be required by the courts.

28.3 The Provider shall ensure that they keep a record of all work undertaken subject to being able to destroy closed cased files in line with the Council's retention policy.

28.4 All statistical data will be recorded onto computerised database, using standard categorisation of issues and capable of electronic integration with other systems. This monitoring data will be made available from time to time to regulatory bodies and the commissioner on request as required.

28.5 The Provider should be supported to access where relevant patients' individual notes for example those stored on Liquidlogic and RIO (or any other recording system).

29 Quality assurance and service improvement

29.1 To ensure consistent quality standards, the Provider will be monitored in accordance with paragraph 30.

29.2 The Provider and the Council are both responsible for monitoring the quality of service provision. Evaluation will include:

29.2.1 Provider's adherence to national standards and best practice.
29.2.2 Feedback from decision makers, including at the end of each individual advocacy engagement period.
29.2.3 Reviewing individual outcomes and their successful achievement.
29.2.4 Evaluating the service deliverables against the service specification.
29.2.5 Monitoring complaints, serious untoward incidents, safeguarding incidents
29.2.6 Reference to written policies, procedures and records for Customers, staff and volunteers.
29.2.7 The findings of any monitoring will be shared between the Provider and the Council to inform continuous improvement in service delivery and planning.

29.3 The Provider will ensure that communications and provision of information are compliant with the Council's policies, relevant legislation and any codes of good practice, including where the Council is signed up to multi-agency policies.

29.4 The Provider will produce an action plan when requested or if the providers own management, stakeholder feedback, review process or other contract management activities reveal the need for remedial action. This action plan must be produced within one month of being formally requested. All action plans will be accompanied by a timetable outlining:

29.4.1 issues and associated risks
29.4.2 suggested solutions and identified contingencies
29.4.3 financial impact analysis
29.4.4 responsible owners for actions
29.4.5 management and monitoring arrangements
29.4.6 impact on service delivery including the potential effect on individuals using the service.

29.5 The Provider will maintain good relationships with the health and social care system and able to respond to changing needs.

29.6 The Provider will ensure that there are robust systems to collect and share information, including trends and issues, with local and national organisations involved in complaints and service improvement.

29.7 The Provider will develop and maintain effective, relevant and appropriate policies and procedures which shall be reviewed regularly.

29.8 As it will provide public functions, the Provider will have duties under the Equality Act 2010 and the Freedom of Information Act as well as safeguarding responsibilities when its staff and members come into contact with vulnerable adults and children.

30 Performance management, monitoring and reporting

30.1 The Provider shall put in place robust performance management arrangements and use these to assure its quality. The Council will work with the Provider to measure what really matters and set proportionate contract measures that can be adapted over the course of the contract to ensure they stay relevant. The Provider will be required to provide the monitoring information detailed in Appendix 1 and complete a comprehensive monitoring spreadsheet in a format agreed with the commissioner.

30.2 The Provider shall be required to collect and report quantitative and qualitative monitoring data analysing performance on a quarterly basis to the Commissioner.

30.3 The Provider will ensure it is able to demonstrate delivery of the commissioned outcomes in Section 6, by collecting feedback from Service Users on how far they feel they have met the specified outcomes.

30.4 The Provider shall deliver the Services to achieve the following Key Performance Indicators:

30.4.1 90% of cases will have an advocate allocated within the specified timeframe;

30.4.2 80% of Service Users will report being satisfied, very satisfied or extremely satisfied with the Service;

30.4.3 100% of monitoring returns shall be completed accurately and submitted on time;

30.4.4 90% of social care and health complaints cases result in a satisfactory outcome;

30.4.5 90% of IMCA reports are considered by the IMCA Manager to be in time for the decision maker to consider.

30.5 The Provider shall co-operate with any request from the Council to identify additional Key Performance Indicators throughout the contract period.

31 Annual Review

31.1 The Provider will be directly accountable for its operations (and any agreed subcontracted activity) and performance against the Specification and Contract. The Provider shall undertake an annual self-assessment of its compliance with all parts of the Contract and any service improvement plans that may be in place. This will be in addition to the contract monitoring requirements for the contract.

31.2 Each year, and separate to the quarterly monitoring process, the Provider will submit an annual report including:

31.2.1 A quantification and description of the activities of the last year;
31.2.2 A profile of the relevant Protected Characteristics of the individuals concerned;
31.2.3 A summary of the individual issues raised and outcomes;
31.2.4 A summary of any collective issues;
31.2.5 Evidence of, and reflection on, service achievements;
31.2.6 Compliance with all parts of the service specification;
31.2.7 Report of annual accounts.

31.3 The annual review meeting will include a review of compliance. The process will include formal discussion of the report between the Commissioner and the Provider.

31.4 Reporting on the delivery of supervision, uptake of the service and the generation of individual personal development plans will form part of the reporting requirement annually within the last quarter contract monitoring meeting.

Service 1: Independent Care Act Advocacy

1 Introduction

1.1 This section sets out requirements for the provision of Independent Care Act Advocacy (ICAA) to meet Bath & North East Somerset Council's (the Council) duties under the Care Act (2014). It should be read in conjunction with the earlier section 'General Requirements - Independent Health and Social Care Advocacy' which sets out core requirements of all services within the Independent Health and Social Care Advocacy ("Adults") contract, including ICAA.

1.2 The Care Act 2014, and associated regulations, requires local authorities to actively promote individual wellbeing and to involve people, as active partners, in preventing, delaying and reducing their need for care and support or where there are any enquiries in relation to abuse or neglect.

1.3 No matter how complex a person's needs, local authorities are required to involve people in the key care and support processes of assessment, care and support planning and review and to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions.

1.4 The Care Act 2014 recognises the growing evidence that some people benefit from independent and peer support to help them through these processes and that an independent advocate can support them to think and articulate their own needs and the outcomes they want.

1.5 The Council will ensure that anyone who would have substantial difficulty in being involved in assessment or developing or revising a plan, or in safeguarding processes (including Safeguarding Adult Reviews) is supported and represented, either by:

1.5.1 an 'Appropriate Person' such as a family member or friend provided that the Council agrees that they are a suitable person for the role, or

1.5.2 an independent advocate arranged by the Council.

1.6 The aim of the ICAA Service, therefore, is to provide independent advocacy to those who have 'substantial difficulty' in being involved in social care processes and who have no Appropriate Person to support and represent them. It will work closely with the other advocacy services in this contract to provide a joined up and seamless service which is focussed on the needs of the individuals.

1.7 This specification also includes provision of information to support people wishing to act as 'appropriate individuals.

2 Eligibility for ICAA Service

2.1 Eligibility for ICAA is based on the requirements of the Care Act 2014 which are:

2.1.1 having a 'substantial difficulty' being involved in adult social care and support processes, including safeguarding, and

2.1.2 having no one appropriate or available to support and represent them.

2.2 The meaning of 'substantial difficulty' is set out in the Care and Support Statutory Guidance and means having a difficulty in any one or more of the following:

2.2.1 understanding relevant information;

2.2.2 retaining information;

2.2.3 Using or weighing the information as part of engaging; and/or

2.2.4 communicating their views, wishes or feelings.

2.3 The Council will determine whether there is an Appropriate Person who can support an individual.

2.4 The duty to involve applies in all settings, including for those people living in the community, in care homes or, apart from safeguarding enquiries and SARs. The Care Act requirements around advocacy also apply to the following:

2.4.1 When a carer's assessment is carried out

2.4.2 Children who are approaching the transition to adult care and support, when a child's needs assessment is carried out,

2.4.3 When a child's carer's assessment is undertaken (therefore some people below 16 years of age)

2.4.4 When a young carers assessment is carried out

2.5 The provision of ICAA applies equally to those people whose needs are being jointly assessed by the NHS and the Council or where a package of support is planned, commissioned or funded by both the Council and a Clinical Commissioning Group (CCG) (a 'joint package' of care).

Combined assessments

2.6 Two people whose needs are to be assessed in a combined assessment may each qualify for an independent advocate. The same advocate may support and represent both individuals provided that the Council is satisfied that:

2.6.1 both people consent to the arrangement, and

2.6.2 there is no conflict of interest between:

2.6.3 either of the two people, or

2.6.4 the independent advocate and either person.

Mental Health

2.7 The Provider will ensure that where individuals who do not retain a right to an Independent Mental Health Advocate (IMHA) and whose care and support needs are being assessed, planned or reviewed shall be considered for an advocate under the Care Act, if they have substantial difficulty in being involved and there is no Appropriate Person to support their involvement.

Mental Capacity

2.8 People who lack capacity who qualify for an IMCA are also likely to qualify for ICAA. In this situation, the Provider will appoint a single advocate to support and represent the person provided that it is satisfied that the advocate can fulfil the requirements of both the Care Act and the Mental Capacity Act.

Provision of advocates when there is an appropriate person

2.9 There are two exceptions in the Care Act (2014) for the provision of an Independent Advocate where there is an Appropriate Person able to facilitate active involvement. If it is deemed within the best interests of an individual who is likely to have substantial difficulty in being involved in key social care and safeguarding processes, the Council will arrange an independent advocate to work in partnership with the person when:

2.9.1 it is likely that an individual will be placed in NHS- funded provision in a hospital for a period of four weeks or more (including places like assessment and treatment units) or a care home for a period of eight (8) weeks or more (Regulation 4)

2.9.2 in circumstances where the Council and the Appropriate Person cannot agree on something fundamental to the individual - and both parties agree that it would be in the best interests of the person to have an IA (Regulation 4).

2.10 The Provider shall support and provide self-help materials to individuals who wish to support a person whom the Council considers to have a ‘substantial difficulty’ in being involved in social care processes, including safeguarding.

Ordinary residence

2.11 The statutory guidance states that it is the local authority which is carrying out the assessment; planning or review of the plan which is responsible for considering whether an advocate is required. In the case of a person who is receiving care and support from one local authority and decides to move and live in another authority, the responsibility will move with the care and support assessment (see chapter 20). For a person whose care and support is being provided out of area (in a type of accommodation set out in the section on ordinary residence (see chapter 19)) it will be the authority in which the person is ordinarily resident that will retain responsibility. Understanding of local communities may be an important

consideration, so the advocate should wherever possible be from the area where the person is resident at the time of the assessment, planning or review.

2.12 The Provider shall follow relevant Council's policies[2] in relation to the appointment of an ICAA:

2.12.1 from advocacy services out of their area that they may not have a direct commissioning relationship with (as it currently is with Independent Mental Capacity Advocate (IMCA));

2.12.2 for people placed out of area temporarily;

2.12.3 for people who move from one area to another following an assessment and care and support planning in which an advocate is involved (the same advocate should be involved wherever practicable).

3 Pathways, referrals and access

3.1 This section is to be read in conjunction with Paragraph 11 of the earlier section, 'General Requirements - Independent Health and Social Care Advocacy'.

3.2 There is an expectation that a response time shall be proportionate to the situation. In order to facilitate safe discharge from hospital, requests from hospitals shall receive a faster response.

3.2.1 For Safeguarding referrals there is the expectation that the advocates will be allocated and have met with the individuals within 4 working days of the referral.

3.2.2 For Social Care Assessments it is expected that the advocate will be allocated within 2 working days and the Service User contacted to arrange the first meeting.

3.3 All receipt of referrals will be acknowledged within 2 working hours.

3.4 The provider shall ensure appropriate processes are in place so that the individual will report a positive experience and the Council's staff are kept informed at all stages of the process.

3.5 The Council will consider and decide whether there is an Appropriate Person who can facilitate a person's involvement in the specified processes prior to making a decision to refer for ICAA:

3.5.1 Where a person is likely to have substantial difficulty in being involved in key social care and safeguarding processes but no one appropriate and willing to involve them the Council will refer the individual for ICAA.

[2] https://www.bathnes.gov.uk/services/care-and-support-and-you/professionals-and-practitioners

3.5.2 When someone is willing and is suitable to act as an Appropriate Person the Council may refer the individual to the ICAA for information to support them in this role.

3.6 It is the Council's responsibility to identify eligibility for Independent Care Act Advocacy. When referrals for ICAA are received from sources other than the Council the Provider will notify the Council's adult social care service (which for the avoidance of doubt are delivered by Virgin Care Ltd and Avon & Wiltshire Partnership Trust) and the Council will then determine whether that person is eligible for an ICAA. They will notify the Council when that involvement ends.

3.7 The Provider shall manage the pathway so that eligible individuals benefit from one advocate for their whole experience of care or safeguarding work. The Provider will work with the Council to track individuals' journeys' through their personal care pathways in order to allocate advocates efficiently and to avoid the unnecessary opening and closing of cases, forming of new relationships and duplication in information collection. Where individuals are eligible for both ICAA and IMCA, the service shall appoint advocates who are qualified to act under both the Care Act and the Mental Capacity Act.

3.8 Advocates shall not remain involved with individuals who cease to be eligible or no longer need a service. If appropriate, the service shall facilitate signposting to other agencies who are able to offer appropriate support to the individual. If appropriate, referrals will be made back to the MASH in order for alternative arrangements to be considered.

3.9 The service will work with the Council and other partners to develop self-help materials for individuals acting as Appropriate Persons.

4 Principles of the service

4.1 The Care Act is underpinned by the principles of wellbeing and prevention. In addition to the principles set out earlier, this service will:

4.1.1 help eligible individuals to express their views, needs, wishes, feelings and beliefs;
4.1.2 assume they are the best judge of their own wellbeing;
4.1.3 ensure they can participate as fully as possible in decisions about their care;
4.1.4 not make unjustified assumptions based on their age, appearance and behaviour;
4.1.5 involve them in decisions made about them and their care and support; and
4.1.6 ensure that they get the care and support they are entitled to.

5 Service description

5.1 The Provider will ensure that all relevant statutory obligations are met along with the additional requirements set out below.

5.2 The Council will consider and decide whether there is an Appropriate Person who can facilitate a person's involvement in the assessment, planning or review process prior to making a decision to refer for ICAA. It is the responsibility of the Council to identify individuals who are eligible for Independent Care Act Advocacy and make a referral to the service.

5.3 The Provider shall ensure that suitably qualified and experienced independent advocates support and represent the Service User in the care and support planning and the review. The Provider shall provide one advocate who is able to provide a person-centred service by following the individual through their care pathway.

5.4 This applies to the following:

- 5.4.1 A needs assessment under section 9 of the Care Act
- 5.4.2 A carers assessment under section 10
- 5.4.3 The preparation of a care and support plan or support plan under section 25
- 5.4.4 A review of a care and support plan or support plan under section 27
- 5.4.5 A child's needs assessment under section 58
- 5.4.6 A child's carers assessment under section 60 (therefore some people below 16 years of age)
- 5.4.7 A young carer's assessment under section 63
- 5.4.8 Safeguarding under section 68

5.5 For clarity, advocacy provided under number 5.4.3 above will include advocacy in relation to the financial assessment, where one takes place as a part of care and support planning.

5.6 In addition to this, the service will contribute to delivering the Council's commitment to promoting independence and active communities by enabling individuals to feel confident and competent at when acting as Appropriate Persons. It will provide support and self-help resources to those who wish to act as an Appropriate Person in order to facilitate a person's involvement in the assessment, planning or review process.

5.7 The role of the independent advocate in relation to the Care Act requirements is to support and represent the person, always with regard to their wellbeing and interests, including assisting a person to:

- 5.7.1 understand the assessment, care planning and review process and safeguarding. This requires advocates to understand local authority policies and processes, and other agencies roles, and processes, the available assessment tools, the planning options, and the options available at the review of a care or support plan and good practice in safeguarding enquiries and SARs. It may involve advocates spending considerable time with the individual, considering their

communication requirements, their wishes and feelings and their life story, and using all this to assist the individual to be involved and where possible to make decisions.

5.7.2 communicate their wishes, views and feelings to the staff who are carrying out an assessment or developing a care or support plan or reviewing an existing plan or to communicate their views, wishes and feelings to the staff who are carrying out safeguarding enquiries or reviews.

5.7.3 understand how their needs can be met by the local authority or otherwise understanding for example how a care and support and support plan can be personalised, how it can be tailored to meet specific needs, how it can be creative, inclusive, and how it can be used to promote a person's rights to liberty and family life.

5.7.4 make decisions about their care and support arrangements. The advocate will assist the person to weigh up various care and support options and to choose the ones that best meet the person's needs and wishes.

5.7.5 understand their rights under the Care Act – for an assessment which considers their wishes and feelings and which considers the views of other people; their right to have their eligible needs met, and to have a care or support plan that reflects their needs and preferences, and in relation to safeguarding, understand their right to have their concerns about abuse taken seriously and responded to appropriately. Also assisting the person to understand their wider rights, including their rights to liberty and family life. A person's rights are complemented by the local authority's duties, for example, to involve the person, to meet needs in a way that is least restrictive of a person's rights.

5.7.6 challenge a decision or process made by the local authority; and where a person cannot challenge the decision even with assistance, then to challenge it on their behalf.

5.8 In terms of safeguarding there are some particular important issues for advocates to address. These include assisting a person to:

5.8.1 decide what outcomes/changes they want

5.8.2 understand the behaviour of others that are abusive /neglectful

5.8.3 understand which actions of their own may expose them to avoidable abuse or neglect

5.8.4 understand what actions that they can take to safeguard themselves

5.8.5 understand what advice and help they can expect from others, including the criminal justice system

5.8.6 understand what parts of the process are completely or partially within their control

5.8.7 explain what help they want to avoid reoccurrence and also recover from the experience

Mental Capacity

5.9 The Provider will have in place policies that address the delivery of non-instructed advocacy for adults who lack competence or capacity to instruct.

6 Liaison between professional parties

6.1 In addition to the requirements expected of all advocacy services, which are set out above, the Provider will liaise proactively with the relevant organisations in order to facilitate the individual's journey through the care and support process. There can be many different contributory reasons for time needed for this journey; this service is expected not to add further delay to resolution as a result of its actions or manner of working.

7 Geographical coverage/boundaries

7.1 Independent Care Act Advocates may be required to visit a person placed outside Bath and North East Somerset who retains Ordinary Residence in Bath and North East Somerset if considered appropriate and prior permission is obtained from the Council.

8 Days and Hours of Operation

8.1 The ICCA Service shall be available for referrals and delivery of service between 9am – 5pm, every working day.

8.2 The service may need to be available outside of these hours only with prior agreement with the Council to meet the needs of the service.

8.3 There is an expectation that a response time shall be proportionate to the urgency of the situation, for example to facilitate safe hospital discharge, requests from hospitals shall receive a faster response.

9 Resources

Staffing

9.1 In addition to the requirements set out above, the Provider is required to:

9.1.1 provide sufficient trained advocates to support and represent the person and to facilitate their involvement in the key processes and interactions with the Council and other organisations as required for the safeguarding enquiry or SAR.

9.1.2 ensure its advocates meet the requirements of the Care Act as to their suitability, skills, competencies and level of training.

Training requirements

9.2 In addition to the requirements set out above, it is the responsibility of the Provider to check that any Staff and unpaid volunteers who are used in the scope of the service undertake the required training to act as an Independent Care Act Advocate meet the legal appointment requirements on training, clearance checks and independence. The failure to do so will be regarded as a breach of contract and will be subject to immediate review by the Council which could result in the withdrawal or suspension of the service.

10 Background

National context and statutory advocacy duties:

10.1 The statutory requirements are set out in Sections 67 and 68 of the Care Act 2014, section 7 of the Care and Support Statutory Guidance, and the Care and Support (Independent Advocacy) Regulations 2014.

10.2 Paragraph 7.4 of the Care and Support Statutory Guidance[3], explains that all local authorities have a duty to arrange "an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of the care plan, as well as in safeguarding enquiries and Safeguarding Adult Reviews (SARs) if 2 conditions are met. That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes, and second, there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer."

10.3 The regulations intend that advocates will decide the best way of supporting and representing the person they are advocating for, always with regard to the wellbeing and interest (including their views, beliefs and wishes) of the person concerned.

10.4 Statutory duties for the local authorities within the Care Act (2014) have expanded and dove tailed with current legislation including the Mental Capacity Act (2005) and the Mental Health Act (1983 as amended 2007). Therefore the Care Act (2014) does not supersede this legislation but increases duties on the local authorities to ensure all persons who would experience substantial difficulty and who would have no other Appropriate Person to support them through NHS and Local Authority Services, have an independent advocate. This is from point of referral through to their assessment and their journey across adult social care and through into NHS Continuing Health Care (CHC) (where relevant).

10.5 This service will work closely with the other advocacy services that meet the Council's duties under the Mental Capacity Act 2005, the Mental Health Act 2007 and the Health and Social Care Act 2012.

Local context

10.6 The Council expects that there will be a small number of people who will be eligible for both an Independent Care Act Advocate and another statutory advocate in certain circumstances, such as an Independent Mental Capacity Advocate. The Provider shall provide one advocate who is able to provide a person-centred service by following the individual

[3] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance. Accessed 5th August 2019

through their care pathway. The advocate shall meet the requirements of the legislation appropriate to the advocacy provision.

Service 2: Independent Social Care Complaints Advocacy

1 Introduction

1.1 This section sets out Bath and North East Somerset Council (the council) additional requirements for the provision of the Independent Social Care Complaints Advocacy service.

1.2 This service is part of a wider contract for the provision of advocacy for adults and should be read in conjunction with the earlier section 'General Requirements - Independent Health and Social Care Advocacy' which sets out core requirements of all services within the contract.

1.3 Whilst local authorities do not have a statutory duty to provide independent advocacy for individuals wishing to complain about adult social care services, the Council wishes to exercise its discretion to provide an independent complaints advocacy for those individuals who require it.

2 Eligibility for Independent Social Care Complaints Advocacy Service

2.1 The service will be provided to:

2.1.1 A person who receives or has received social care services from Bath & North East Somerset Council or service commissioned by the Local Authority; or

2.1.1.1 A person who is affected, or likely to be affected, by the action, omission or decision of the service which is subject of the complaint.

2.2 The provider will develop a triage protocol for prioritizing the allocation of advocacy resource. This will be based on people's ability to access the complaints procedure and will consider:

2.2.1 Language barriers
2.2.2 Cognitive impairment
2.2.3 Complexity of case
2.2.4 Availability of other support

2.3 The service shall have a policy for the management of persistent and unreasonable complainants.

3 Pathways, referrals and access

3.1 This section is to be read in conjunction with Paragraph 11 of the earlier section, 'General Requirements - Independent Health and Social Care Advocacy'.

3.2 Referrals to the service will be accepted from the Service User themselves or a third party making a complaint on the Service Users behalf.

3.3 The Provider must acknowledge receipt of the referral with the referrer within 2 working hours.

3.4 The Provider must have a process in place to determine whether they can accept the referral and then allocate an advocate within 10 working days of acknowledging the referral.

4 Principles of the service

4.1 This specification sets out the required provision for the Independent Social Care Complaints Advocacy Service to support people who wish to make a complaint about services commissioned and/or provided by the local authority.

4.2 A person may wish to make a complaint about any aspect of the way a local authority uses its powers under the Care Act. A local authority must therefore make clear what its complaints procedure is and provide

information and advice on how to lodge a complaint and set out details of how to contact the Local Government Ombudsman.

4.3 Current legislation states that local authority social services must ensure that information and advice is provided on: how to complain or make a formal appeal to the authority, what they involve and when independent advocacy should be provided and be widely available.

4.4 The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority must make its own arrangements for dealing with complaints in accordance with legislation and ensure that those who make complaints receive, as far as reasonably practicable, assistance to enable

them to understand the complaints procedure or advice on where to obtain such assistance.

4.5 The service will enable eligible people living in Bath and North East Somerset to have access both to information about how to make a complaint about social services and the potential of support to make one.

4 Service description

5.1 The role of the Advocate is to empower and assist people to go through the relevant complaints procedure. To do this the Provider(s) will focus on providing support at each of the following points or activities:

5.1.1 Identifying what the available options and possible outcomes are, and deciding which option to take;
5.1.2 Making the complaint to the appropriate organisation(s);
5.1.3 Deciding how to proceed with the complaint, following the initial response;
5.1.4 Completing the local resolution phase by attending meetings or entering into correct correspondence;
5.1.5 Making a complaint to the Ombudsman; and
5.1.6 Understanding the Ombudsman's final decision.

5.2 The Provider(s) will ensure that they issue clear guidance for referrals to the service. This guidance shall address referrals made in person, as well as those made via other routes.

5.3 Service Users will be associated with a wide range of personal, social, economic and health issues. The service will need to be a flexible and responsive to meet diverse needs.

5.4 The Provider(s) will be required to communicate in the most appropriate method, such as use of language translation service, or materials in various formats, as appropriate.

5.5 The Provider(s) shall be able to offer specialist knowledge, or skills that would allow them to support people with more complex needs, such as those suffering with mental health needs, those with learning disabilities,

communication difficulties, sight or hearing impairment or people without English as their first language.

5.6 The Provider(s) is required to promote understanding and awareness about the Service to NHS and social care staff, voluntary and community sector organisations and the public to facilitate access to the service.

5.7 The Provider(s) will work closely with Bath and North East Somerset complaints officers, and with Health Watch, to provide feedback on trends of complaints.

5.8 The Provider(s) will provide a number of different services, including:

5.8.1 explaining how the complaints process work;
5.8.2 providing self-help packs;
5.8.3 signposting to more appropriate organisations where appropriate;
5.8.4 helping people understand and write letters;
5.8.5 telephone advice;
5.8.6 face to face meetings;
5.8.7 research in support of individual cases and
5.8.8 support at meetings relating to the complaint.

6 Liaison between professional parties

6.1 The provider will ensure that advocates receive training on the social services complaints procedure and that they liaise with the Bath and North East Somerset Complaints Manager to ensure there is a consistent approach to the handling of complaints.

7 Geographical coverage/boundaries

7.1 Independent Social Care Complaints Advocacy will be provided for eligible people who wish to make a complaint about services commissioned and/or provided by Bath and North East Somerset local authority, irrespective of their place of residence.

8 Days and Hours of Operation

8.1 The Independent Social Care Complaints Advocacy Service shall be available for referrals and delivery of service between 9am – 5pm, every working day.

Service 3: Independent Mental Capacity Advocacy

1 Introduction

1.1 This section sets out Bath & North East Somerset Council's (the Council) additional requirements for the provision of the Independent Mental Capacity Advocacy Service, referred to as the IMCA Service.

1.2 This service is part of a wider contract for the provision of advocacy for adults and should be read in conjunction with the earlier section 'General Requirements - Independent Health and Social Care Advocacy' which sets out core requirements of all services within the contract.

2 Eligibility for IMCA Service

2.1 The IMCA Service must be a generic service, for a wide variety of people who have an impairment of the mind and /or brain such as learning disabilities, dementia, acquired brain injury and mental health needs, and other conditions leading to a lack of mental capacity. The service shall provide high quality 'non-instructed' advocacy for individuals, who may have a variety of communication needs.

2.2 The people who will be referred to the IMCA Service will be those who:

2.2.1 have been formally assessed as lacking capacity, in line with the provisions of the Mental Capacity Act 2005 and Code Of Practice, in relation to one of the decisions or acts described in 2.3 below and have no appointed Deputy, no-one who has Lasting Power of Attorney for them and no-one close to them who it would be appropriate to consult, other than people engaged in their care or treatment in a professional or paid capacity

2.2.2 have been formally assessed as lacking capacity, in line with the provisions of the Mental Capacity Act 2005 and Code of Practice, in relation to one of the decisions or acts described in paragraph 2.3 below, or are the subject of an application under the provisions of the Deprivation of Liberty Safeguards or Liberty Protection Safeguards

2.3 The IMCA service must provide decision specific advocacy around circumstances where eligible individuals are required to make decisions:

2.3.1 Where an NHS body is proposing serious medical treatment

2.3.2 Where an NHS body is proposing to provide hospital accommodation for more than 28 days.

2.3.3 Where an NHS body is proposing to change a person's accommodation to another hospital or care home for more than 28 days.

2.3.4 Where a Local Authority proposes to provide residential accommodation for more than 8 weeks.

2.3.5 Where a Local Authority proposes to change residential accommodation for more than 8 weeks.

2.4 A Local Authority or an NHS body shall also have a duty to consider instructing an IMCA in appropriate accommodation reviews and Safeguarding cases.

2.5 A Local Authority or NHS body shall also, in appropriate circumstances, be required to instruct an IMCA to represent and support Service Users when considering applications for deprivation of liberty authorisations and for the duration of the DoLS or LPS Authorisation as per the legislation, Code of Practice and other statutory guidance.

2.6 The Provider shall reference the Deprivation of Liberty Safeguards Code of Practice issued as a supplement to the Mental Capacity Act 2005 Code of Practice. This provides a detailed outline of the role and responsibilities of the IMCA in the application for a Deprivation of Liberty order. In case of any ambiguity in this specification, the current version of the Mental Capacity Act Code of Practice shall have precedence. Additional duties to be agreed, dependent on the revisions of the Code of Practice and legislation.

2.7 A Paid RPR must be appointed where the best interest assessor is unable to recommend a person to act as the relevant person's representative. The supervisory body must then appoint someone to perform this role in a professional capacity – the Paid Relevant Person's Representative, which may be the Advocacy Service.

2.8 Adults who have the capacity to make their own decisions or have family/ friends to represent their best interest are not eligible for this service.

3 Pathways, referrals and access

3.1 This section is to be read in conjunction with Paragraph 11 of the earlier section, 'General Requirements - Independent Health and Social Care Advocacy'.

3.2 The Provider must acknowledge receipt of the referral with the referrer within 2 working hours.

3.3 It is expected that the service will contact the referrer to discuss the urgency of the situation within 3 working days unless it is an urgent request, in which case the referrer will make this clear on the referral.

3.4 There is an expectation that a response time shall be proportionate to the urgency of the situation, for example to facilitate safe hospital discharge,

requests from hospitals shall receive a faster response. We determine that an ‘urgent’ case shall be dealt with within a period of 24 hours.

3.5 The Provider shall work with the Council and NHS Trusts to ensure that effective, efficient and appropriate processes and systems are in place for the delivery of a streamlined service. When mobilising this contract, the Provider shall work with the Council to develop the pathway through the service so that the service and referrers are able to fulfil their respective duties in a timely manner for the benefit of the individuals in need of an IMCA or RPR.

3.6 Referrals will be made by a number of local authority and health staff including doctors and nurses providing serious medical treatment and Social Workers arranging hospital discharges, as well as Social Workers and Care Managers planning long-term accommodation moves.

3.7 Referrals to the IMCA Service will also be made by local authority and health staff, when carrying out the responsibilities of supervisory bodies in respect of the Deprivation of Liberty Safeguards or Liberty Protection Safeguards when they come in effect.

3.8 The IMCA Service is required to verify that the instruction was made by an Authorised Person. In checking whether the instruction was made by an Authorised Person, the IMCA Service is required to check that the reason for an instruction falls within the scope of this specification. Once provided with an authorised instruction, the IMCA Service must be provided unless the instruction is withdrawn by the authorised person.

Duties of the IMCA Referrer

3.9 In relation to duties covered in the main Code of Practice, the referrer is under a statutory duty to consult the IMCA and make sure that the particular decision-maker or person proposing to take the action in question takes account of the information provided and submissions made by the IMCA in determining the best interests of the person concerned.

3.10 In relation to the Deprivation of Liberty Safeguards, the relevant supervisory body is responsible for instructing the IMCA and for taking account of the information provided and their submissions in these circumstances.

3.11 In order to comply with these duties, the referrer must have in place procedures to ensure that:

3.11.1 All relevant staff are aware of the particular situations requiring an IMCA.
3.11.2 All relevant staff are aware to access IMCA services
3.11.3 All reasonable requests for information or access to relevant personal records made by IMCAs in carrying out their duties under the Act are complied with
3.11.4 Proper records are made of the involvement of an IMCA and of the advice and representations made by the IMCA
3.11.5 Proper records are made by the person proposing the decision or action as to how the IMCAs advice has been taken into account and, where relevant, his/her reasons for disagreeing with or ignoring that advice.
3.11.6 Where a disagreement arises between the IMCA and anyone employed by or acting on behalf of the referrer, every effort must be made to resolve the disagreement at the earliest possible stage, where necessary using the authority's dispute resolution or the Provider's complaints procedures.

4 Service description

4.1 The aim is to provide an IMCA Service to people as specified by the Mental Capacity Act 2005 and The Deprivation of Liberty Safeguards (DoLS) 2009. The service will be required to adapt and allow for the changes introduced to statutory IMCA provision via the Mental Capacity Act amendment bill (2019 and in line with any amendments and updates to local policies and procedures.

4.2 The purpose of the statutory IMCA Service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted. IMCAs must be independent.

4.3 The service also involves providing the Deprivation of Liberty Service (DoLS) and Paid Relevant Person's Representative (RPR) services until such time as the legislation changes. The RPR plays an important role in providing the person with representation and support that is independent.

4.4 IMCAs shall provide representation and support for particularly vulnerable people who lack capacity and who are facing important decisions about serious life changing situations.

4.5 The service must understand that mental capacity is broad and relates to many diverse groups of people. It requires skills in communicating in non-standard ways, for example with people who have no spoken language. It requires a holistic approach to working with people, not relying on their 'instructions' but on an assessment of their rights and needs.

4.6 Under section 42(4) (d) of the Mental Capacity Act 2005, IMCAs are required to have regard to any relevant guidance in the Code of Practice

and the Deprivation of Liberty Safeguards supplement to the Code of Practice when carrying out their functions:

4.6.1 Representing and supporting the person who lacks capacity, so that the person may participate as far as possible in any relevant decision;

4.6.2 Obtaining and evaluating information;

4.6.3 As far as possible, ascertaining the person's wishes and feelings, beliefs and values, or what these would be likely to be;

4.6.4 Ascertaining alternative courses of action – for example, looking at different care arrangements or residential homes;

4.6.5 Obtaining a further medical opinion, if necessary;

4.6.6 Making submissions to the Supervisory Body or any assessor under Deprivation of Liberty safeguards procedures as necessary;

4.6.7 Assisting the relevant individual and their representative to understand the effect of a Deprivation of Liberty Authorisation; and

4.6.8 Assisting the relevant individual and their representative to apply for a review of a Deprivation of Liberty Authorisation or application to the

Court of Protection.

4.7 In order to carry out these functions, IMCAs shall:

- 4.7.1 investigate the particular circumstances of the vulnerable person;
- 4.7.2 consider whether the principles set out in Section 1 of the Mental Capacity Act 2005 have been complied with;
- 4.7.3 consider the factors as set out in the statutory 'best interests check list';
- 4.7.4 take account of any relevant guidance in the Code of Practice and the Deprivation of Liberty Safeguards supplement to the Code of Practice;
- 4.7.5 have a right to meet in private the person they are supporting;
- 4.7.6 be allowed access to relevant healthcare records and social care records
- 4.7.7 provide support and representation specifically while the decision is being made;
- 4.7.8 act quickly so their report can form part of decision-making and will be flexible & responsive to changes in person's situation.

4.8 The views expressed by advocates on behalf of people who lack mental capacity will be made in a manner that safeguards the individuals' rights, dignity and privacy and respects them and their individuality.

DoLS Types of Referrals

4.9 The Deprivation of Liberty Safeguards (DoLS) introduced a number of new roles for IMCAs. The service shall provide sufficient advocates to carry out the roles required by 39A, 39C and 39D.

The Role of an RPR

4.10 One of the key safeguards for people who are deprived of their liberty under DoLS is the appointment of an RPR. The RPR is there to represent the wishes and feelings of the person who is subject to the deprivation of liberty. It is important to recognise that this may be different from representing the best interests of the person. This can sometimes be a difficult distinction to make.

4.11 As an unpaid RPR may often be a family member their natural instinct may be to do what they believe to be best for the person who lacks capacity, but this may be at odds with the person's stated wishes. This is particularly important in relation to appealing against a DoLS authorisation. Like everyone else, a person who lacks capacity has a right to have their appeal heard and the RPR has to enable them to do that – even if they don't agree with the appeal.

4.12 If an unpaid RPR feels that they are unable to fully fulfil their role then they can request an IMCA to support them (39D) or ask that another RPR is appointed.

4.13 An IMCA must be instructed as soon as an application for DOL authorisation is made, if the relevant person does not have family / friends or anyone else to consult with. An IMCA may be instructed at any time during the process where:

4.13.1 the relevant person does not have a paid professional representative

4.13.2 6.14.2 the relevant person or their unpaid RPR (family or other unpaid carers) requests that an IMCA is instructed to help them

4.13.3 the Supervisory Body believes that instructing an IMCA Will help to ensure that the person's rights are protected.

4.13.4 An IMCA must be instructed during gaps in the appointment of a RPR.

4.14 Once a standard DoLS authorisation has been given, the Supervisory Body must appoint the RPR as soon as possible to represent the person who has been deprived of their liberty. If neither the relevant person or a donee or deputy selects an eligible person and the Best Interests Assessor is unable to recommend anyone, the Supervisory Body must identify an eligible person often via the commissioned IMCA Service.

4.15 The DoLS are soon to be replaced by the Liberty Protection Safeguards (LPS) therefore the requirements noted above will be amended in accordance with the Mental Capacity (Amendment) Act 2019. The Code of Practice and Regulations will clarify the IMCA roles further, but there will continue to be a requirement for an IMCA to be involved during an assessment for LPS and in the replacement RPR role of Appropriate Person. It is therefore expected that the service will be able to meet the requirements of the new legislation.

5 Liaison between professional parties

5.1 In addition to the requirements expected of all advocacy services, which are set out in the earlier section 'General Requirements - Independent Health and Social Care Advocacy', the Provider will liaise proactively with the relevant organisations in order to facilitate the individual's journey through the care and support process. There can be many different contributory reasons for time needed for this journey; this service is expected not to add further delay to resolution as a result of its actions or manner of working.

5.2 The IMCA Service shall work in partnership with other agencies, whether they be statutory, independent or voluntary. This will include hospital discharge staff, doctors, nurses, social workers, care managers, and managers of care homes. It must assist those staff and service managers who are likely to refer people to the Service, to understand the role of IMCAs and how and when it is appropriate to access the Service.

6 Geographical coverage / boundaries

6.1 The IMCA Service will be delivered within Bath & North East Somerset Council's geographical boundaries.

6.2 The IMCA Service is to be available for anyone resident or in hospital in the Bath & North East Somerset area (wherever the decision is to be made).

6.3 The Local Authority in which the relevant person's placement is located is responsible for providing an IMCA service when required. This is the position irrespective of whether the relevant person's ordinary residence is elsewhere or the relevant person is placed in a care home or hospital.

6.4 In exceptional circumstances, the Council may require the Provider to deliver a service to an individual located outside of the county. This will only be on prior agreement with the Council.

6.5 The provision of Paid Reps under the Deprivation of Liberty Safeguards is commissioned by the Local Authority of where the person is considered to be Ordinarily Resident or deemed Ordinarily Resident. This service may therefore be requested for residents who live outside of the Bath and North East Somerset area.

7 Days and Hours of Operation

7.1 The IMCA Service shall be available for referrals and delivery of service between 9am – 5pm, every working day.

7.2 The IMCA Service may need to be available outside of these hours only with prior agreement with the Council to meet the needs of the service.

8 Resources

Staffing

8.1 In addition to the requirements set out in the earlier section 'General Requirements - Independent Health and Social Care Advocacy', above the Provider is required to provide sufficient trained and experienced advocates and RPRs to deliver this specification.

8.2 The Provider shall ensure maximum flexibility in the services delivered and may consider the use of full and part time IMCAs. A number of part time IMCA's (who may combine the specialist IMCA role with other forms of advocacy) may provide a more flexible Service than full time IMCA's.

Training Requirements

8.3 In addition to the requirements set out in the earlier section ‘General Requirements - Independent Health and Social Care Advocacy’, it is the responsibility of the Provider to check and ensure that any Staff made available to act as an IMCA or RPR meet the legal appointment requirements on training, clearance checks and independence. The failure to do so will be regarded as a breach of contract and will be subject to immediate review by the Council which could result in the withdrawal or suspension of the service.

8.4 There are 6 capabilities that IMCAs are expected to evidence on an on-going basis via Continued Professional Development (CPD). These are set out below:

8.4.1 **Key capability 1**: The ability to have a sound understanding of, and keep up-to-date with the MCA, DoLS and other relevant legislative frameworks and relevant case law

8.4.2 **Key capability 2**: The ability to work in a manner that promotes the MCA and the rights of those who may be affected by the MCA

8.4.3 **Key capability 3**: The ability to have a sound understanding of capacity assessments, best practice and creative assessments and the ability to challenge capacity assessments in an appropriate and outcome focused manner when relevant to do so

8.4.4 **Key capability 4**: The ability to promote supported decision making for those who lack capacity: i.e. ensuring decisions made on behalf of those who lack capacity start from the point of view of the person and not the opinions of those in control of making those decisions

8.4.5 **Key capability 5**: The ability to deliver high quality instructed and non-instructed advocacy when carrying out the IMCA roles: namely:

8.4.5.1 Change of accommodation

8.4.5.2 Serious medical treatment

8.4.5.3 Care reviews

8.4.5.4 Adult protection

8.4.5.5 s.39A

8.4.6 **Key capability 6**: Additional safeguard i.e. challenging decisions formally and informally

8.5 It is imperative that IMCAs continue to develop their skills and knowledge and remain up-to-date with case law, legislative changes and best practice guidance. Continued professional development is required to ensure IMCAs progress in their skill and knowledge development and remain an effective advocate for those people who require their support. IMCA practitioners will therefore be required to complete yearly CPD.

9 Outcomes

9.1 In addition to demonstrating the successful delivery of the specification through the outcomes listed in the earlier section ‘General Requirements - Independent Health and Social Care Advocacy’; the Provider shall demonstrate that its IMCAs have made a difference in the following areas:

9.1.1 How the person was involved in the decision-making process or what was known about their views and wishes.
9.1.2 The outcome of the decision-making process for the person
9.1.3 Other aspects of the person's care and support
9.1.4 The practice of health and social care staff.

10 Background

National context and statutory advocacy duties

10.1 The Independent Mental Capacity Advocate (IMCA) service was created under Sections 35-41 of the Mental Capacity Act 2005 (MCA). The purpose of the IMCA service is to support people who lack capacity regarding significant decisions in line with the Mental Capacity Act when decisions are being made on their behalf. IMCAs will work with, support and represent the person's views to those making best interests' decisions regarding serious medical treatment, changes of accommodation, safeguarding concerns and care reviews who have no family or friends that would be appropriate to consult regarding such decisions. IMCAs are not decision makers. IMCAs will discharge statutory duties in relation to DoLS and the LPS legislation due to replace DoLS in the near future.

10.2 People who lack capacity in hospitals and care homes are currently protected by the Deprivation of Liberty Safeguards introduced as an amendment to the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards (DoLS) were created to provide a legal framework for the provision of care arrangements which amount to a deprivation of liberty and ensure that any decision to deprive someone of their liberty is made after careful consideration and consultation with those necessary

10.3 The DoLS under the MCA allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests.

10.4 People have the right to challenge any decision to deprive them of liberty, and in order to support them to do so they have the right to a representative or an advocate to act for them to protect their interests. People also have the right to have their status reviewed and monitored on a regular basis. At any stage, the person, their representative or advocate will be able to appeal against their deprivation of liberty to the Court of Protection.

10.5 This is a statutory service under the MCA and the DOLS, governed by the Act, the relevant Codes of Practice and Guidance as issued from time to time.

10.6 In July 2018, the government published the 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. The target date for implementation is October 2020. The Council anticipates that, in time, this will impact on the scope of this service and that the IMCA service will play an increasing role in the legal protections for people lacking capacity.

10.7 The code of practice and regulations in relation to the MCA amendment bill (2019) Liberty Protection Safeguards has not yet been published; this is now expected in early 2020. It is not appropriate to delay the process to undertake the tender exercise until this time, therefore will need to allow flexibility in the contract to accommodate the forthcoming changes and have the conversation with the new contract provider as to how this may impact referral numbers. Some initial calculations on the potential impact on the service are included within this document.

10.8 The Supreme Court Judgement in the Cheshire West case led to a major increase in DoLS referrals to the Council since 2014. This has led to a significant increase in the need for IMCA DoLS and Paid Rep since 2014. The data suggests that following a dramatic increase in the number of DoLS requests between 2014-2016, the rate of referrals appears to have stabilised during the last two financial years and first 6 months of this year. The decision of the Court of Protection in AJ v a Local Authority (2015) led to a rise in the number of paid Relevant Person's Representative (RPR) referrals due to the increased need for an appropriate PR who will stand up for the rights of individual.

10.9 The Council is aware that changes to the statutory DoLS processes are due to be enacted in the lifetime of the current Parliament via the Liberty Protection Safeguards. Commissioners and Provider will monitor demand as part of the Performance monitoring process.

10.10 The Council expects that there will be a small number of people who will be eligible for both an IMCA and another statutory advocate in certain circumstances. The Provider shall provide one advocate who is able to provide a person-centred service in the required circumstances.

Principles of the IMCA service

10.11 In addition to the principles set out in the earlier section 'General Requirements - Independent Health and Social Care Advocacy' this service will act according to the principles set out in the Mental Capacity Act, the MCA Code of Practice [4], the Deprivation of Liberty Safeguards Code of Practice [5] and any subsequent Code or Regulations pertaining to the MCA and the MCA Amendment Act.

10.12 The Mental Capacity Act is underpinned by the following principles:

10.12.1 A person must be assumed to have capacity unless it is established that he/she lacks capacity.

10.12.2 A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

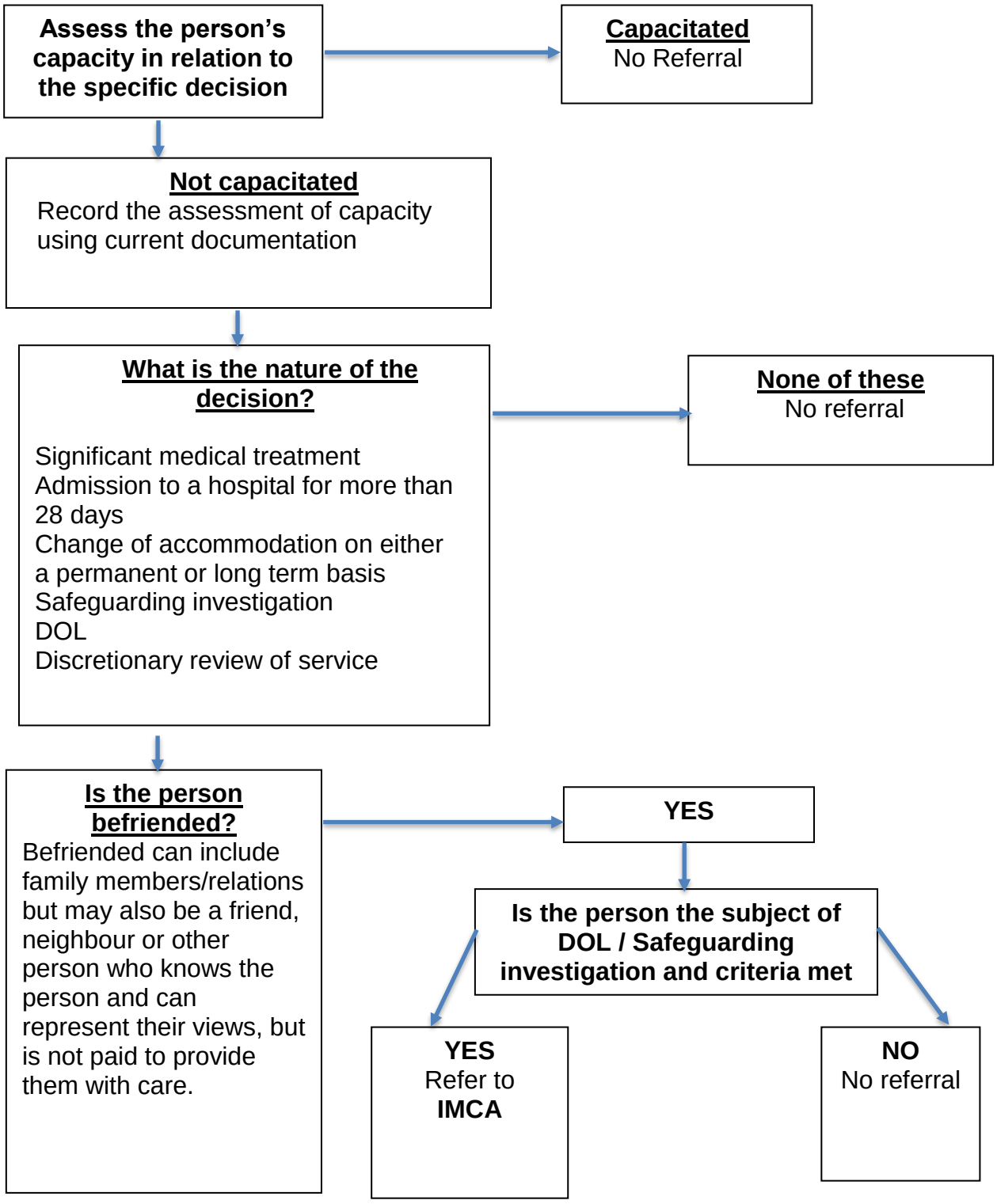
10.12.3 A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

10.12.4 An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

[4] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

[5] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Schedule 1 B&NES IMCA Referral Route



Service 4: Independent Mental Health Advocacy (IMHA)

1 Introduction

1.1 This section sets out requirements for the provision of independent mental health act advocacy to meet Bath & North East Somerset Council's (the Council) duties under the Mental Health Act 2007. It should be read in conjunction with the earlier section which sets out core requirements of all services within the Independent Health and Social Care Advocacy ("Adults") contract, including the IMHA Service.

1.2 An Independent Mental Health Advocate (IMHA) is a statutory mental health advocate, granted specific roles and responsibilities under the Mental Health Act 2007 (MH Act). The role of IMHAs is to help qualifying patients understand the legal provisions to which they are subject under the Mental Health (MH) Act 1983, the rights and safeguards to which they are entitled, and to help them exercise their rights through supporting participation in decision-making.

2 Eligibility for IMHA Service

2.1 Local Authorities have a statutory duty to arrange for independent advocacy for the following groups of qualifying patients and the Provider will provide support to the following qualifying patients:

2.1.1 Detained under the 1983 MH Act (even if on leave of absence from the hospital) apart from those patients detained under sections 4, 5(4), 135 or 136;
2.1.2 Conditionally discharged restricted patients;
2.1.3 Subject to 'Guardianship under the MH Act; or on
2.1.4 Supervised community treatment orders (SCT's)

2.2 This includes patients not covered by any of the above but who are:
2.2.1 Being considered for a treatment to which Section 57 applies (i.e. treatments requiring consent and a second opinion "a section 57 treatment").
2.2.2 Under 18 and being considered for electro-convulsive therapy or any other treatment to which Section 58A applies (i.e., treatments requiring consent or a second option "a section 58A treatment"). (See MHA, 130C (3)).

2.3 In line with IMHA Commissioning Guidance (DoH December 2008) the following additional services over and above the IMHA statutory duty should be provided recognising the IMHA's statutory powers only apply to the services outlined above:
2.3.1 Informal in-patients in mental health hospitals

2.3.2 Service Users in contact with a Mental Health Acute Response Service (previously known as Crisis Resolution & Home Treatment Team).
2.3.3 Service Users receiving MHA 1983 Section 117 Aftercare.
2.3.4 Carers of qualifying patients referring them to carer specific services where indicated
2.3.4.1 Hospital Inpatient facilities
2.3.4.2 Recovery Units
2.3.4.3 Service Users own home
2.3.4.4 Residential/Nursing Homes
2.3.4.5 Supported Accommodation

2.4 Care and treatment for qualifying patients is largely provided by Avon and Wiltshire Partnership (AWP) in Bath & North East Somerset. The Provider will have knowledge of the consent to treatment provisions under the Mental Health Act 1983. Eligible qualifying patients will be present in:

2.4.1 Adults with functional disorder e.g. schizophrenia
2.4.2 Forensic Services
2.4.3 Learning disability services
2.4.4 Children and Young Peoples Services (CYPS)
2.4.5 Older people's services

3 Pathways, referrals and access

3.1 This section is to be read in conjunction with Paragraph 11 of the earlier section, 'General Requirements - Independent Health and Social Care Advocacy'.

3.2 The Provider must acknowledge receipt of the referral with the referrer within 2 working hours.

3.3 It is expected that the Provider will contact the referrer to discuss the urgency of the situation within 3 working days unless it is an urgent request, in which case this will be clear in the referral. We define this as a response within 24 hours.

3.4 There is an expectation that a response time shall be proportionate to the urgency of the situation, for example to facilitate safe hospital discharge, requests from hospitals shall receive a faster response.

4 Principles of IMHA service

4.1 The IMHA service will adopt a flexible, empowering and proportionate model of intervention, for example facilitating individuals to self-advocate where possible and in their best interests.

4.2 The IMHA Provider must:

4.2.1 Clearly define their role to ensure it is understood by qualifying patients, Carers and Healthcare Provider staff.
4.2.2 Adopt an approach which emphasises recovery, self-determination and is person-centred.
4.2.3 Be independent from mental healthcare provider services.
4.2.4 Ensure they can meet diverse needs.
4.2.5 Have good links to other forms of advocacy provision and clear transition pathways.
4.2.6 Be accessible to all qualifying patients.

5 Service Description

(source: Department of Health, 2008)

5.1 An IMHA will support qualifying Service Users to understand the legal provisions to which they are subject under the Mental Health Act 1983 as revised by the Mental Health Act 2007, and the rights and safeguards to which are entitled. This could include assistance in obtaining information about any of the following areas, which the Provider must be able to provide and deliver from commencement on the contract:

5.1.1 Their rights under the MH Act
5.1.2 The rights which other people (e.g. nearest relative) have in relation to them under the MH Act.
5.1.3 The particular parts of the MH Act which apply to them (e.g. the basis upon which they are detained) and which therefore make them eligible for advocacy.
5.1.4 Any conditions or restrictions to which they are subject (e.g. as a condition of leave of absence from hospital, or as a condition of a community treatment order or as a condition of conditional discharge).
5.1.5 Any medical treatment that they are receiving or might be given and the reasons or requirements that would apply in connection with the giving of that treatment (or proposed treatment).
5.1.6 The legal authority for providing that treatment, and the safeguards and other requirements of the MH Act which would apply to that treatment.

5.2 Helping patients to exercise their rights, which can include representing them and speaking on their behalf.

5.3 Supporting patients in a range of other ways to ensure that they can participate in decisions.

Role, Model and Type of Advocacy Service Required

5.4 The Provider shall ensure that IMHAs are made available to help qualifying patients understand the legal provisions that they are subject to

under the MHA, and the rights and safeguards to which they are entitled (see Chapter 6 of MHA Code of Practice). This may include assistance in obtaining information about any of the following:

5.4.1 The provisions of the legislation under which the qualifying patient qualifies for an IMHA,

5.4.2 Any conditions or restrictions that the qualifying patient is subject to; the legal authority under which this would be given and the requirements that would apply;

5.4.3 The qualifying patient's rights under the Act and how those rights can be exercised.

5.4.4 The Providers' personnel will be required to have a good working knowledge of the Mental Capacity Act 2005.

5.4.5 The Provider must take account of DoH reference guidance to the MH Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008, which provides guidance on issues arising in connection with Independent Mental Health Advocates access to information in patient records under Section 130B of the MHA that would not be disclosed directly to qualifying patients.

5.4.6 The Provider will take account of the weekly routines of qualifying patients; therefore an ability to work flexibly will be expected. The methods by which the Provider's personnel shall provide the Service shall include, but not be limited to:

5.4.7 Telephone advocacy

5.4.8 Attending the hospital wards of Service Users; and

5.4.9 Accompanying Service Users during key meetings including (without limitation) managers meetings and care plan meetings.

Non qualifying patients or informal patients

5.5 As not all qualifying patients in Bath & North East Somerset will be able to instruct IMHA services, the Provider will have in place policies that address the delivery of non-instructed advocacy.

5.6 Non-qualifying patients may be helped to exercise their rights which can include representation and speaking on their behalf or support to develop their ability to self-advocate and/or support others as peer advocates.

5.7 Referrals to the IMHA service will be made:

5.7.1 By qualifying patients directly; referrals will only be accepted if they are made with the knowledge and consent (whether verbal or written) of the relevant patient;

5.7.2 An advance directive (which shall mean a written document signed by the qualifying patient specifying their required advocacy input);

5.7.3 Referral by a carer/friend/relative;

5.7.4 By a mental health professional or other professional (for example, hospital managers, the responsible clinician, approved mental health professional or the local social services authority).

5.8 If a Service User lacks capacity to give their consent in accordance with paragraph 5.7, the Provider may offer non-instructed advocacy

5.9 Where someone transitions from an out of area placement into a hospital in Bath & North East Somerset, and is still an eligible patient, there shall be a handover process from the previous IMHA to the B&NES IMHA Service.

The role of mental health services (Source Social Care Institute for excellence 2015)

5.10 The Code of Practice (Department of Health, 2008) places a duty on hospital managers to inform qualifying patients about IMHA services as soon as is practically possible. In practice, these duties will be delegated to appropriate staff. Approved Mental Health Professionals (AMHPs) and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if it seems unlikely that the patient is unable or unlikely to make the request themselves. However they should not do so, if they know or strongly suspect that the patient does not want IMHA support (NIMHE, 2008).

5.11 Mental health services should enable IMHAs to meet with patients in private. Further, IMHAs must be able to attend meetings between patients and professionals involved in their care and to access mental health notes as appropriate. IMHA services do not:

5.11.1 Replace other advocacy and support services available to the Service User and shall work in conjunction with them.

5.11.2 Affect the individual's rights to seek legal advice and patients have the right not to use an advocate.

5.11.3 Provide a direct service for relatives or carers, although they may be in contact with families and carers.

6 Liaison between professional parties

6.1 The Provider will be required to develop a Memorandum of Understanding to establish the way in which IMHA services will be delivered, agreed between the Provider, B&NES and AWP. We will also monitor this in the performance framework we agree with the provider/providers.

7 Outcomes

7.1 The IMHA Service will be delivered on an individual basis with qualifying patients. In general, the IMHA Service will support the qualifying patient in their chosen course of action, unless this course of action puts the qualifying patient, the IMHA or others at risk of danger, or if the action is illegal.

7.2 IMHAs will also be made available to help qualifying patients to exercise their rights. This help may include:

7.2.1 To access information including providing information and helping them to understand what is happening to them;

7.2.2 To explore options, making better-informed decisions and actively engaging with decisions that are being made;

7.2.3 To give people a voice who would not be able to have their voice heard and articulate their own views without this help and who do not have anyone else appropriate to support them;

7.2.4 To speak on the qualifying patient's behalf and representing them if necessary;

7.2.5 To ensure qualifying patients' views are understood by mental health professional's e.g. supporting qualifying patients in hospital managers meetings, care planning meetings, aftercare meetings etc.

8 Geographical coverage/boundaries

8.1 The Provider will make available IMHAs for qualifying patients within all relevant Bath & North East Somerset Mental Health provisions.

8.2 The Provider and their Personnel must work in partnership with other agencies: statutory, independent and voluntary.

8.3 The Provider must assist staff and service managers who are likely to refer their qualifying patients and Service Users in understanding the role of the IMHA service and how to access the service.

9 Days and Hours of Operation

9.1 The Provider is not expected to provide a 24 hour, 7 day a week response to requests, or react to emergency calls. Neither will the IMHA service act as an 'expert witness' or be expected to function as 'appropriate adults' (Police and Criminal Evidence Act, 1984).

9.2 The IMHA Service shall be available for referrals and delivery of service between 9am – 5pm, every working day.

9.3 The service may need to be available outside of these hours only with prior agreement with the Council to meet the needs of the service.

9.4 There is an expectation that a response time shall be proportionate to the urgency of the situation, for example to facilitate safe hospital discharge, requests from hospitals shall receive a faster response.

9.5 Response to a referral for IMHA support for qualifying patients will be dealt with within two working days.

10 Staff skills

10.1 It is expected that all IMHAs will have the relevant skills and competencies for the task and will be willing to undertake further training and development. This will include successfully completing the IMHA module of the National Advocacy Qualification, or equivalent, for all relevant Provider Personnel as soon as possible and within one year of an IMHA starting employment (making necessary adjustments for any maternity

leave, long-term sickness or other similar absences). Documentary evidence of this may be requested by the Commissioner.

10.2 In addition, all IMHAs will have adequate training in matters relating to mental health and the legal and social implications for someone with a mental health condition including the Mental Capacity Act 2005. The Provider will be fully aware of current best practice in skills and competencies for mental health advocacy, plus safeguarding awareness and refresher training, child protection and the specific needs of specific groups:

10.2.1 People with learning disabilities,
10.2.2 People from BME communities and those whose first language is not English
10.2.3 Older people with dementia
10.2.4 People who are hearing impaired or deaf
10.2.5 Children and young people
10.2.6 People on CTO's
10.2.7 People placed out of the area

10.3 The Provider will ensure that it communicates with children and young people in a child sensitive manner including use of appropriate tools e.g. 'Headspace' toolkit: http://www.headspaceireland.ie/

10.4 The Provider will only make persons available to act as an IMHA if they believe them to be of integrity and good character. If the Provider subsequently knows or suspects of any actions on the part of the IMHA that could compromise their suitability to act in the IMHA role, that person shall not be allowed to act as an IMHA until these concerns have been resolved.

10.5 The Provider will have a health and safety policy and all IMHAs will have undertaken training in health, safety and security and other areas as deemed necessary to work safely within different settings.

10.6 IMHAs seeing qualifying patients in AWP wards or other local health or social care premises will be required to undertake the following health and safety training: lone working, risk assessments, and compliance with Health & Safety procedures of their base and any other premise where they have contact with qualifying patients.

11 Background to IMHA

11.1 The IMHA Service gives qualifying patients with mental health difficulties access to dedicated, reliable, independent support in getting the right information they need to understand what is happening to them and what their choices and rights are, and in getting their voice heard and listened to. They help to preserve a patient's dignity and self-respect, as well as protecting their legal and human rights. IMHA services provide an

additional safeguard for patients who are subject to the MH Act 1983 and are specialist advocates who are trained to work within the framework of the Act.

11.2 IMHAs will help represent the Service User's views in relation to their mental health care and treatment, an effective IMHA service is one which aims to deliver good outcomes for the person receiving the advocacy support.

11.3 IMHA provision should not be open ended on any issue or used a as a substitute for a service that should be provided by the responsible inpatient or community staff.

11.4 Other relevant references include:

- 11.4.1 Care Act 2014, sections 67 and 68 (Act)
- 11.4.2 Care and Support (Independent Advocacy) Regulations 2014 (Reg)
- 11.4.3 Care and Support statutory guidance (2016 update) – Chapter 7 (G)
- 11.4.4 Mental Capacity Act 2005 (MCA)
- 11.4.5 The Mental Capacity Act (Independent Mental Capacity Advocates) (General) Regulations 2006 (MCA Gen.Reg)
- 11.4.6 The Mental Capacity Act (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 (MCA Exp.Reg)
- 11.4.7 IMHA Commissioning Guidance (DoH December 2008)
- 11.4.8 Equalities Act 2010

11.5 Inpatient Services in Bath & North East Somerset are provided by Avon and Wiltshire Partnership and include:

- 11.5.1 Acute Mental Health Hospital: Hillview Lodge, Royal United Hospital, Bath, BA1 3NG – 15 beds
- 11.5.2 Hospital for specialist assessment, treatment and care for older people with dementia in: Ward 4, St Martin's Hospital, Bath, BA2 5RP – 12 beds.

11.6 Community patients who may be supported by AWP, Virgin Care or Oxford and Bucks (CAMHS) services.

Mental Health Act Assessments

11.7 The data on the number of Mental Health Act Assessments undertaken from the Local Authorities recording system is as follows: BANES AMHP Team carried out 365 MHA assessments in the year 2018/29, however this will include people who were not subsequently detained nor made subject to the Act so would not be eligible for the service.

11.8 Many people who are detained or admitted by the BANES AMHP team are admitted to hospitals outside of BANES so would require the IMHA service which is available in the Hospital locality.

Service 5: Independent Health Complaints Advocacy

1 Introduction

1.1 This section sets out Bath & North East Somerset Council's (the Council) additional requirements for the provision of the Independent Health Complaints Advocacy service, referred to as the IHCA Service.

1.2 This Service is part of a wider contract for the provision of advocacy for adults and should be read in conjunction with the earlier section 'General Requirements - Independent Health and Social Care Advocacy' which sets out core requirements of all services within the contract.

1.3 The aim of the Service is provide a flexible, accessible and person centred service that empowers anyone who wishes to resolve a complaint about healthcare commissioned and/or provided by the NHS in England.

1.4 The underlying ethos will be to facilitate self-advocacy by promoting self-help materials where appropriate. It will also share the intelligence it collects to influence to service improvements.

2 Eligibility for Independent Health Complaints Advocacy Service

2.1 The service is for the benefit of people who wish to pursue a complaint or grievance related to any aspect of healthcare, as described in Health and Social Care Act 2012 in relation to publicly funded health services provided in the county of Bath & North East Somerset.

2.2 The service will need to be accessible to carers, family, friends and representatives of those who wish to pursue a complaint or grievance related to any aspect of health service delivery.

2.3 The service shall be accessible to anyone living or working in Bath & North East Somerset including:

- 2.3.1 adult users of health services within Bath & North East Somerset
- 2.3.2 children accessing health services in Bath & North East Somerset
- 2.3.3 residents of Bath & North East Somerset using health services delivered elsewhere
- 2.3.4 people progressing a complaint about health care provision on behalf of others – representatives, carers, parents, relatives etc

2.4 This covers all NHS services, including:

- 2.4.1 NHS Trusts, including NHS Foundation Trusts

2.4.2 primary health care services provided for the NHS by GPs, dentists, opticians and community pharmacies
2.4.3 clinical commissioning groups
2.4.4 private health care organisations if the treatment has been paid for by the NHS
2.4.5 all other health services commissioned by the NHS

2.5 In addition, the service will establish effective arrangements concerning such services used by the people of Bath & North East Somerset but located outside of the county.

2.6 Referrals will only be accepted if they are made with the knowledge and consent of the patient, whether written or verbal.

2.7 It will be possible for individuals to be eligible for other advocacy services within this contract. This service may need to collaborate particularly with the Independent Care Act Advocacy Service when individuals wish to complain about health and care services.

2.8 The service shall have a policy for the management of persistent and unreasonable complainants.

3 Pathways, referrals and access

3.1 This section is to be read in conjunction with Paragraph 11 of the earlier section, 'General Requirements - Independent Health and Social Care Advocacy'.

3.2 The Provider shall work with the Council, NHS Trusts, PALS and Healthwatch Bath & North East Somerset to ensure that effective, efficient and appropriate processes and systems are in place for the delivery of a streamlined service. These shall include effective referral systems for individuals accessing existing advocacy services.

3.3 There can be many different contributory reasons for time needed to resolve complaints; this service is expected not to add further delay to resolution as a result of its actions or manner of working.

3.4 The service will liaise proactively with the relevant organisations in order to facilitate resolution for the complainant, including but not only the NHS complaints services and Patient Advice and Liaison Services (PALS) in Bath & North East Somerset.

3.5 The Provider must acknowledge receipt of the referral with the referrer within 2 working hours.

3.6 Referrals will be allocated within two working days of receipt. Completion of the case should be within 30 days of allocation.

3.7 The service, when appropriate and at the direction of the Service User, can make referrals to professional bodies such as the General Medical Council (GMC), and to specialist support such as medico-legal advice, bereavement support, mental health support, etc.

3.8 Advocates shall not remain involved with individuals who cease to be eligible but shall facilitate signposting to other agencies who are able to offer appropriate support to the individual.

3.9 The Provider will work with the other services in this contract to develop appropriate referral structures which ensure, where possible, a seamless pathway for those using advocacy services in Bath & North East Somerset. This may involve working with Healthwatch Bath & North East Somerset.

3.10 The Providers website shall be enabled for screen reader type software such as Browsealoud to ensure full accessibility.

4 Service objectives and description

4.1 This Specification details a service requirement for the delivery of the Bath & North East Somerset Independent Health Complaints Advocacy (ICHA) Service for the benefit of people to who wish to pursue a complaint or grievance related to any aspect of healthcare, as described in Health and Social Care Act 2012. It has been informed by the Local Government Association's Practice Guidelines for Independent Health Complaints Advocacy Services published in December 2015.

4.2 The requirements expected of all advocacy services are set out in the earlier section 'General Requirements - Independent Health and Social Care Advocacy'. In addition to these, the IHCAS will:

4.2.1 support individuals with a complaint or grievance related to any aspect of healthcare including that which falls under the jurisdiction of the Health Service Ombudsman, such as complaints about poor treatment or service provided through the NHS in England;

4.2.2 ensure that independent advocacy skills are used to provide practical support and direction to people to assist them to find a solution to their complaints. The service will identify available options and possible outcomes, to assist individuals to decide which option to take;

4.2.3 ensure that individuals are informed of all relevant options and provided with guidance on the most appropriate solution, including resources to self-advocate;

4.2.4 through partnership working with NHS and local authority commissioners and providers the service will ensure joined up and seamless support across statutory, voluntary and independent services and maximise the opportunities for added value;

4.2.5 focus on empowerment and the promotion of self-advocacy, wherever appropriate; and

4.2.6 actively encourage those using and working with the service to provide feedback about their experience of using IHCAS. This information shall be used to inform ongoing service development.

4.3 The service will respond to the needs of the individual in a way that recognises the anxiety involved in taking forward a complaint, minimises the 'fear of retribution'. It will support individuals and demonstrate an understanding of their 'right' to dignity, quality and individual satisfaction when accessing services.

Support options

4.4 The Provider may become aware of issues that relate to more than one individual or that are raised by groups of individuals (collective issues). The Provider shall set out a protocol for handling such issues, which they will discuss with the Council, Healthwatch Bath & North East Somerset and other local providers as appropriate.

4.5 Whether delivered in partnership or through a single organisation the service must use a number of methods to deliver the service in addition to face to face case advocacy. The Provider will focus on providing support at each of the following points or activities in the NHS complaints procedure, those being:

4.5.1 identifying what the available options and possible outcomes are, and deciding which option(s) to take;

4.5.2 making the complaint to the appropriate authority;

4.5.3 deciding how to proceed with the complaint, following the initial response;

4.5.4 completing the local resolution phase by attending meetings or entering into correct correspondence;

4.5.5 making a complaint to the Parliamentary and Health Service Ombudsman; and

4.5.6 understanding the Health Service Ombudsman's final decision.

4.6 The Provider will build in flexibility and accessibility into the service by promoting the use of web-based and telephone advocacy solutions; use existing advice and information centres, where available, to deliver face to face advocacy across the county.

4.7 In addition, this service shall provide easily accessible materials to enable individuals to self-advocate.

5 Outcomes

5.1 In addition to the outcomes specified in the earlier section ‘General Requirements - Independent Health and Social Care Advocacy’, this Service shall achieve the following outcomes:

5.1.1 Service Users and their representatives are able to make informed choices about their health and care as a result of the Advocacy provided by the Service.

5.1.2 Service Users and their representatives are supported to seek satisfactory resolution to their complaints.

5.1.3 The views and experiences of Service Users and/or their representatives influence commissioning decisions to improve health care services.

6 Liaison between professional parties

6.1 Referrals to the service will be accepted from the Service User themselves or a third party making a complaint on the Service Users behalf.

7 Geographical coverage/boundaries

7.1 The geographical area of the service is Bath and North East Somerset. However, with patient choice, access the boundaries may vary a little as some patients will reside in communities outside the county boundary. Temporary residents such as students using services within Bath and North East Somerset will be eligible for this service. BaNES patients who are referred to health care providers outside of the B&NES area will be required to use the advocacy service as commissioned by the NHS responsible for that area.

8 Days and Hours of Operation

8.1 The Independent Health Complaints Advocacy Service shall be available for referrals and delivery of service between 9am – 5pm, every working day. Access to information on the internet about the service shall be operational 24/7 with clear information about any delays or service issues.

9 Background

9.1 An effective complaints process is essential not only in putting things right for individuals when health services have fallen short but also in

identifying strategic issues and driving improvements across the system. Independent health complaints advocacy is a vital component of the local complaints system. It supports people who, for a range of reasons, find it difficult to navigate the complaints system themselves. Independent advocacy helps people to speak up, supports a person to express their views, have these taken seriously and achieve personal outcomes.

9.2 The Health and Social Care Act 2012 requires local authorities with adult social care responsibilities to "make such arrangements as it considers appropriate for the provision of independent advocacy in relation to its area" in the provision of assistance for individuals making or intending to make a NHS complaint.

Glossary of Terms

Advocacy or Instructed Advocacy
Helping a person to express their needs and wishes, to secure their rights, including the right to take risks, and to obtain the care and support they require. This definition assumes that an individual has mental capacity, information is provided rather than advice, the advocate will represent the person's wishes not their best interest, which is for the individual with capacity to determine.

Non-instructed Advocacy
This describes the form of advocacy that must be adopted when a service-user lacks mental capacity in relation to a specific issue or decision. The advocate must represent that person's best interest by utilising communication skills, gathering knowledge of that person and understanding of their needs, by consulting with relevant parties, applying professional judgement and knowledge of the law.

Informal Advocate
Someone who provides advocacy from the position of being a relative or friend, i.e. someone who is familiar to the person concerned but who is not a paid carer, a health or social care worker.

Independent Advocate
An advocate appointed under Section 67 of the Care Act 2014 to facilitate the involvement of a person who would otherwise have substantial difficulty in being involved, in the preparation or review of their care & support plans or under Section 68 in respect of a safeguarding enquiry.

Substantial Difficulty
A difficulty in:-
(a) Understanding relevant information;
(b) Retaining that information;
(c) Using or weighing that information as part of the process of being involved;
(d) Communicating the individual's views, wishes or feelings

Independent Mental Capacity Advocate (IMCA)

An advocate appointed under the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards

Independent Mental Health Advocate (IMHA)
An advocate appointed under the Mental Health Act to provide support to people who may be detained or subject to a range of orders under the Mental Health Act

NHS Independent Complaints Advocate (NHS.ICA)
An advocate provided under the Health & Social Care Act 2012 to provide support to those using the NHS complaints procedure

Self Advocacy
A range of measures which may support a person to express / represent their own interests and obtain the care and support they need. This may include information, advice, peer support, self –help tool-kits and templates.

Specification Appendix 1 – Monitoring Requirements

1. **Narrative Report**

Bath & North East Somerset Council

Advocacy Contract Report

2020/21

Service Name:

Provider Name:

Reporting Period: *(please indicate dates)*

Quarter 1: 1st July to 30th September	**Quarter 3:** 1st January to 31st March
Quarter 2: 1st October to 31st December	**Quarter 4:** 1st April to 30th June

Note in year 1 the Provider shall submit a contract report monthly for the first 6 months, moving to quarterly thereafter.

The purpose of this Contract Report is to enable Bath & North East Somerset Council and each contracted advocacy service to review and manage the delivery of the commissioned outcomes.

The Specification for this service sets the commissioned outcomes. This report provides the opportunity to share the evidence that illustrates how these outcomes are met as the contract progresses. It is intended that the Commissioner and contracted providers work towards the NDTI outcomes framework for advocacy[6], and as such space is included for the insertion of any additions agreed at contract meetings that are helpful to evidence the delivery of the specified outcomes and work towards the NDTI outcomes framework.

This report will be completed by the contracted organisation and submitted 10 days following the end of the reporting period. Contract review meetings will be used to review the report and consider the issues it raises along with any other contract delivery issues. The suitability of this report will be considered at the first meeting and revisions agreed if as necessary to work towards the NDTI outcomes framework.

Please return your completed report to the allocated contract manager.

[6] https://www.ndti.org.uk/our-work/our-projects/advocacy-and-voice/

Bath & North East Somerset Council Advocacy Contract Report

2020/21

1. Summary of Reporting Period Please summarise the highlights, progress and achievements in the reporting period as well as challenges and opportunities. Please include: details of finances, any organisational changes and any current improvements the service is making.
2. Finance and expenditure Please give details of any temporary or permanent variation from budget with reasons.
3. Staffing Please comment on current staffing levels, turnover and provide details of any vacancies. Include the use of volunteers to support the service. Please provide one example of supervision notes and action plan, covering all the services over the year and one example of personal development plan.
4. Training and Staff Development Please provide an update on the training and staff development activities that have taken place over the reporting period.
5. Partnership working Please provide an update on partnership activities that have taken place over the reporting period. Include evidence of sharing information with other organisations and promoting the service.
6. Safeguarding Please summarise any safeguarding issues in the period
7. Compliments, comments, concerns and complaints Please provide details of feedback received during the reporting period and actions which have been taken as a result. Please identify trends and provide details of response (or planned response). Please include evidence of regular, effective and systematic feedback on service effectiveness and satisfaction.
8. Service User and Referrer engagement / co-production Please provide an update on engagement / co-production activities that have taken place over the reporting period, with both referrers and individuals in receipt of a service.
9. Issues and Concerns Please list any issues which are likely to compromise service delivery or contract outcomes. Please indicate for each issue how this is being addressed and what commissioner or partner support is needed.
10. Exception Reporting

Please give a summary of cases that do not meet the expected requirements of the contract.
11. Reflections and Learning Please include opportunities, challenges and risks identified within the service as well suggestions for partners.
12. Priorities for next reporting period Please summarise key priorities and plans for the next reporting period
13. Issues for discussion at contract meeting Please list any issues that the service would like to discuss with the commissioner

2. Statistical Monitoring Requirements for the Independent Health and Social Care Advocacy Contract (v 26/11/19)

This document summarises the Council's statistical data requirements. Commissioners will work with the appointed provider to agree the final reporting required. It is important that there is standardisation across all the services within the contract and to that end the services are expected to work with the Commissioner towards the NDTI advocacy outcomes framework. Data needs to be presented in a manner that shows the numbers reported over time. In addition to this reporting, the appointed provider will return a number of other documents included in the Monitoring Schedule.

Reporting Period – monthly in the first 6 months of the contract, then quarterly thereafter

<table>
<tr><th colspan="4">Contract Summary</th></tr>
<tr><td colspan="4">Dates of period
Total contracted hours available
Hours delivered, broken down by each service and:
• Management
• Staff – contact hours
• Staff – non contact hours
• Staff total
• Total contracted hours delivered
% staff hours delivered of contracted hours, use of volunteers</td></tr>
<tr><th colspan="4">Each service will report separately on the following items:</th></tr>
<tr><td>Need and Demand
• No. referrals received
• No referrals accepted
• Breakdown to show the outcome of referrals: eligible, needed onward referral, given information and signposted.
• Source of referrals (consistent list of organisations to be used across all services)
• No. of referrals on waiting list
• Geographical area of person at referral</td><td>Supply
• Referral response times
• No. open cases at start of period
• No. cases closed during period
• No. cases open at end of period
• Duration of closed cases (less than 1 month 1-3, 3-6 or 6+ months)</td><td>Quality
• No. and types of compliments, concerns, comments & complaints
• Feedback from referrers, people instructing the service and those using the service, where able.
• Case studies (minimum of 2 per service, per quarter)</td><td>Staffing
• Age, gender, ethnicity of each advocate by type of advocacy delivered
• Evidence of qualifications of each advocate, CPD and their full time equivalent indicating the type of advocacy delivered
• Caseload per advocate</td></tr>
</table>

• Demographic/equalities profile of all new people entering the service within the period • Support and communication requirements including: mobility, literacy, mental health and language. Include use of interpreters, frequency of use, language required, translation, telephone interpreting etc.	• No advocate involvement due to failure of referrer to give adequate information • No advocate involvement due to failure of referrer to give adequate time before the decision had to be made. • No. hours delivered during period broken down by qualified, non qualified staff and volunteers		

The details required under Contract Summary, Need and Demand and Supply shall all be supplied using the provided template. The details required under Quality and Staffing shall be provided separately.

Service specific reporting items				
Independent Health Care Complaints	**Care Act**	**IMCA**	**IMHA**	**Independent Social Care Complaints**
• No. of Service Users that are: ○ Adult patients ○ Child patients ○ B&NES residents using services elsewhere	• No. of Service Users referred for: ○ Needs assessment ○ Carers assessment ○ Review of support plan	• No. of Service Users referred for: ○ Change of accommodation ○ Serious medical treatment ○ Safeguarding ○ Care Review	• No. of Service Users referred for: ○ Detained under the 1983 MH Act (even if on leave of absence from the hospital) apart from those	• No. of complaints regarding: ○ Adults ○ Children ○ 3rd party complaints • No. of hours delivered also broken down

○ 3rd party complaints • No. of hours delivered also broken down according to eligibility list above • No. people given information & advice • No. people receiving telephone/email support • No. people receiving face to face support • Breakdown of NHS organisations receiving the complaint • Themes of complaints and no. of cases per theme • No. local resolution meetings attended • No. cases escalated to the Ombudsman • Case closure outcomes • No. cases reaching a satisfactory resolution • No. cases that did not reach a satisfactory resolution	○ Safeguarding ○ CHC ○ Request for information from a prospective 'appropriate involver' • No. of hours delivered also broken down according to eligibility list above • No. of meetings attended in relation to: ○ Care Act assessments/reviews ○ Safeguarding ○ CHC • Number of service users represented at meetings, broken down according to list above • Number of written reports submitted, broken down according to list above	○ S39a ○ S39c ○ s39d ○ Relevant Persons Representative • No. of hours delivered also broken down according to eligibility list above • No. RPR reports • No. IMCA reports (verbal/written) which the IMCA manager judged to be in time for the decision maker to consider. • No. reports that were not submitted on time • Total no. reports provided by the IMCA service to the decision maker	patients detained under sections 4, 5(4), 135 or 136; ○ Conditionally discharged restricted patients; ○ Subject to 'Guardianship under the MH Act; or on ○ Supervised community treatment orders (SCT's) • No. of hours delivered also broken down according to eligibility list above • No. of people provided with an IMHA who are: ○ Informal in-patients in mental health hospitals ○ In contact with a mental health acute service ○ Receiving MHA 1983 Section 117 Aftercare ○ Carers of qualifying patients referring them to carer specific	according to eligibility list above • No. people given information & advice • No. people receiving telephone/email support • No. people receiving face to face support • Breakdown of organisations receiving the complaint • Themes of complaints and no. of cases per theme • No. local resolution meetings attended • No. cases escalated to the Ombudsman • Case closure outcomes • No. cases reaching a satisfactory resolution • No. cases that did not reach a satisfactory resolution

			services where indicated ○ In hospital inpatient facilities ○ In recovery units ○ Service Users in their own home ○ Service Users in Residential/Nursing Homes ○ Service Users in Supported Accommodation • No of contacts with IMHA services out of area where B&NES patients have been detained	

The service specific details in the above table shall all be supplied using the provided template.

Bath & North East Somerset Council

3. Draft Advocacy Case Study (v 26/11/19)

	Provider Name/Contract
Type of advocacy received	
Date supported started and ended	
Age of person	
Gender	
Any issues (e.g. dementia, visual impairment, disability, mental health issue, substance misuse)	
Location of client (not actual address)	
Accommodation type including tenure	
Any other relevant information about the clients circumstances	
What was the planned outcome or outcomes for the client at this stage	
Were the outcomes achieved? **What happened?** **Were their any barriers which prevented/ delayed the outcome being achieved** **How were these barriers overcome?**	
What has been the most positive outcome as a result of advocacy	
Has the support had a wider impact?	
Any other comments	
Name of Advocate	

4. Financial Monitoring

The provider shall submit quarterly finance reports in accordance to the requirements set out in the Monitoring Schedule. The headings for this report will be agreed as part of the mobilisation phase.

Function	**Total costs per service**
Independent Care Act Advocacy	
Independent Mental Capacity Advocacy	
Independent Mental Health Advocacy	
Independent Health Complaints Advocacy	
Independent Social Care Complaints Advocacy	

Breakdown of full service expenditure	**Cost**
Salaries	
Social security costs	
Pension costs	
Temporary staff	
Total staff costs	
Non staff costs	**Cost**
Rent	
Rates	
Utilities (heat, light, water)	
Insurances	
Telephone & fax	
CRM system	
Website hosting	
Licence fees	
Campaign resources	

Print/post/stationery	
Advertising and promotion	
Travel	
Equipment	
Legal and professional	
Audit and accountancy	
General office expenses	
Other	
Recruitment costs	
Training costs	
Volunteers – expenses, travel costs	
DBS checks	
Total non staff costs	

Bath & North East Somerset Council

Appendix 2