

## Cabinet

10 October 2017

### Health Advocacy Services Redesign: Consultation Findings and Proposed Service Model

#### Recommendations

That Cabinet:

- 1) Agree the outcomes and findings of the consultation process which has informed Health Advocacy Service redesign.
- 2) Approve the proposed new service model, in order to proceed with the procurement of the new Health Advocacy Service.
- 3) Authorises the Joint Managing Director (Communities) to commence an appropriate procurement process and to award any contracts for the redesigned Health Advocacy Service on terms and conditions acceptable to the Joint Managing Director (Resources).

#### 1.0 Background and rationale

- 1.1 There are 9 advocacy services commissioned by Warwickshire County Council. Three of these are funded through Public Health: NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy. For a summary of these health advocacy services and what they provide for the residents of Warwickshire please see background paper 1.
- 1.2 The three contracts for the health advocacy services are currently due to expire on 31st March 2018. The current combined annual contract values for the services in 17-18 are £209,500. Through the One Organisational Plan 2020 requirements, the combined annual value for these services is likely to range between £160,000 to £190,000. A competitive tender process will be undertaken to achieve best quality and value for money in the delivery of these services.
- 1.3 In addition to these health advocacy services, there are 6 other advocacy and advice services commissioned by Warwickshire County Council through Strategic Commissioning, People Group.
- 1.4 To aid Cabinet to appraise all of the different contracts and consultation and engagement activity undertaken for the entire advocacy service provision, two separate reports are being presented to Cabinet. This Health Advocacy Services report focuses on the Warwickshire County Council contracts funded through Public Health, but should be read in conjunction with the Advocacy,

Information, Advice and Support Services report also being presented to Cabinet.

- 1.5 Whilst two separate reports are being presented to Cabinet, the procurement process of all 9 advocacy service areas commissioned by Warwickshire County Council is being undertaken with a joined up process, approach and timeline. A joint working group has been established involving commissioners in Public Health and People Group, led by Procurement, to ensure consistency of approach across the Council and outcomes for Warwickshire residents.
- 1.6 The current advocacy contracts also include provision for residents of Coventry. For the Health Advocacy Services, this includes provision within the Independent Mental Health Advocacy contract for the statutory element of the service.
- 1.7 Through the One Organisational Plan 2017-20, the County Council describes how it will rise to the challenge of making Warwickshire the best it can be. Over the last three years, the County Council has delivered £92 million of savings and is now faced with making further savings of £67 million. This means shaping the future of a very different County Council and different public service provision that can be afforded both now and up to 2020.
- 1.8 Since 2015/16 Public Health has experienced a significant and recurrent reduction to its ring fenced grant funding from the Department of Health. In addition to local Council savings, the impact of these reductions is significant and a challenge to achieve. In order to meet this challenge, Public health is redesigning its services, ensuring that prevention and early intervention are a major part of the new offer to the public, whilst continuing to commission priority, high quality and value for money services. We must ensure that vulnerable citizens are supported and that services are as efficient and effective as possible.
- 1.9 This paper provides details of the key findings and outcomes of the consultation process for the three health advocacy services which have informed the proposed service model outlined later in this report.

## **2.0 Consultation process**

- 2.1 An 8 week consultation started on 9 June 2017 and ended on 31 July 2017. The aim of this consultation activity was to effectively engage with current, previous and potential advocacy service users, and other key stakeholders, (including health advocacy service referrers and advocacy service providers) on the proposed service model, and ensure there were opportunities for them to influence and shape the new service.
- 2.2 A range of engagement methods were employed to maximise opportunities for service users and other key stakeholders to put forward their views. Advocacy services work with vulnerable people who are often seldom heard,

therefore, maximum effort was made to ensure that these groups had ample opportunity to feed into this process. Methods of consultation included:

- Survey (both on line and paper format)
- Other options were provided for individuals who require additional support to contribute, including focus groups and discussion based individual feedback
- Provider engagement/market testing event held on 19 July 2017
- Engaging stakeholders at planned local events and forums e.g. Making Space Mental Health Service User forums, focus groups via Grapevine for people with learning disabilities
- Face to face engagement at relevant hospital locations

2.3 Where possible and appropriate, shared consultation activities were carried out in conjunction with other Public Health commissioners who were also conducting consultation activity with similar time frames. This approach helped to avoid over consulting and duplication of engagement with similar stakeholders as well as providing an opportunity for Public Health to promote and share information on a range of services to a wider audience.

2.4 Costs relating to the consultation were met within current Public Health budgets.

2.5 A full consultation report has been prepared (see background paper 2). Section 3 of this report provides headline results of the consultation.

### **3.0 Consultation findings**

3.1 The findings of the consultation represent the views of **105** members of the public, advocacy service users, advocacy service providers and professionals.

3.2 The consultation focused on exploring 3 main areas for the proposed new service model:

- Access to Health Advocacy Services via an integrated service model
- Timescales for receiving services
- Partnership working with Healthwatch

Respondents were also invited to comment on ways in which the promotion and marketing of the health advocacy services could be improved, so that both referrers and potential clients are fully aware of them. The results of this section are presented in the full consultation report.

3.3 Following collation and analysis of all responses received there was an overall general consensus from respondents who strongly agreed with the majority of the service principles. This consensus was then further reinforced through respondents' comments providing qualitative insight which has been used to further shape and influence the proposed service model.

3.4 Integrated Service Model - combining the three health advocacy services under one contract

- The vast majority of respondents, both individuals and providers agreed with the proposal to combine the three services into one advocacy service, as this would result in the following benefits:
  - Simplified referral pathway
  - Reduced confusion amongst service users and professionals about the different types of advocacy
  - More efficient triage to prioritise and manage referrals
  - Better value for money
  - Service users will only have to tell their story once
- However, respondents expressed some concerns, as follows:
  - Combining the services under one contract would result in a wide spectrum of services
  - Staff issues, including TUPE, disparate staff teams, staff potentially needing to have knowledge of all three advocacy areas, impact on staff workload

### 3.5 Links with Healthwatch

- Individuals were generally supportive of the proposed plan to develop the partnership with Healthwatch. It was felt that this would strengthen both services through picking up of emergent trends in health services
- Suggestions for partnership working included: co-location, joint working on projects.
- There was agreement for the link to Healthwatch needing to be clearer, as some individuals think they provide advocacy. Clarity over purpose would reduce duplication of provision.

### 3.6 Timescales for service: flexible waiting times for people accessing non-statutory advocacy provision

- People accessing statutory advocacy services have response times for their service to commence stated in the relevant legislation, and the new service model will require providers to meet these requirements. Where people are referred for non-statutory advocacy provision, the consultation asked for views on a flexible waiting time model.
- The flexible waiting times issue was the most contentious across all of the consultation areas
- Respondents felt that there were issues around fairness and equality of access to the service, and they were concerned about the impact of waiting times on people's wellbeing
- 42% of respondents to the survey expressed concern that more flexible waiting times for non-statutory advocacy provision would lead to increased stress amongst non-statutory service users, which may result in people falling through the net and not receiving the help they require. These respondents felt that people in the community are often

the most vulnerable and most in need, and that statutory service users should not be prioritised over them.

- Advocacy providers commented that they have well developed systems and processes to manage demand and referrals, and this includes systems to respond effectively to statutory and non-statutory referrals so that cases are allocated based on need and urgency of referral, for both statutory and non-statutory referrals.

## **4.0 Proposed Service Model**

- 4.1 All the responses received through the various engagement mechanisms employed during the consultation process and the emerging key themes have helped to shape and influence the proposed new Health Advocacy service model.
- 4.2 The proposed new service model will bring together the three current health advocacy services in Warwickshire (NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy) into one integrated Health Advocacy Service to be delivered by one provider or partnership of providers. This will provide a single point of entry to health advocacy services across Warwickshire, making it easier for residents of Warwickshire to access this support. Close links will also be made to the other advocacy services commissioned by Warwickshire County Council through a joint tender process for all services.
- 4.3 The proposed new Health Advocacy Service contract will also include provision of Independent Mental Health Advocacy for Coventry: both statutory IMHA funded by Coventry City Council, and non-statutory IMHA funded by Coventry and Rugby Clinical Commissioning Group. This will ensure that patients of mental health services in Coventry and Warwickshire will have one provider for their IMHA provision across the STP foot-print, and referrers who are mainly from Coventry and Warwickshire Partnership Trust, will also only have one provider to refer too. The annual contract value for this element of provision, subject to final approvals within the commissioning organisations in Coventry, and a competitive tender process to achieve best value for money is likely to range between £100,000 and £130,000. Opportunities to join up the process with Solihull were also explored, but timelines for a joined up process were not feasible.
- 4.4 The contract period will be for a period of 3 years, with options to extend for period(s) up to 24 months, subject to satisfactory performance by the provider. This will be replicated through all of the advocacy services contracts across the Council so that they can be reviewed together at the end of the new contract period.
- 4.5 The new service will be outcome focused, placing the needs of service users at the core of service delivery, and aligned to the Advocacy Outcomes

Framework produced by the National Development Team for Inclusion. The framework details outcomes in four main areas:

- **Changes for the individual**, to include: increased voice and personal control, improved opportunities, challenging injustice, increased independence, individual's rights are upheld
- **Changes for the health and social care sector**, to include: improved service quality and experience for the user, service change and improvement, coproduced services
- **Changes in the wider community**, to include: increased social inclusion and contribution, and exercising of democratic rights
- **Changes in the advocacy organisation**, to include: improved accessibility of advocacy provision, improved governance and application of best practice, including coproduction of the service.

Commissioners across both Public Health and People Group will be incorporating requirements for providers to demonstrate that they meet these outcomes within the relevant advocacy service specifications.

- 4.6 Service delivery will be in accordance with best practice for the delivery of advocacy services, with providers expected to demonstrate high quality performance in accordance with relevant guidance and standards. This will include demonstrating that service delivery meets the Advocacy Code of Practice, and for NHS Complaints Advocacy that service delivery meets Healthwatch England's proposed standards for the delivery of NHS Complaints Advocacy.
- 4.7 The new service specification will also require providers to demonstrate effective practice in terms of managing and prioritising referrals into the new integrated service. The provider will be expected to develop and agree with commissioners a referral management protocol and procedure (triage), in order to ensure that the wellbeing of service users accessing non-statutory advocacy provision is not put at risk through flexible waiting times. Ongoing monitoring of this will be prioritised and robustly monitored through scheduled and regular contract monitoring meetings.
- 4.8 Through the review and consultation of the Health Advocacy Services provision, the relationship between Healthwatch and the Health Advocacy Service provision has been considered. Options for consideration have included developing a stronger partnership between the services, to also considering options for a more aligned contractual and tender process for these services. Building on the consultation and review findings, a stronger partnership will be required as part of the new service model, one in which collective trends and emerging issues noted by the Health Advocacy Service will be shared with Healthwatch, so that Healthwatch can champion required changes and improvements to local health services. Referrals from Healthwatch to the Health Advocacy Services provider will also be strengthened through enhanced partnership working between the two services. This will ensure clarity of role between the Healthwatch function and the Health Advocacy Service function, for both referrers and clients accessing the provision.

- 4.9 Strengthening the partnerships between the Health Advocacy Service and other key stakeholders will also be a core requirement of the new service. The commissioned provider will be required to operate closely with other advocacy providers and services in Warwickshire, to ensure that relevant links and cross referrals are made between services. The Health Advocacy Service provider will also be expected to develop a good knowledge of, and links to, related services in Warwickshire which clients may need to be supported to access, including for example: finance and debt management services, housing related support services and mental health services. This will also include developing good links to the Mental Health Coproduction Service, which is funded by Public Health to ensure that mental health service users are involved in the commissioning process of mental health services.
- 4.10 An outcomes based performance framework will be used to measure service user outcomes, provider performance and activity for each of the three types of advocacy provided under the proposed integrated health advocacy service. This will enable commissioners to monitor performance against each service area: NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy ensuring that the nuance of each of these types of advocacy provision is not lost through an integrated model.

## 5.0 Equality Impact Assessment

- 5.1 Following the consultation process, the Equality Impact Assessment has been reviewed and updated to reflect the consultation findings and profile of respondents and is awaiting final approval (see background paper 3).

## 6.0 Timescales associated with the decision and next steps

- 6.1 Following cabinet's decision, the table below sets out the critical milestones and key deadlines for the tendering and commissioning of the Health Advocacy Service.

<b>Milestones</b>	<b>Deadline</b>
Cabinet meeting	12 October 2017
Tender process begins	1 November 2017
Tender process closes	30 November 2017
Tender evaluation period	30 December 2017
Contract award	26 January 2018
Service transition period	February and March 2018
New service starts	1 April 2018

Cabinet is asked to note that commissioners are currently seeking permission to extend the existing contracts expiration date to 30<sup>th</sup> June 2018, to allow for a longer transition period to new services. If this is approved, the new services will commence on 1<sup>st</sup> July 2018.

6.2 Providing feedback to respondents is a vital element of the consultation process and this will be undertaken by ensuring the final consultation report is made publicly available on 'Ask Warwickshire' and widely shared with all partners and stakeholders.

## Background papers

None

## Appendices

1. Description of health advocacy services
2. Consultation Report
3. Equality Impact Assessment

	<b>Name</b>	<b>Contact Information</b>
Report Authors	Catherine Rigney Public Health Officer	<a href="mailto:catherinerigney@warwickshire.gov.uk">catherinerigney@warwickshire.gov.uk</a> Tel: 01926 413794
	Paula Mawson Commissioning Lead Public Mental Health	<a href="mailto:paulamawson@warwickshire.gov.uk">paulamawson@warwickshire.gov.uk</a> Tel: 01927 413713
Head of Service	John Linnane	<a href="mailto:johnlinnane@warwickshire.gov.uk">johnlinnane@warwickshire.gov.uk</a>
Joint Managing Director	Monica Fogarty	<a href="mailto:monicafogarty@warwickshire.gov.uk">monicafogarty@warwickshire.gov.uk</a>
Portfolio Holder	Cllr Les Caborn	<a href="mailto:lescaborn@warwickshire.gov.uk">lescaborn@warwickshire.gov.uk</a>

The report was circulated to the following members prior to publication:

Local Member(s): N/A

Other members: Councillors Caborn, Redford, Golby, Parsons, Morgan, Rolfe



## **Appendix 1 - Description of three health advocacy services**

### NHS Complaints Advocacy

NHS Complaints Advocacy is a statutory service, which means local authorities are required to make arrangements for it to be provided. It supports people in Warwickshire who may want to raise a complaint about NHS funded care (including a complaint to the Parliamentary and Health Service Ombudsman). Services range from provision of self-help and signposting, dedicated advocates to support people through the process, to include; assistance in letter writing, filling in NHS forms and attendance at health related meetings, if required.

### General Health Advocacy

General Health Advocacy is a non–statutory advocacy service and is focused on supporting individuals with more complex needs, including people aged over 65, people with learning and /or physical disabilities who would benefit from advocacy support whilst receiving NHS treatment, particularly at the point of discharge.

### Independent Mental Health Advocacy

Independent Mental Health Advocacy (statutory service) supports qualifying mental health patients to understand the legal provisions, rights and safeguards to which they are entitled under the Mental Health Acts. This help may include:

- Supporting patients in accessing information and better understanding what is happening to them;
- Supporting qualifying patients in exploring options, making better informed decisions and actively engaging with decisions that are being made;
- Supporting qualifying patients in articulating their own views;
- Speaking on the patient’s behalf and representing them;
- Supporting patients in other ways to ensure they can participate in the decisions that are made about their care and treatment
- Patients are able to access this provision whilst they are in-patients and whilst being treated in the community where they meet the full service access criteria.

In addition, non-statutory IMHA provision is also available, so that all mental health inpatients can access an advocate, not just those on qualifying sections for statutory IMHA. Furthermore, community IMHA is also available to support patients accessing specialist mental health services in the community to enable them to maintain their

wellbeing and recovery, and working with clients to resolve emerging or ongoing issues. This could include for example supporting patients to access debt management or housing services, and / or help patients to have their voice heard in their care planning.

# Appendix 2 - Health Advocacy Services Consultation Report

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## 1.0. Introduction

There are currently three health advocacy services commissioned by Warwickshire County Council through Public Health Warwickshire, these include NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy.

NHS Complaints Advocacy (statutory service) supports people in England who may want to raise a complaint about the NHS (including a complaint to the Parliamentary and Health Service Ombudsman). Services range from provision of self-help and signposting, dedicated advocates to support people through the process, to include; assistance in letter writing, filling in NHS forms and attendance at health related meetings, if required.

General Health Advocacy (non-statutory service) is focused on supporting individuals with complex needs who would benefit from advocacy support whilst receiving NHS treatment, particularly at the point of discharge. It is targeted towards individuals over the age of 65, or people who have either physical disabilities and/or learning disabilities.

Independent Mental Health Advocacy (statutory and non-statutory service) supports qualifying mental health patients to understand the legal provisions, rights and safeguards to which they are entitled under the Mental Health Acts. This help may include:

- Supporting patients in accessing information and better understanding what is happening to them;
- Supporting qualifying patients in exploring options, making better informed decisions and actively engaging with decisions that are being made;
- Supporting qualifying patients in articulating their own views;
- Speaking on the patient's behalf and representing them;

- Supporting patients in other ways to ensure they can participate in the decisions that are made about their care and treatment
- Patients are able to access this provision whilst they are in-patients and whilst being treated in the community where they meet the full service access criteria.
- Non – statutory mental health advocacy provision is also provided so that all mental health inpatients (not just those on a statutory section) can access an advocate. Alongside this, advocates are also available in the community to meet with patients who are receiving specialist mental health care and treatment in the community.

The current contracted services for NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy comes to an end on 31st March 2018. An 8 week consultation process was undertaken during June and July 2017 to seek stakeholder views on a proposed new service model for Health Advocacy Service provision in Warwickshire. Public Health carried out engagement work with stakeholders, service users and their families and current providers in preparation for the redesign of this service which has informed the updated Needs Assessment.

### 1.1. Proposed service model

There are three key changes that we are proposing to make to Warwickshire’s Health Advocacy Services provision. These changes are outlined in Table 1:

**Table 1: Three key changes that we are proposing to make to Warwickshire’s Health Advocacy Services**

Proposed change	More information
<b>Access to Health Advocacy Services</b>	<p>Currently, to access any of the three Health Advocacy Services, you, or your referrer, need to know about and approach the three services separately. We would like to change this so that the three Health Advocacy services are delivered as one service, and delivered by one provider (or a partnership of providers). This model is available in other parts of the country.</p> <p>We think a combined model might help to:</p> <ul style="list-style-type: none"> <li>• make it easier for people to know about the services and seek support from them</li> <li>• reduce the need for people to be seen by more than one service provider, as we know that some people need support from more than one health advocacy service</li> <li>• reduce the amount of times that clients have to describe their experiences more than once to different advocates and providers</li> <li>• make our services more efficient and effective for the</li> </ul>

	<p>people who use them</p> <ul style="list-style-type: none"> <li>• help us to deliver better value for money for the public, from the public purse</li> </ul>
<p><b>Timescales for Service</b></p>	<p>Individuals who have a statutory right to an advocate (NHS Complaints Advocacy &amp; Statutory Independent Mental Health Advocacy) also have rights to be seen by their advocate within set timescales. We will continue to make sure that the new health advocacy service provider (or partnership) meets the requirements for responding to referrals, and seeing new clients within the statutory guidelines. However, this may mean that individuals who are referred for non-statutory provision (General Health Advocacy &amp; non-statutory Independent Mental Health Advocacy) may have more flexible waiting times as statutory referrals will be prioritised first.</p> <p>Flexible waiting times for non-statutory advocacy services could result in some individuals waiting a longer time period to be seen by an advocate, but it could also mean that some clients will be seen more quickly. For example, if you are an informal inpatient in mental health services, and you approach an advocate on the ward during their ward visits, they may be able to respond to your issue immediately and help you to resolve it. Where individuals have to wait longer we are keen to hear views about what might be helpful during this period, and we have included some suggestions in our consultation questions for consideration.</p>
<p><b>Partnership working with Healthwatch</b></p>	<p>Through working with their clients, Health Advocacy Services get to know a lot about what is working well with our NHS health services, and what could be improved. We think that this collective knowledge could be better used to help improve our local health services, particularly by sharing themes and trends with our local Healthwatch service.</p> <p>We are therefore proposing to create a stronger partnership between our local Health Advocacy Services and our local Healthwatch service. Healthwatch is a statutory service and it exists to be the consumer champion for accessing local health and social care services. You can find out more about the existing Healthwatch service here:  <a href="http://www.healthwatchwarwickshire.co.uk/">http://www.healthwatchwarwickshire.co.uk/</a></p> <p>We are not proposing that any personal information about any of the clients that the Health Advocacy Services or Healthwatch service works with is shared. It would only involve the providers discussing themes and trends that people are facing with health services locally, so that Healthwatch can champion for</p>

	improvements to be made. We hope that a stronger partnership will also result in Healthwatch making more referrals to the Health Advocacy Services.
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To inform the proposed service model, Warwickshire County Council, Public Health has already undertaken the following work:

- Completed a full service review of the existing service
- Completed a needs analysis for health advocacy services in Warwickshire

Through the One Organisational Plan 2017-20, the County Council describes how it will rise to the challenge of making Warwickshire the best it can be. Over the last three years, the council has delivered £92 million of savings and is now faced with making further savings of £67 million. This means shaping the future of a very different County Council and different public service provision that can be afforded both now and up to 2020.

Since 2015/16 Public Health has experienced a significant and recurrent reduction to its ring fenced grant funding from the Department of Health. In addition to local Council savings, the impact of these reductions is significant and a challenge to achieve. In order to meet this challenge, Public health is redesigning its services, ensuring that prevention and early intervention are a major part of the new offer to the public, whilst continuing to commission priority, high quality and value for money services. We must ensure that vulnerable citizens are supported and that services are as efficient and effective as possible.

## **2.0. Consultation process**

### **2.1. Background**

An 8 week consultation started on 9 June 2017 and ended on 31 July 2017. The aim of this consultation activity was to effectively engage with current and previous advocacy service users and other key stakeholders on the proposed service model and ensure there were opportunities for them to influence and shape the new service.

A range of engagement methods were employed to maximise opportunities for service users and other key stakeholders to put forward their views, these included. Advocacy services work with vulnerable people who are often seldom heard, therefore, maximum effort was made to ensure that these groups had ample opportunity to feed into this process. Methods of consultation included:

- Survey (both on line and paper format)
- For individuals who require additional support to contribute, other options were provided, including focus groups and discussion based individual feedback
- Provider engagement/market testing event held on 19 July 2017
- Engaging stakeholders at planned local events and forums e.g. Making Space Mental Health Service User forums, focus groups via Grapevine for people with learning disabilities
- Face to face engagement at relevant hospital locations

Where possible and appropriate, shared consultation activities were carried out in conjunction with other Public Health commissioners who were also conducting consultation activity with similar time frames. This approach helped to avoid over consulting and duplication of engagement with similar stakeholders as well as providing an opportunity for Public Health to promote and share information on a range of services to a wider audience.

Costs relating to the consultation were met within current Public Health budgets.

An Equality Impact Assessment (EqIA) was completed to support the consultation. The EqIA was reviewed and updated as part of this consultation process (see background paper 3).

## 2.2. Consultation/engagement activity

### 2.2.1. Communication channels

The Health Advocacy Service consultation was promoted via internal and external communications channels (Table 2).

**Table 2: Internal and external channels utilised to promote the Health Advocacy Services consultation**

Channel	Detail
<b>External</b>	
Ask Warwickshire	warwickshire.gov.uk/ask
Email	External and internal - see distribution list below
Social Media	Posts to Twitter, Facebook, Instagram
Face to face	Public engagement in libraries, hospitals, community forums
Newsletters	SWCCG newsletter, WCAVA grapevine, Healthwatch newsletter and internal newsletters (see below).
Press notice x 4	Sent to countywide media
Hospitals	CCG comms leads, SWFT hospital magazine
WCC libraries	Public engagement
GP surgeries	Email
Pharmacists	Email
<b>Internal</b>	
Re:member	Newsletter to councillors
Intranet homepage	Headline slot
MD briefing	Joint Managing Director briefing to all staff
Your Warwickshire	Newsletter to MP's
Group briefings	Included in Resources, Communities and Fire & Rescue, People Group
Public Health Matters	Public Health department newsletter

#### Email Distribution List

- Countywide press
- District and borough councils
- Parish councils
- Warwickshire MP's
- Members - county councillors
- Third sector contacts
- CCG's
- Public Health master list
- GP's
- Pharmacies
- Colleges
- Drug and alcohol contacts
- Move Improve contacts
- Re:member
- Group briefings - F&R, Communities, Resources, People
- Comms Leads
- Fitter Futures contacts
- Healthwatch newsletter



- CAVA - Grapevine
- Schools - heads up and schools post
- MD Briefing
- Website - health and wellbeing updates (600 subscribers)
- Police and Crime Commissioner
- Coventry and Warwickshire Partnership Trust
- South Warwickshire Foundation Trust
- Patient Advice and Liaison

### 2.2.2. Consultation/engagement activity

Further targeted work was undertaken to engage Warwickshire residents in the Health Advocacy Service consultation (Table 3).

**Table 3: Targeted work undertaken to engage with residents on the Health Advocacy Services consultation**

Activity	Date(s)	Number of consultees
Mental health service user involvement forums	11 July 2017 17 July 2017 20 July 2017 21 July 2017	33
Consultation with Social Work Operational Teams at WCC	24 July 2017	7
Focus groups run by Grapevine – service user involvement for people with learning disabilities	13 July 2017 17 July 2017	24
Completing surveys and promoting the consultation in St Michaels and Cauldon Centre (secondary care mental health treatment centres)	9 June – 31 July 2017	Approximately 20
Completing surveys and promoting the consultation at Warwick and Stratford libraries	9 June – 31 July 2017	Approximately 20
Completing surveys and promoting the consultation at Warwick Hospital	9 June – 31 July 2017	Approximately 50
Completing surveys and promoting the consultation at University Hospital Coventry and Warwickshire	9 June – 31 July 2017	Approximately 20
Market engagement activity	19 July 2017	
Promotion of the consultation to the Warwickshire North Delivery Group	9 June – 31 July 2017	
Letter from current providers to current and previous service users, promoting the consultation	9 June – 31 July 2017	110
Promotion of the consultation to all staff at Coventry and Warwickshire Partnership Trust. Activity included links to the survey in 2 e-bulletins to staff, distribution of the postcards and posters	9 June – 31 July 2017	

### **2.2.3. Detail about main consultation methods**

#### **2.2.3.1. Survey**

A survey was developed as an accessible and generic version to support the wide range of potential respondents and was available on the council's Ask Warwickshire webpage. Paper copies of the survey were also made available with prepaid envelopes and ballot boxes, which were distributed to 7 Wellbeing Hubs across Warwickshire for service users, their families and staff to complete.

An email was sent out to all stakeholder organisations and agencies on the first day of the consultation period which included a hyperlink to the on line version of the survey. A telephone line and consultation email address were created for queries and those needing more support.

The survey received 46 responses, where over half (52%) of respondents completed the survey online and the remaining respondents (48%) completed the paper version of the survey.

#### **2.2.3.2. Focus Group**

Public Health Warwickshire asked Grapevine to consult people with a learning disability about proposals to change the way Health Advocacy Services are delivered. Grapevine undertook four consultation sessions involving 24 individuals. Two of the sessions took place in Stratford upon Avon, one was in Leamington Spa and one was in Nuneaton.

Grapevine used materials designed in-house to make the consultation questions easier to understand. This included

- an easy read version of the consultation document, used in group sessions to outline the potential changes to the service and stimulate discussion
- a 'keywords' list that gave easy read explanations of some of the difficult terms in the original document
- re-worded consultation questions so that they would be easier to understand, but still have the information people needed in order to give an answer. For each question in the consultation, Grapevine produced a feedback form that included either a simple tick box list for recording opinions, or an empty speech bubble for noting more detailed responses. The tick box list options were backed up with pictorial prompts from Photo Symbols.

Some who took part in the consultation sessions could read and write, so Grapevine supported them to record their feedback when this was needed.

It was ensured that the focus groups gave rise to a safe place for service users, family, staff and others to express their honest thoughts and feelings around the current service provision for Health Advocacy Services, and what they hoped to see delivered in the future. Commissioners and supporting officers felt this form of

engagement was particularly valuable, and all views were considered as part of creating the service specifications.

#### **2.2.3.3. Market engagement**

Public Health organised two market engagement days to give potential providers of the new service the opportunity to comment on the proposals and ask questions. The days were advertised through CSW-Jets. It was decided to offer individuals appointments, rather than hold a workshop-style event to allow for more detailed discussions to take place with providers. In addition, providers were also able to contribute via completing a market test questionnaire.

#### **2.2.3.4. Stakeholder engagement**

A number of meetings were also attended during the consultation period including Social Care Teams Operational Meeting and CCG Members Engagement Meeting which included local GPs/Practice managers and nurses to raise awareness of the consultation and respond to any specific questions from stakeholders.

#### **2.2.3.5. Mental health forums**

Public Health Warwickshire asked Making Space, mental health service user co-production service, to support with the consultation. Making Space work with individuals with mental health problems, and run mental health service user co-production forums, which are an opportunity for mental health service users to discuss views and opinions in relation to mental health service provision and identify key issues, which are then passed on to commissioners.

Public Health was invited to four forums across Warwickshire: (Nuneaton 11th July 2017, Stratford on Avon 17th July 2017, Rugby 20th July 2017 and Warwick 21st July 2017). Public Health staff and forum attendees discussed the key proposals under consultation and responses were recorded and themed.

### **2.3. Profile of Respondents**

Due to the informal nature of some of the consultation methods, it is not possible to summarise the respondent profile succinctly.

The consultation responses represent the views of around 105 individuals:

- Survey – 46 responses
- Grapevine focus groups – 23 attendees
- Mental health forums – 23 attendees
- Providers – 6 attendees face to face, with 2 organisations submitting online
- Stakeholders – 7 attendees

## 3.0. Results

This consultation report provides further detailed analysis of the responses received during the consultation period together with a set of emerging key messages.

For a full detail of all survey respondent profiles, please see Table 4. The survey received 46 responses in total, of which 35% were from either current or former health advocacy service users. Carers represented 16% of respondents, with health or care professionals/referrers representing 21% of respondents. Members of the public who have not used advocacy services before represented 25% of respondents.

The majority (59%) of respondents were female, with 41% of respondents aged 30-44. 47% of respondents reported that they have a long standing illness or disability, with 87% identifying themselves as White British and 51% recording their religion as Christian. The majority of respondents (77%) reported their sexuality as heterosexual or straight, with a fairly representative geographical profile of respondents (the highest proportion of respondents were from Warwick district (25%), with the lowest proportion from Rugby Borough (9%), reflecting the underlying population sizes).

47% of responses related to all three health advocacy services, with 24% relating specifically to NHS Complaints Advocacy, 18% referring to General Health Advocacy and 12% referring to Independent Mental Health Advocacy.

### 3.1. Survey

The 'Health Advocacy Services (NHS Complaints Advocacy, General Health Advocacy and Independent Mental Health Advocacy)' consultation took place between 9th June and 31st July 2017. The survey received 46 responses, where over half (52%) of respondents completed the survey online and the remaining respondents (48%) completed the paper version of the survey.

#### 3.1.1. Key Messages

- The majority of respondents (81%) were in support of the proposed change to combine the three health advocacy services into one service that would be delivered by one provider (or one partnership of providers). Respondents felt this would reduce confusion, but highlighted that staff would need to have knowledge of all three service areas. Concerns were raised regarding the challenge of managing a potentially very large service.
- Over three-quarters (76%) of respondents agreed that the proposal to combine the three services into one advocacy service would result in the benefits outlined.
- 42% of respondents expressed concern that more flexible waiting times for non-statutory advocacy provision would lead to increased stress amongst non-statutory service users, which may result in people falling through the net and not receiving the help they require. These respondents felt that people in

the community are often the most vulnerable and most in need and that statutory service users should not be prioritised over them.

- The majority of respondents selected all of the suggestions provided to help minimise any negative impacts that may result from more flexible waiting time for non-statutory advocacy service users.
- Nearly all of the respondents (98%) agreed that it would be helpful for Health Advocacy Services and Healthwatch Warwickshire to work more closely together. Respondents felt this was a great idea and questioned why it had not been done before. Concerns were raised amongst a few respondents around staff turnover and competing advocacy services trying to undercut each other for contracts.
- The most popular method for finding out about services was ‘Service leaflets / posters available in health settings (Hospitals, GP surgeries)’ with 61% of all respondents selecting this approach. This was followed by ‘Health professionals telling you about the services as part of your treatment and care planning’ (50%). Some respondents suggested people would not look at County Council websites to find out about services and that professionals need more training and knowledge in order to promote the services.
- Respondents felt more advertisement and awareness of the serviced offered was needed for future advocacy services and that it should be the best service that is commissioned, not the cheapest.

### 3.1.2. Respondents

Details of the respondent profile can be found in Table 1. Nearly half (47%) of all respondents comments related to all of the advocacy services outlined. Over one quarter of respondents (29%) were either current or former advocacy service users.

**Table 4: Respondent Profile for Health Advocacy Consultation**

		Count	%
<b>Gender</b>	Male (including trans man)	18	39%
	Female (including trans female)	27	59%
	Other (including non-binary)	1	2%
<b>Age in years</b>	Under 18	1	2%
	18-29	10	22%
	30-44	19	41%
	45-59	13	28%
	60-74	3	7%
	75+	1	2%
<b>Long standing illness or disability</b>	Yes	20	47%
	No	23	54%
<b>Ethnicity</b>	White – English/ Welsh/ Scottish/ Northern Irish /	39	87%
	White - Irish	2	4%
	Mixed - Any other mixed background	1	2%
	Asian or Asian British - Indian	1	2%
	Black or Black British - African	1	2%

	Black or Black British - Caribbean	1	2%
<b>Religion</b>	Christian	23	51%
	Hindu	1	2%
	Other - please specify	4	9%
	None	12	27%
	Prefer not to say	5	11%
<b>Sexuality</b>	Heterosexual or straight	33	77%
	Gay or lesbian	2	5%
	Bisexual	1	2%
	Prefer not to say	7	16%
<b>District/ Borough</b>	North Warwickshire	7	16%
	Nuneaton & Bedworth	9	21%
	Rugby	4	9%
	Stratford-on-Avon	8	18%
	Warwick	11	25%
	Other	7	16%
<b>Are you...</b>	A current Health Advocacy service user	6	11%
	A former Health Advocacy service user	10	18%
	A member of the public – has not used advocacy services before	14	25%
	A health or care professional/referrer	12	21%
	Someone who looks after or cares for an individual	9	16%
	Other, please state*	6	11%
<b>What service(s) do your comments relate to?</b>	NHS Complaints Advocacy	12	24%
	General Health Advocacy	9	18%
	Independent Mental Health Advocacy	6	12%
	All	24	47%

The following descriptions were given for those selecting the other category:

- A former NHS complaints advocacy user
- Former advocate
- I am a mental health service user
- I am a mental health user in recovery
- Mental Health Service user
- Retired ward sister in MH services

### 3.1.3. Proposals

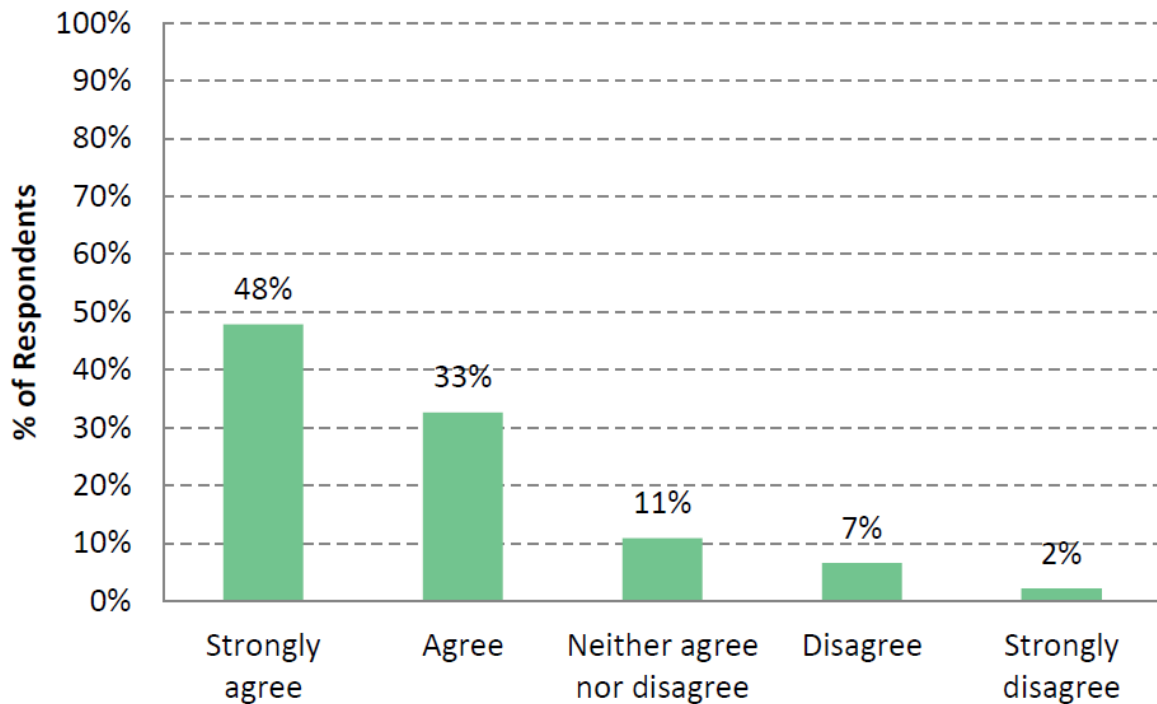
#### 3.1.3.1. Access to Health Advocacy Services

Respondents were given the following information:

*Currently, to access any of the three Health Advocacy Services, you, or your referrer, need to know about and approach the three services separately. We would like to change this so that the three Health Advocacy services are delivered as one service, and delivered by one provider (or a partnership of providers). This model is available in other parts of the country.*

**1a) Do you agree or disagree with the proposed change for the three health advocacy services to be combined into one service that would be delivered by one provider (or one partnership of providers)?**

The majority of respondents (81%) were in support of the proposed change outlined in question 1a (figure 1). Respondents who identified themselves as ‘a member of the public’ were most likely to disagree with the proposal (table 2), though caution should be exercised with these findings given the small base-counts.



**Figure 1: Agreement levels for question 1a**

**Table 5: Levels of agreement by respondent type for question 1a**

	Base count	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
A current Health Advocacy service user	6	0%	0%	0%	50%	50%
A former Health Advocacy service user	10	10%	0%	0%	70%	20%
A member of the public – has not used advocacy services before	14	0%	14%	7%	36%	43%
A health or care professional/referrer	12	0%	0%	17%	33%	50%

Someone who looks after or cares for an individual	9	0%	11%	11%	22%	56%
Other	6	0%	0%	0%	17%	83%

Respondents were asked to add any further comments they may have. The following key themes emerged from the 26 open-ended responses:

One service would reduce confusion

Many respondents were in favour of combining the current three advocacy services into one service to be delivered by one provider. Respondents felt this would reduce confusion, increase efficiency, and increase accessibility.

*“There is currently too much confusion amongst the public and also professionals about what services are available, what they do and a great deal of people are missing out on services and too much time wasting referring to wrong service.”*

*“A combined service is better when users changed from detained informal or community, it means that they have continuity and don’t have to see another person in another service when they have built up a rapport and trust with an advocate... ensures that users don’t fall into a gap between services as they often give up on help if the system is too difficult to navigate”*

*“having one amalgamated service would reduce confusion, and aid practitioners to refer to the correct service more easily to enable access to service for clients.”*

Staff need to have knowledge of all three service areas

Some respondents whilst in support of combining the three services into one, highlighted that this would only work with adequately trained staff.

*“...provider will need to have specialist knowledge of each of these areas-rather than generic staff with insufficient training and resource.”*

*“...an independent advisor must be available who is aware of the three areas.”*

Will it be too big and therefore difficult to manage?

Some respondents were concerned that combining the three services into one would result in too large a service that would be difficult to manage.

*“Putting all three things under one roof has got to be beneficial, as long as its not so big that it cannot be managed correctly.”*



*“Provided standards of service are maintained...”*

*“Too big a workload for one organisation.”*

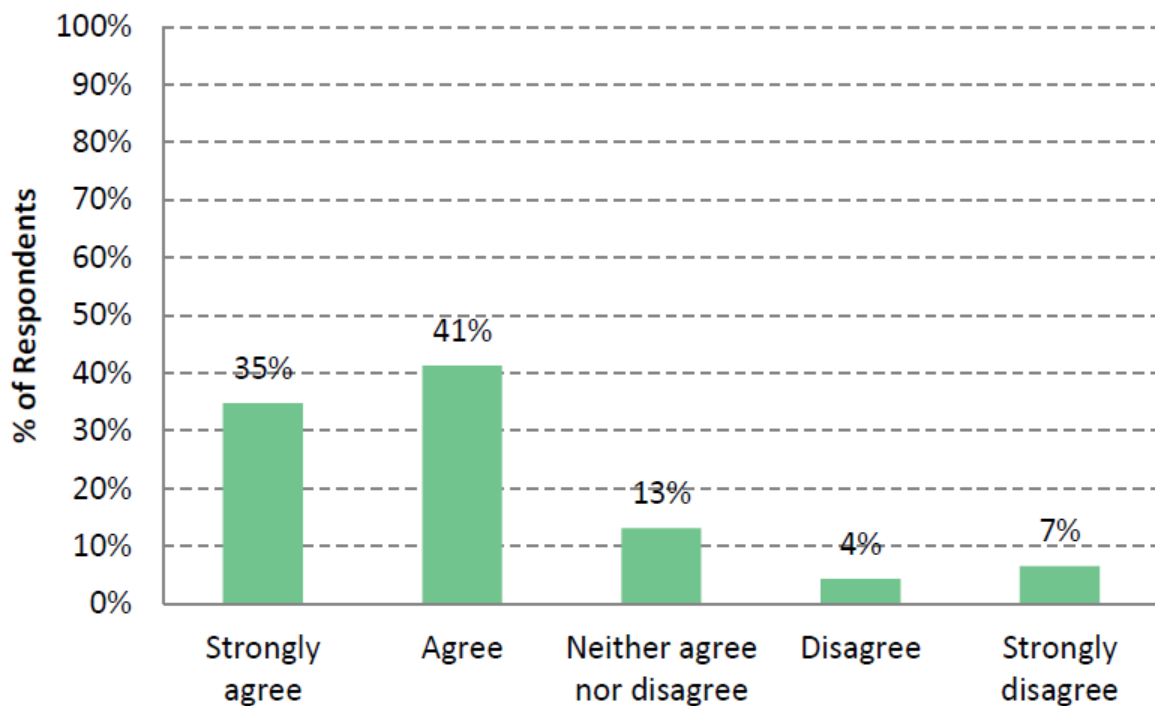
**1b. Do you agree or disagree that our proposal to combine the three services into one advocacy service will result in the benefits outlined?**

Respondents were given the following information:

*We think a combined model might help to:*

- *make it easier for people to know about the services and seek support from them*
- *reduce the need for people to be seen by more than one service provider, as we know that some people need support from more than one health advocacy service*
- *reduce the amount of times that clients have to describe their experiences more than once to different advocates and providers*
- *make our services more efficient and effective for the people who use them*
- *help us to deliver better value for money for the public, from the public purse.*

Over three-quarters (76%) of respondents agreed that the proposal to combine the three services into one advocacy service would result in the benefits outlined (figure 2). Table 3 demonstrates the breakdown of responses by respondent type.



**Figure 2: Agreement levels for question 1b**

**Table 6: Levels of agreement by respondent type for question 1b**

	Base count	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
A current Health Advocacy service user	6	17%	0%	0%	67%	17%
A former Health Advocacy service user	10	20%	0%	0%	60%	20%
A member of the public – has not used advocacy services before	14	0%	7%	21%	36%	36%
A health or care professional/referrer	12	0%	0%	17%	58%	25%
Someone who looks after or cares for an individual	9	0%	11%	0%	56%	33%
Other	6	0%	0%	0%	17%	83%

Respondents were asked to add any further comments they may have. The following key themes emerged from the 14 open-ended responses:

In theory the benefits will be achieved, but we cannot be certain

Though the majority of respondents agreed that the proposal to combine the three services into one service would result in the benefits outlined, some respondents were fearful that it may lead to a lack of local knowledge.

*“Combining services does not necessarily achieve the benefits described. There may be some losses by losing local knowledge.”*

*“Although I agree with the services merging, this should not result in the Advocates themselves losing their knowledge of a particular part of the work by expecting them to work in all areas so that they do not have the depth of knowledge or by using volunteers who may not have the same time or commitment or knowledge of paid employees.”*

*“Combining these into a single service does not ensure quality or effectiveness of the service.”*

**3.1.3.2. Timescales for non-statutory advocacy service**

Respondents were given the following information:

*Individuals who have a statutory right to an advocate (NHS Complaints Advocacy and statutory Independent Mental Health Advocacy IMHA) also have rights to be seen by their advocate within set timescales. We will continue to make sure that the*

*new health advocacy service provider (or partnership) meets the requirements for responding to referrals, and seeing new clients within the statutory guidelines. However, this may mean that individuals who are referred for non-statutory provision (General Health Advocacy and non-statutory IMHA), may have more flexible waiting times as statutory referrals will be prioritised first.*

*Flexible waiting times for non-statutory advocacy services could result in some individuals waiting a longer time period to be seen by an advocate, but it could also mean that some clients will be seen more quickly. For example, if you are an informal inpatient in mental health services, and you approach an advocate on the ward during their ward visits, they may be able to respond to your issue immediately and help you to resolve it. Where individuals have to wait longer we are keen to hear views about what might be helpful during this period, and we have included some suggestions in our consultation questions for consideration.*

**2a. People who are accessing statutory advocacy provision (NHS Complaints Advocacy and statutory Independent Mental Health Advocacy for people sectioned under the Mental Health Act) will be prioritised to receive support. What impact do you think having more flexible waiting times for non-statutory advocacy provision (General Health Advocacy and non-statutory Independent Mental Health Advocacy) might have on individuals using the service? Please add any further comments you may have.**

Over half (67%) of all respondents chose to leave a comment. The following key themes emerged from the 31 open-ended responses:

What about people who have been discharged and are in the community?

A number of respondents were concerned that people in the community would not receive the help they need. Some respondents felt that it was these individuals who were most vulnerable and therefore most in need.

*“When people are discharged from statutory services, they are instantly dropped. So I think it's not fair for people not in statutory services to not get priority.”*

*“The clients who are not priority whose issues cannot be resolved during the advocates visit to the ward may have been discharged by the time the advocate is able to address their issues with them, I am not sure if after referral the advocacy service would visit clients in the community.”*

*“It is very disappointing because there are some people who need this support desperately in the community and they are not prioritised.”*

*“I believe that the non-statutory community service is vital as advocates support people to remain in the community before reaching crisis point and becoming statutory or inpatient. There appear to be more people in the community who are reaching crisis point but unable to access a hospital bed or support for prevention.”*

*“A huge impact for people accessing community based services who needs support, for example adults with a Learning Disability, or Autism, living in the community. With the Transforming Care drive to avoid hospital admission, we would hope that patients will not be on wards, and will therefore not access statutory advocacy. These individuals still desperately need advocacy, for example in helping them to access appropriate care, financial support, and housing, and they will face even longer waiting times and isolation. These individuals are already isolated, vulnerable, and struggle to access or negotiate services. The proposed changes will impact negatively on the most vulnerable people in the community.”*

#### People with mental health issues need to be prioritised

Some respondents agreed that individuals with mental health issues should be prioritised.

*“Patients sectioned on the MHA need to be prioritised to ensure that their rights under legislation to appeal etc are safeguarded.”*

*“More support for mental ill people”*

*“Should alleviate stress for sectioned patients and enable them to voice their concerns more easily.”*

#### This will create stress and stop people from accessing the services they need

Some respondents were opposed to priority being given to people accessing statutory advocacy provision. Reasons for this opposition included the belief that people would fall through the net, and that it would create distress amongst those expected to have more flexible waiting times.

*“Delay causes dispute giving up and not achieving the service needed.”*

*“Each case needs to be assessed on its merits. An individual's personal circumstances can make them much more vulnerable than another person in a more favourable overall situation regardless of fitting into simple statutory criteria.”*

*“I think people can be prioritised based on need more a combined model.. It's sometimes difficult for users to hear that they can't get help from the advocate who is helping someone else because they have to access a different service.”*

*“Lower priority - longer waits, more frustration, for non-priority individuals. Ultimately will they lose the service altogether?”*

*“This may lead to frustration and anxiety for some clients. A prospective timescale should be provided as far as possible.”*

*“The impact will be people waiting longer for advocacy and not getting a service at all.”*

**2b. Would any of the following suggestions help to minimise any negative impacts? Select all that apply**

Table 4 shows that the majority of respondents selected all of the suggestions provided. Over three quarters (76%) of respondents selected ‘Better service promotion so that people are referred into the non-statutory service earlier and before reaching a crisis point’ as a suggestion to help minimise any negative impacts resulting from more flexible waiting times for non-advocacy provision.

There was little variation to this question based on the respondent type (table 5).

**Table 7: Number of responses received for each option in question 2b**

	Count	% of respondents selecting this option
<i>Better service promotion so that people are referred into the non-statutory service earlier and before reaching a crisis point</i>	35	76%
<i>Increased knowledge of the Health Advocacy Services by health, social care and other professionals so that they refer or signpost</i>	34	74%
<i>Making self-referral routes available so that people don't have to wait for a professional to make a referral</i>	33	72%
<i>Providing toolkits and other self-help information to support people to self-advocate whilst they are waiting for an advocate from the</i>	29	63%
<i>Regular updates and contact from the advocacy provider about when the advocacy service will commence, so people are not left</i>	29	63%
<i>Advocacy Service volunteers making contact with the client/keeping in touch with the client to understand any changing circumstances</i>	28	61%
<i>Other, please state:</i>	11	24%

The following suggestions were provided by respondents who selected ‘Other’ to question 2b:

- *“Communication and promote self-help by boosting knowledge and confidence”*
- *“Have used self-referral at Warwick Hospital. It worked well”*
- *“I think they have the knowledge but not the time to educate”*
- *“Mine keep in regular contact with each other”*
- *“Not sure what are the 'suggestions'!!”*
- *“Please do not promote unless you have invested enough money to provide enough advocacy time”*
- *“Self-referral may result in people who are able to speak up for themselves asking for help and taking the time of advocates that should be given to*

patients who are more seriously ill unless a lot more money for advocacy is available so that all patients can be reached”

- “The statutory NHS and independent advocacy are both required to help mental service users”

**Table 8: Number of responses received for each option in question 2b by respondent type**

	A current Health Advocacy service user (n=6)	A former Health Advocacy service user (n=10)	A member of the public – has not used advocacy services before (n=14)	A health or care professional /referrer (n=12)	Someone who looks after or cares for an individual (n=9)	Other (n=11)
	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option
<i>Better service promotion so that people are referred into the non-statutory service earlier and before reaching a crisis point</i>	5 (83%)	5 (50%)	11 (79%)	12 (100%)	7 (78%)	5 (45%)
<i>Increased knowledge of the Health Advocacy Services by health, social care and other professionals so that they refer or signpost people to services earlier</i>	5 (83%)	6 (60%)	9 (64%)	11 (92%)	8 (89%)	5 (45%)
<i>Making self-referral routes available so that people don't have to wait for a professional to make a referral</i>	5 (83%)	8 (80%)	9 (64%)	10 (83%)	8 (89%)	3 (27%)
<i>Providing toolkits and other self- help information to support people to self-advocate whilst they are waiting for an advocate from the service provider/partnership</i>	5 (83%)	6 (60%)	8 (57%)	10 (83%)	8 (89%)	3 (27%)

<i>Regular updates and contact from the advocacy provider about when the advocacy service will commence, so people are not left waiting indefinitely</i>	4 (67%)	6 (60%)	10 (71%)	10 (83%)	7 (78%)	3 (27%)
<i>Advocacy Service volunteers making contact with the client/keeping in touch with the client to understand any changing circumstances</i>	4 (67%)	6 (60%)	9 (64%)	9 (75%)	6 (67%)	3 (27%)
<i>Other</i>	0	1 (10%)	4 (29%)	1 (8%)	4 (44%)	3 (27%)

### 3.1.3.3. Partnership working with Healthwatch

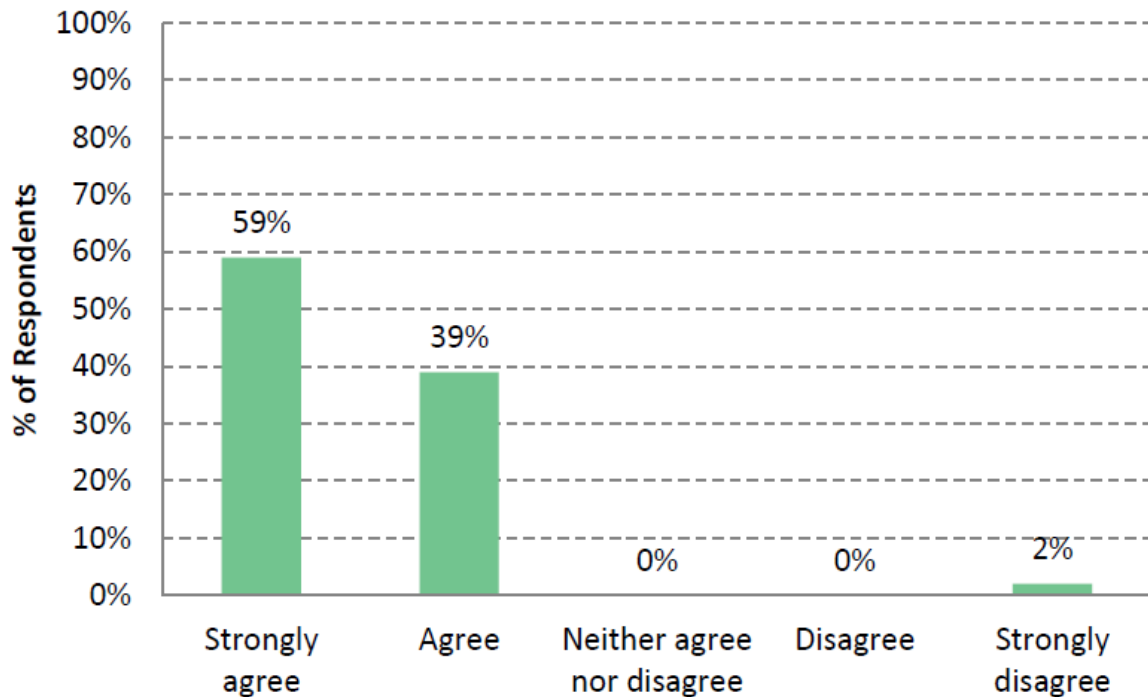
Respondents were given the following information:

*‘Through working with their clients, Health Advocacy services get to know a lot about what is working well with our NHS health services, and what could be improved. We think that this collective knowledge could be better used to help improve our local health services, particularly by sharing themes and trends with our local Healthwatch service. We are therefore proposing to create a stronger partnership between our local Health Advocacy Services and our local Healthwatch service. Healthwatch is a statutory service and it exists to be the consumer champion for accessing local health and social care services.*

*We are not proposing that any personal information about any of the clients that the Health Advocacy Services or Healthwatch service works with is shared. It would only involve the providers discussing themes and trends that people are facing with health services locally, so that Healthwatch can champion for improvements to be made. We hope that a stronger partnership will also result in Healthwatch making more referrals to the Health Advocacy Services.’*

#### **3a. Do you agree or disagree that it would be helpful for Health Advocacy Services and Healthwatch Warwickshire to work more closely together, sharing trends and themes on emerging common issues, and promoting more referrals from Healthwatch to Advocacy Services?**

Nearly all of the respondents (98%) agreed that it would be helpful for Health Advocacy Services and Healthwatch Warwickshire to work more closely together (figure 3). Only one respondent disagreed with this proposal, and they identified themselves as a former advocacy service user.



**Figure 3: Agreement levels for question 3a**

Respondents were asked to add any further comments they may have. The following key themes emerged from the 10 open-ended responses:

This is a great idea, why hasn't it been done before?

Respondents supported this proposal and questioned why it had not been done before.

*"Why hasn't this been done before?"*

*"It sounds essential - why is this not already happening??"*

It's a great idea, but I have a few concerns

Some respondents, whilst in support of this proposal, did have some concerns.

*"Closer coordination always makes sense. One problem can be turnover of staff and then someone can easily 'drop the ball'."*

*"Identifying common issues and trends is a good idea, however smaller and obscure issues are important to the client as well and I would be concerned if services were provided that excluded smaller issues in favour of bigger ones"*

*"There is too much waste with competing organisations for advocacy trying to undercut each other and contracts/tenders changing every few year with set up and*



run down times at each end also creating more confusion for the public and referrers.”

### 3.1.3.4. Service Promotion and Marketing

Respondents were given the following information:

*We would like to do more to make sure that people who need Health Advocacy Services know about them and can access them easily at the appropriate time.*

#### **4a. The following list describes some of the ways that these services could be promoted – please tick your top three preferred ways to find out about these services**

The most popular method for finding out about services was ‘Service leaflets / posters available in health settings (Hospitals, GP surgeries)’ with 61% of all respondents selecting this approach (Table 6). This was followed by ‘Health professionals telling you about the services as part of your treatment and care planning’ (50%). Preference did not appear to be influenced by respondent type (table 7).

**Table 9: Number of responses received for each option in question 4a**

	Count	% of respondents selecting this option
<i>Service leaflets / posters available in health settings (Hospitals, GP surgeries)</i>	28	61%
<i>Information on the advocacy service provider web-sites</i>	8	17%
<i>Information on the County Council web-site</i>	7	15%
<i>Information on health service web-sites (hospitals, GPs, Clinical Commissioning Groups)</i>	8	17%
<i>Health professionals telling you about the services as part of your treatment and care planning</i>	23	50%
<i>Other staff telling you about the services (eg Healthwatch, charities and voluntary sector organisations).</i>	13	28%
<i>Opportunities to speak to the advocacy service providers informally (e.g. if they attended health events or held drop-ins in hospital settings)</i>	16	35%
<i>All of the above</i>	14	30%
<i>Other, please state:</i>	7	15%

The following suggestions were provided by respondents who selected ‘Other’ to question 4a.

- *‘Postal communication automatically to anyone in the system’*
- *‘Wellbeing hubs across North Warwickshire’*
- *‘Advertising on tv ,local radio and news paper’s*

- *‘Make it easily found on the internet via say google. It does not matter whose website it is on i.e. professional. Search optimisation’*
- *‘This is a big job! Health professionals and social care staff do not know what their responsibilities are, we are very confused about advocacy’*
- *‘TV and radio adverts, targeted mailings’*

**Table 10: Number of responses received for each option in question 4a by respondent type**

	A current Health Advocacy service user (n=6)	A former Health Advocacy service user (n=10)	A member of the public – has not used advocacy services before (n=14)	A health or care professional /referrer (n=12)	Someone who looks after or cares for an individual (n=9)	Other (n=11)
	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option	Count and % of cohort selecting this option
Service leaflets / posters available in health settings (Hospitals, GP surgeries)	4 (67%)	6 (60%)	9 (64%)	7 (58%)	6 (67%)	4 (67%)
Information on the advocacy service provider websites	2 (33%)	3 (30%)	3 (21%)	3 (25%)	1 (11%)	0
Information on the County Council website	2 (33%)	3 (30%)	1 (7%)	5 (42%)	1 (11%)	0
Information on health service websites (hospitals, GPs, Clinical Commissioning Groups)	1 (17%)	1 (10%)	3 (21%)	2 (17%)	0	0
Health professionals telling you about the services as part of your treatment and care planning	3 (50%)	4 (40%)	9 (64%)	6 (50%)	4 (44%)	4 (67%)

Other staff telling you about the services (eg Healthwatch, charities and voluntary sector organisations).	1 (17%)	2 (20%)	4 (29%)	4 (33%)	4 (44%)	2 (33%)
Opportunities to speak to the advocacy service providers informally (e.g. if they attended health events or held drop-ins in hospital settings)	2 (33%)	3 (30%)	5 (36%)	6 (50%)	3(33%)	1 (17%)
All of the above	3 (50%)	4 (40%)	4 (29%)	4(33%)	2 (22%)	1 (17%)
Other, please	0	1 (30%)	2 (14%)	3 (25%)	4 (44%)	1 (17%)

Respondents were asked to add any further comments they may have. The following key themes emerged from the 11 open-ended responses:

#### People won't look at County Council websites

A couple of respondents suggested people would not look at County Council websites, and that not everyone has the skills or resources to access such sites.

*"Not everyone has access to a computer, the skills to use a computer or if they are unwell may not have the concentration/ cognitive functioning. Most people would not know to look on council websites etc"*

*"I don't think people would naturally look at County Council websites or advocacy provider website - unless specifically looking for that"*

#### Professionals need more training and knowledge in order to promote the services

A couple of respondents felt that professionals lacked the knowledge to promote advocacy services.

*"A lot of the problem is that health and social care professionals do not know what their duty is under MHA and MCA and Care At. They need training first before that are able to inform the public"*

*"Many people do not receive the support they need because health and social care professionals are ignorant of their obligations and when they try to obtain an*

*advocate, confused about which advocate and which service does what and therefore people are missed and time wasted”*

### 3.1.3.5. Any other comments

*Is there anything else you feel is important for us to know to help shape how these three Health Advocacy Services are delivered in the future?*

The following key themes emerged from the 13 open-ended responses:

#### There needs to be more advertising and awareness of the services offered

A few respondents suggested advocacy services required more advertisement and universal awareness.

*“I like the idea of an advocate visiting healthcare settings on set days, this makes the service accessible to clients and reinforces the existence of the service to health care professionals. Having worked in a ward where an advocate came on a weekly basis I found the services were well used as the clients and staff knew the advocate was coming and so the service was in the forefront and on staff’s toolkit”*

*“Increased awareness/promotion of and access to services, joined-up service provision and efficient, timely service delivery will improve outcomes for local people.”*

*“A universal awareness about them all” “Better advertising of these services.”*

#### The best service needs to be commissioned, not the cheapest

Some respondents felt competition to win contracts resulted in inadequate advocacy services, with the focus being on making the service cheap, rather than effective.

*“The current advocacy services tick boxes and provide statistics but due to competing forces and demands they are cut to a minimum and are not able to offer the sort of service that may prevent the ‘revolving door’ issue with patients because they are juggling with the numbers of people they meet with and spend time with trying to fit into ‘boxes’ and meet criteria placed upon them by the commissioners of the services.”*

*“There is far too much competition between the advocacy services to drive down their bid to win the contract and cut corners. Their reports to you do not tell the full story. There is too much emphasis placed on this by commissioners. As a result there are advocates who have not received any pay rise for some years...I have worked closely with Advocates and their morale is very low. They feel that they are not supporting their clients as they should. Their mental health is suffering due to*

*these tight reporting contracts which the local authority would not expect of their own staff. Put standards in the contract to monitor this!"*

## 3.2. Grapevine Focus Groups

### 3.2.1. Respondent profile

Table 11: Respondent profile of Grapevine focus groups

		Count	%
<b>Gender</b>	Male (including trans man)	16	70%
	Female (including trans female)	7	30%
	Other (including non-binary)	0	0%
<b>Age in years</b>	Under 18	0	0%
	18-29	6	26%
	30-44	10	42%
	45-59	5	22%
	60-74	2	7%
	75+	0	0%
<b>Long standing illness or disability</b>	Yes	23	100%
	No	0	0%
<b>Ethnicity</b>	White – English/ Welsh/ Scottish/ Northern Irish /	21	91%
	White - Irish	1	4%
	Mixed - Any other mixed background	0	0%
	Asian or Asian British - Indian	1	
	Black or Black British - African	0	0%
	Black or Black British - Caribbean	0	0%
<b>Religion</b>	Christian	16	70%
	Sikh	1	4%
	None	6	26%
<b>Sexuality</b>	Heterosexual or straight	15	65%
	Gay or lesbian	0	4%
	Bisexual	1	4%
	Prefer not to say	5	22%

### 3.2.2. Summary

- The majority of the people consulted agree that it is a good idea to merge the three advocacy services into one and that this will result in a better service over all.
- However, there was some unease about how the change would affect access to the service. Of particular concern was the prospect of longer waiting times for non-statutory advocacy, and specifically General Health Advocacy. Most people said that all the suggested ways of helping people while they are waiting should be implemented.

- The idea of linking Healthwatch more closely to Health Advocacy services was very popular.
- People said that the best ways to share information about the service are leaflets or posters in health care settings and face to face meetings with health professionals or Health Advocates.

*NB the number of people who gave a particular response is noted in brackets below. Some people chose not to answer all of the questions.*

**1 a ‘In the future, the three advocacy services could be joined into one. Do you think this is a good idea?’**

- Most people either strongly agreed (6) or agreed (5) with this idea. Some of the reasons they gave were that merging the services might save money; having the services in one place would make them more accessible; there would be a single standard for the advocacy service; and it would take less time to make arrangements to use the service.
- Three people said they neither agreed nor disagreed with the idea. One of these people explained the reason for this response was that they were not clear on how the service would work.
- Some people disagreed (6) or strongly disagreed (1). They were worried that the change would mean fewer people will be able to use the service if there are reductions in funding and staffing levels. One person said they feared that people with a learning disability will not get enough help and advice in a single service.

**1b: ‘Do you think joining the three advocacy services together will make a better service over all?’**

- A majority of people said that they strongly agreed (9) or agreed (4) with this idea (“Because it is a good thing and it will make...life feel a lot better...”; “Because it will make a better offer of chances to people with mental health issues”)
- Three people said they neither agreed nor disagreed. One of these people said they were not sure how the service would work in terms of funding, staffing and location. The person was concerned that people could lose their jobs and commented that the ideas were “a lot to take on board”.
- Two people disagreed and two strongly disagreed. The people who disagreed expressed concerns about cuts to funding and staffing and longer waiting times. They were worried that people might lose access to specialist advocacy support, for example, around mental health problems. People also felt that those who need general advocacy might be ‘sidelined’ or have to wait

longer for support unless they make a complaint. Some people with a learning disability would need help to understand how to make a complaint.

**2a 'People who are having support from the statutory elements of the service will be seen first. This means it could take longer for people who need support from the non-statutory elements to be seen. What do you think about this?'**

- The feedback to this question showed that people were troubled by the prospect of longer waiting times for General Health Advocacy/non-statutory provision. They felt that there were issues around fairness and equality of access to the service and they were concerned about the impact of waiting times on people's wellbeing ("Really not fair! People will become worried and anxious"; "This is not fair...why should they have to wait longer? They may need help ASAP"; "[It will] Make people more poorly. Block more beds up"; "Lack of communication between NHS and patient – advocacy could address this").
- One person said they thought it was a "good idea to see people with mental health [problems] quicker", but this might cause "frustration for other people [who are] waiting".

**2b 'Joining the three Health Advocacy Services together may mean that some people need to wait for an advocate. Do you think any of these things may help these people?'**

- Most people felt that all the suggestions in the tick box list would help people. Some people said they did not think it would help if people could make their own referrals. Some also said keeping in touch with people to see if anything has changed or to let them know when they will be seen would not help.

**3 'Do you think it is a good idea for Health Advocacy Services and Healthwatch Warwickshire to work more closely together?'**

- A clear majority of people said that they strongly agreed (11) or agreed (6) with this idea. These people felt that more 'team working' might help the service run smoothly. They suggested that more people will hear about the service because Healthwatch will help to share information. There was also a feeling that if there were any problems with the service, Healthwatch would be in a better position to find out about them and help resolve them.
- Two people were unsure about the idea; one person disagreed and one strongly disagreed. These people did not record any reasons for their opinions.

**4 'We would like to do more to make sure that people who use Health Advocacy Services know about them and get them when they need them. Tick the top three ways you would like to find out about the service'.**

- The joint top three most popular ways of finding out about the service were:
  - Leaflets / posters in hospitals and GP surgeries
  - Health professionals telling you about the service as part of your treatment and care planning
  - Face to face meetings or drop-in sessions with the Health Advocacy provider
- Nobody suggested any additional ways of finding out information other than the ones given in the tick box list.

**5 'Is there anything else you want to say about joining the three Health Advocacy Services together?'**

- Of the seven responses to this question, four were broadly positive (“Give it a try, worth giving it a go”; “I think it’s a good idea”; “Hope people with LD have a good service”; “The nurses help you”).
- Two responses expressed concern about the possible effects of changes (“I think it’s alright but it means jobs will go and there will be cuts”; “Ensure it doesn’t mean staff cuts!”)
- One person suggested that “a complaints service would be useful”.

### **3.3. Mental health forums**

The forums included 21 service users and 2 co-production staff. Table 12 summarises the key themes that emerged against each of the key consultation proposals.



Table 12: Key themes from mental health forums

Service proposal	Key themes
<b>Combining three contracts into one contract</b>	<ul style="list-style-type: none"> <li>• General agreement that combining the three contracts would:               <ul style="list-style-type: none"> <li>○ Simplify the referral pathway</li> <li>○ Prevent confusion</li> </ul> </li> <li>• However, some comments referred to:               <ul style="list-style-type: none"> <li>○ Concerns about impact on staff workload</li> <li>○ Concerns over perceived lack of provision in the North</li> <li>○ Working hours - shouldn't be 9-5</li> <li>○ Wide spectrum of services - could one provider realistically do all 3?</li> </ul> </li> </ul>
<b>Service promotion</b>	<ul style="list-style-type: none"> <li>• Suggestions promotional methods included:               <ul style="list-style-type: none"> <li>○ Linking with the CAVA Directory</li> <li>○ More outreach work by Advocacy staff</li> <li>○ Information should be provided on discharge from hospital</li> <li>○ Promotion in GP surgeries</li> <li>○ Structured education for GPs</li> <li>○ Information to be provided online</li> </ul> </li> <li>• There was also agreement about the need for more clarity for professionals on provision, referral, eligibility etc.</li> </ul>
<b>Links with Healthwatch</b>	<ul style="list-style-type: none"> <li>• Individuals were generally supportive of the proposed plan to develop the partnership with Healthwatch</li> <li>• The link to Healthwatch provision needs to be clearer as some individuals think they provide advocacy</li> </ul>
<b>Flexible waiting times</b>	<ul style="list-style-type: none"> <li>• Agreement that prioritisation would be effective and appropriate</li> </ul>

### 3.4. Market engagement

Three organisations requested to attend the market engagement day on 19 July 2017, with two further organisations responding to the market testing questionnaire.

Table 13 summarises the key themes that emerged against each of the key consultation proposals.

Table 13: Key themes from market engagement

Service proposal	Key themes
<p><b>Combining three contracts into one contract</b></p>	<ul style="list-style-type: none"> <li>• Providers were in agreement with combining the three services into one integrated service.</li> <li>• Agreement that combining the three contracts would result in the following positives:               <ul style="list-style-type: none"> <li>○ Seamless access for service users, continuity</li> <li>○ Integration</li> <li>○ Clients will tell their story once</li> <li>○ One easy point of contact</li> <li>○ More efficient triage</li> <li>○ Better value for money – resource allocation, cost-base, more efficient</li> <li>○ 1 service manager – to allocate clients to relevant advocates – triage</li> <li>○ Opportunity for a partnership/consortium approach</li> <li>○ Utilise volunteers more</li> </ul> </li> <li>• Highlighted risks included:               <ul style="list-style-type: none"> <li>○ TUPE</li> <li>○ Disparate staff team</li> <li>○ Careful management of transition</li> <li>○ Practicalities around co-commissioning</li> </ul> </li> </ul>
<p><b>Service promotion</b></p>	<ul style="list-style-type: none"> <li>• Usage of community hubs would be beneficial for drop in sessions to help promote awareness in the community</li> <li>• Consider how you shape the message to describe what advocacy is</li> <li>• Comms/messaging should be tested by service users</li> <li>• Be targeted</li> <li>• Use a range of methods</li> <li>• Have an engagement protocol with other services</li> <li>• Service needs to be visible to NHS staff</li> <li>• Include time for marketing and awareness raising in the specification</li> <li>• Providers to consider ways to engage with very hard to reach</li> <li>• Use volunteers</li> </ul>
<p><b>Links with Healthwatch</b></p>	<ul style="list-style-type: none"> <li>• Agreement that strengthening links with Healthwatch would result in the following positives:               <ul style="list-style-type: none"> <li>○ Aligned offer that does not duplicate - particular linkages with NHS Complaints</li> <li>○ Can pick up on emergent issues/trends – positive and negative</li> <li>○ Potential for joint working on projects</li> </ul> </li> <li>• The following risk was identified:               <ul style="list-style-type: none"> <li>○ If there is not clarity of roles between Healthwatch and advocacy, clients can be confused.</li> </ul> </li> </ul>
<p><b>Flexible waiting times</b></p>	<ul style="list-style-type: none"> <li>• Agreement that flexible waiting times could be effectively managed through:               <ul style="list-style-type: none"> <li>○ Referral management policies and procedures based</li> </ul> </li> </ul>

- on the needs of individuals – structured approach
- Prioritisation of referrals based on individual circumstances and needs
- Could evaluate this after certain period to ensure working well
- The following potential risks were highlighted:
  - Need to be effective management
  - Be clear on referral pathways - professional only or is self- referral available for all elements, or only some
  - Contingencies needed

### 3.5. Stakeholder engagement

7 social workers were involved with the consultation work. Key themes that emerged against the proposals under consultation are summarised in 4.

Table 14: Key themes from consultation with Social Workers

<b>Service proposal</b>	<b>Key themes</b>
<b>Combining three contracts into one contract</b>	Teams thought a single point of entry would be very useful
<b>Timescales for responses</b>	<p>Teams felt that a decision tool would be helpful to aid correct referrals into the range of advocacy provision, and to clarify overlap between different advocacy provision.</p> <p>To help with referral management, teams requested an option to include standard or urgent referral option to be included on the form</p>
<b>Healthwatch</b>	No views expressed.
<b>Service promotion</b>	<p>Suggestions promotional methods included: advocates attending duty meetings, MDT meetings, conversations direct with the Senior Discharge Nurse.</p> <p>Social work teams were not aware of all the eligibility and referral criteria and different response times. Needs to be simplified.</p> <p>Non-statutory advocacy, particularly General health Advocacy needs to be promoted more to teams so that they are aware of these.</p>
<b>Other issues raised</b>	<p>Teams would like for consideration to be given to online secure referral routes.</p> <p>Include some time in the new specification for advocates to attend evening meetings</p>

Clarify for teams whether clients going through Continuing healthcare assessment review are eligible to use NHS Complaints advocacy

## 4.0. Conclusion and next steps

### 4.1. Conclusion

Through analysing both the questionnaire responses and the feedback received through the face to face engagement mechanisms there were a number of common overarching themes which emerged during the course of the consultation. These included:

- **Combining three contracts into one contract**
  - The vast majority of respondents agreed with the proposal to combine the three services into one advocacy service, as this would result in the following benefits:
    - Simplified referral pathway
    - Reduced confusion amongst service users and professionals about the different types of advocacy
    - More efficient triage
    - Better value for money
    - Service users will only have to tell their story once
  - However, respondents expressed some concerns, as follows:
    - Combining the services under one contract would result in a wide spectrum of services - could one provider realistically do all 3?
    - Challenge of managing a potentially large service may be challenging
    - Staff issues, including TUPE, disparate staff teams, staff potentially needing to have knowledge of all three advocacy areas, impact on staff workload
- **Service promotion**
  - There was general agreement that more advertising and promotion of the services is needed
  - The most popular methods of promotion included: service leaflets/posters available in health settings, health professionals telling you about the service
  - There was agreement that professionals (potential referrers) need more training and knowledge around the different services, eligibility and referral criteria and different response times
  - There was the suggestion that Advocates should attend duty meetings and/or MDT meetings
  - There was agreement that more outreach work by Advocacy staff, for example drop-in sessions in in community hubs would be beneficial
- **Links with Healthwatch**
  - Individuals were generally supportive of the proposed plan to develop the partnership with Healthwatch. It was felt that this would strengthen both services through picking up of emergent trends in health services

- Suggestions for partnership working included: co-location, joint working on projects
- There was agreement for the link to Healthwatch needing to be clearer, as some individuals think they provide advocacy. Clarity over purpose would reduce duplication of provision.
- **Flexible waiting times**
  - The flexible waiting times issue was the most contentious in all methods of engagement
  - The majority of respondents selected all of the suggestions provided to help minimise any negative impacts that may result from more flexible waiting time for non-statutory advocacy service users
  - Prioritise based on individual circumstances and needs
  - They felt that there were issues around fairness and equality of access to the service and they were concerned about the impact of waiting times on people's wellbeing
  - 42% of respondents expressed concern concerned that more flexible waiting times for non-statutory advocacy provision would lead to increased stress amongst non-statutory service users, which may result in people falling through the net and not receiving the help they. These respondents felt that people in the community are often the most vulnerable and most in need and that statutory service users should not be prioritised over them.
  - Need to ensure systems and protocols are in place e.g. for wait lists – managed effectively
  - Be clear on referral pathways - professional only or is self- referral available for all elements, or only some
  - Request a referral management policy based on the needs of individuals – structured approach

Following collation and analysis of all responses received there was an overall general consensus from respondents who strongly agreed with the majority of the service principles. This consensus was then further reinforced through respondents' comments providing qualitative insight which has been used to further shape and influence the proposed service model.

## **4.2 Next Steps**

This Consultation Report will be used to support the report which the council's cabinet members will consider when approving the proposed new service model. The report will also be made available via the Ask Warwickshire webpage providing feedback to all those who participated in the consultation process.

Warwickshire County Council, Public Health would like to thank all those who participated in the Consultation process, whether it was through attending one of our face to face events, or through completing the questionnaire.

## **APPENDIX 3**

# **EQUALITY IMPACT ASSESSMENT/ ANALYSIS (EqIA)**

## **Public Health Advocacy Services:**

**Warwickshire County Council**

**Independent Mental Health Advocacy.**

## Equality Impact Assessment/ Analysis (EqIA)

<b>Group</b>	<b>Communities</b>
<b>Business Units/Service Area</b>	<b>Public Health</b>
<b>Plan/ Strategy/ Policy/ Service being assessed</b>	<b>Public Health Advocacy Services:</b> NHS Complaints Advocacy, General Health Advocacy, Independent Mental Health Advocacy.
<b>Is this is a new or existing policy/service?</b>  <b>If existing policy/service please state date of last assessment</b>	Existing Service
<b>EqIA Review team – List of members</b>	Paula Mawson Catherine Rigney
<b>Date of this assessment</b>	First assessment: August 2016 Updated: September 2017
<b>Signature of completing officer (to be signed after the EqIA has been completed)</b>	Paula Mawson
<b>Are any of the outcomes from this assessment likely to result in complaints from existing services users and/ or members of the public?</b> If yes please flag this with your Head of Service and the Customer Relations Team as soon as possible.	<b>YES/ NO</b>
<b>Name and signature of Head of Service (to be signed after the EqIA has been completed)</b>	John Linnane
<b>Signature of GLT Equalities Champion (to be signed after the EqIA is completed and signed by the completing officer)</b>	Phil Evans

**A copy of this form including relevant data and information to be forwarded to the Group Equalities Champion and the Corporate Equalities & Diversity Team**





## Form A1

### INITIAL SCREENING FOR STRATEGIES/POLICIES/FUNCTIONS FOR EQUALITIES RELEVANCE TO ELIMINATE DISCRIMINATION, PROMOTE EQUALITY AND FOSTER GOOD RELATIONS



High relevance/priority



Medium relevance/priority



Low or no relevance/ priority

**Note:**

1. Tick coloured boxes appropriately, and depending on degree of relevance to each of the equality strands
2. Summaries of the legislation/guidance should be used to assist this screening process

Business Unit/Services:	Relevance/Risk to Equalities																										
	Gender			Race			Disability			Sexual Orientation			Religion/Belief			Age			Gender Reassignment			Pregnancy/ Maternity			Marriage/ Civil Partnership (only for staff)		
State the Function/Policy /Service/Strategy being assessed:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
NHS Complaints Advocacy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
General Health Advocacy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Independent Mental Health Advocacy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p>These have been marked as low relevance, as Advocacy services meet the needs of the whole population, and particularly those from the protected or vulnerable groups. Therefore there is no negative or detrimental risk to the protected characteristics.</p> <p>Are your proposals likely to impact on social inequalities e.g. child poverty for example or our most geographically disadvantaged communities? <b>If yes please explain how.</b></p> <p>Public Health funds three Advocacy Services to enable some of the most vulnerable people living in Warwickshire to be aware of and protect their rights whilst receiving NHS funded health care. Two of the services are statutory services: NHS Complaints and Independent Mental Health Advocacy (helps to support and protect people on statutory mental health act sections in-hospital). As such, all of these services impact on social inequalities. General Health Advocacy is targeted to individuals with particularly</p>																							<p><b>YES</b></p>				

<p>complex needs who need additional support to voice their needs, particularly at the point of discharge from hospital.</p>	
<p>Are your proposals likely to impact on a <b>carer</b> who looks after older people or people with disabilities? <b>If yes please explain how.</b></p> <p>By continuing to fund and commission these services, carers will be assured that their family members have access to support to enable them to exercise their rights and be heard in relation to their treatment, care or complaints, thus supporting carers.</p>	<p><b>YES</b></p>

**Form A2 – Details of Plan/ Strategy/ Service/ Policy**

**Stage 1 – Scoping and Defining**

(1) What are the aims and objectives of Plan/Strategy/Service/Policy?

Public Health funds three Advocacy Services which are complimentary to those funded and commissioned via the People Group:

NHS Complaints Advocacy is a statutory service which local authorities have responsibility for the commissioning of. Its purpose is to support individuals who wish to make and resolve a complaint about healthcare provided or funded by the NHS.

General Health Advocacy is a non-statutory service that is targeted to individuals with particularly complex needs, including people with physical disabilities or learning disabilities, who are receiving health services. Its purpose is to enable individuals who would find it difficult to communicate their needs, to be involved in planning their care, treatment or discharge.

Independent Mental Health Advocacy (IMHA) is focused on people receiving mental health treatment. Statutory IMHA is commissioned for people who are detained under certain sections of the Mental Health Act, and it exists to enable people to understand the legal provisions that they are subject to and the rights and entitlements they are entitled to whilst they are detained. This element of provision is enhanced with two non-statutory elements: In-hospital IMHA which is available to all mental health in patients to enable them to express their views and participate in their care / treatment planning and discharge, and Community IMHA which is available to people receiving mental health treatment in community settings who require support and safeguards in order to remain within the community and become as independent as possible.

The savings plans outlined in the OOP2 should all be achievable through service re-design and re-alignment to achieve efficiencies, which will be achieved through a competitive tender process, and as such it is not expected that availability or access to services will change for service users. Providers will be expected to develop a service transition plan as part of their tender documents, which will include reference to access

	into the service and contingencies in relation to all groups for if access to service changes. This will be monitored as part of contract management.
(2) How does it fit with Warwickshire County Council's wider objectives?	The services contribute to 3 of the County Council's outcomes: <ul style="list-style-type: none"> <li>• Our communities and individuals are safe and protected from harm and are able to remain independent for longer</li> <li>• The health and wellbeing of all in Warwickshire is protected</li> <li>• Resources and services are targeted effectively and efficiently whether delivered by the local authority, commissioned, or in partnership</li> </ul>
(3) What are the expected outcomes?	Patients accessing NHS funded or provided healthcare will feel supported to: <ul style="list-style-type: none"> <li>• contribute to their care, treatment or discharge planning;</li> <li>• be aware of their rights and entitlements whilst detained under the mental health act</li> <li>• make and resolve a complaint about NHS funded healthcare</li> </ul>
(4) Which of the groups with protected characteristics is this intended to benefit? (see form A1 for list of protected groups)	All people with protected characteristics should benefit from opportunities to access advocacy services. This will be demonstrated by using inclusive eligibility criteria.
<b><u>Stage 2 - Information Gathering</u></b>	
(1) What type and range of evidence or information have you used to help you make a judgement about the plan/ strategy/ service/ policy?	Examples of information used to help future planning for the commissioning of these services includes: <ul style="list-style-type: none"> <li>• Performance management data from existing services.</li> <li>• Local Government Association Advocacy Services guidance</li> <li>• Social Care Institute for Excellence Guidance</li> <li>• Consultation activity which will include stakeholders, providers, service users and potential service users</li> </ul>

<p>(2) Have you consulted on the plan/ strategy/ service/policy and if so with whom?</p>	<p>An 8 week consultation started on 9 June 2017 and ended on 31 July 2017. The aim of this consultation activity was to effectively engage with current and previous advocacy service users and other key stakeholders on the proposed service model and ensure there were opportunities for them to influence and shape the new service.</p> <p>Consultation was undertaken with current and previous advocacy service users, providers, members of the public and professionals. The consultation represents the views of 86 individuals.</p>
<p>(3) Which of the groups with protected characteristics have you consulted with?</p>	<p>Consultation included people with protected characteristics, particularly people with disabilities and learning disabilities. 47% of survey respondents reported having a long term illness or disability and 100% of the focus group attendees reported the same. Consultation was also undertaken with 21 mental health service users.</p> <p>The consultation was tailored to people with disabilities and those with chronic illnesses, by undertaking road shows in hospitals.</p> <p>12% of survey respondents were from BME groups which is in line with general population demographics. 59% of respondents were female and all age categories were represented. 7% of respondents reported that they were gay, lesbian or bisexual, which higher than the proportion in the general population.</p>
<p><b><u>Stage 3 – Analysis of impact</u></b></p>	

<p>(1) From your data and consultations is there any adverse or negative impact identified for any particular group which could amount to discrimination?</p> <p>If yes, identify the groups and how they are affected.</p>	<p style="text-align: center;"><b>RACE</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;"><b>DISABILITY</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;"><b>GENDER</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>
	<p style="text-align: center;"><b>MARRIAGE/CIVIL PARTNERSHIP</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;"><b>AGE</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;"><b>GENDER REASSIGNMENT</b></p> <p style="text-align: center;"><b>NO</b></p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>

	<p style="text-align: center;">RELIGION/BELIEF</p> <p style="text-align: center;">NO</p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;">PREGNANCY MATERNITY</p> <p style="text-align: center;">NO</p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>	<p style="text-align: center;">SEXUAL ORIENTATION</p> <p style="text-align: center;">NO</p> <p>The service is predominately aimed at and is utilised by vulnerable groups; this is apparent from service monitoring data. Therefore, the service will not have any negative impact amounting to discrimination on this group. If any negative impacts emerge following the consultation, these will be addressed through the development of mitigations in the specification.</p>
(2) If there is an adverse impact, can this be justified?	<p>All service providers will be expected to produce, implement and review an Equality Impact Assessment for the advocacy services and this will be monitored through performance management data and contract review meetings with commissioners to ensure that people with protected characteristics are able to access and utilise the services commissioned.</p>		
(3) What actions are going to be taken to reduce or eliminate negative or adverse impact? (this should form part of your action plan under Stage 4.)	<p>As part of the tendering process, providers will be required to demonstrate their understanding of equality and diversity and their response will be assessed within the quality criteria, including the requirement for an equalities policy. Throughout the life of the contract, providers will be expected to deliver the service in line with the Public Sector Equality Duty, in which all provides are required to meet the General Equality Duty aims which are:</p> <ul style="list-style-type: none"> <li>• Eliminate unlawful discrimination</li> <li>• Advancing Equality of opportunity</li> <li>• Fostering good relations</li> </ul>		



(4) How does the plan/strategy/service/policy contribute to promotion of equality? If not what can be done?	These services are particularly targeted to the most vulnerable in our communities, for example, those with long term health conditions and disabilities, and will therefore take account of accessibility in terms of where it is delivered, times of delivery, appropriate venues to meet customer need and communication needs and preferences.
(5) How does the plan/strategy/service/policy promote good relations between groups? If not what can be done?	The service is available for all groups, and equitable access will be provided regardless of any protected characteristics. Services are provided within hospital or general community settings and as such there may be opportunities to foster good relations between groups – e.g. challenging stigma towards people with mental health problems.
(6) Are there any obvious barriers to accessing the service? If yes how can they be overcome?	Providers will need to demonstrate that they can provide provision to meet the communication needs of different individuals particularly when they are unwell e.g. ensure access to an interpreter, ability to communicate effectively with people with learning disabilities.
(7) What are the likely positive and negative consequences for health and wellbeing as a result of this plan/strategy/service/policy?	The purpose of the delivery of these services is to improve population health and wellbeing (please see response to question 3 for full details), by allowing people to participate in their care and treatment planning and discharge, and by helping them to make and resolve complaints about NHS funded care.
(8) What actions are going to be taken to reduce or eliminate negative or adverse impact on population health? (This should form part of your action plan under Stage 4.)	In relation to Mental Health Advocacy, the provider is expected to be an active member of the Warwickshire Mental Health Co-production and Participation Group, facilitated by Public Health, which aims to identify emerging population level issues with service provision and raise such issues with the Arden Mental Health Commissioners group. As such, this should ensure that population health is protected by these services.
(9) Will the plan/strategy/service/policy increase the number of people needing to access health services? If so, what steps can be put in place to mitigate this?	These services should not increase the number of people accessing health services, but it should enable those already are to participate more fully in their care planning, treatment and discharge thus maximising the outcomes they achieve.
(10) Will the plan/strategy/service/policy reduce health inequalities? If so, how, what is the evidence?	Advocacy Services are commissioned to protect and support the most vulnerable members of our communities, and as such, they form part of a planned response to reducing health inequalities.

**Stage 4 – Action Planning, Review & Monitoring**

<p>If No Further Action is required then go to – Review &amp; Monitoring</p> <p>(1) Action Planning – Specify any changes or improvements which can be made to the service or policy to mitigate or eradicate negative or adverse impact on specific groups, including resource implications.</p>	<p>EqlA Action Plan</p>			
<p>(2) Review and Monitoring State how and when you will monitor policy and Action Plan</p>	<p>The plan will be reviewed bi-monthly as part of the project documentation until a new provider has been appointed. We will agree appropriate review periods post contract award with the provider.</p>			

Action	Lead Officer	Date for completion	Comments
Consultation on proposals	Paula Mawson	August 2017	Complete
Service specification	Paula Mawson	September 2017	
Invitation to Tender	Paula Mawson	December 2017	
Document will be reviewed following consultation	Paula Mawson	August 2017	Complete

Please annotate your policy with the following statement:

**‘An Equality Impact Assessment/ Analysis on this policy was undertaken on (August 2016) and will be reviewed at regular intervals through the consultation and tender process and then in November 2019).**