Tameside Metropolitan Borough Council

Communities, Children's, Adults and Health Services

Tender Submission Form

Provision of an Independent Mental Capacity Advocacy Service

NAME OF ORGANISATION

NATIONAL SCHIZOPHRENIA FELLOWSHIP t/a Rethink Mental Illness

Tender submission prepared by: Rethink Mental Illness

Name: [redacted]

Position held: Business Development Business Partner

Organisation: National Schizophrenia Fellowship t/a Rethink Mental Illness

Date: 7th November 2014

Contract Price

The maximum first year budget available for this service is £90,000. Submissions below the maximum budget will score higher than those equal to the maximum cost. Under the Council's Procurement Standing Orders any submissions received over £90,000 will be considered non-compliant.

Please note however that it is the Commissioners intention to review the budget available for the first year of this contract, post-award and following consultation with the successful advocacy provider. This will allow the commissioners to take into account how the Supreme Court ruling relating to DoLs has, over the intervening 6+ months, effected the demand for IMCA's and to budget accordingly.

Year 1 contract price (Exclusive of VAT)
[redacted]

Hourly rate/spot purchase price
[redacted]

Quality

Please do not answer questions by referring to other documents or to specific paragraphs within other documents and do not attach any other documentation produced by or on behalf of your organisation, unless these are specifically requested.

There are no word counts ascribed to your responses, but word guides are included. Please be mindful of these when responding. Evaluation panel members will have up to five other submissions to read and consider in addition to yours. It is important to keep your answers as focused as possible, whilst at the same time including sufficient detail to enable us to evaluate your tender application.

	Please provide a brief overview of your organisation. This section will not be evaluated, but is your opportunity to tell us about your organisation with particular reference to the delivery of this service. We are interested in: • Your values and motivation • How your organisation is constituted • A brief history • Your achievements as you see them **Guideline 500 words**

Response:

Rethink Mental Illness was established over 40 years ago by carers and service users seeking information and support to cope with the effects of mental illness. People directly affected by mental illness continue to be at the heart of the organisation.

Our values and motivation

Our vision and motivation is to **challenge attitudes and change lives**. Our mission is to **lead the way to a better quality of life for everyone affected by severe mental illness**. Our work brings us into contact with over 60,000 people a year and a further 500,000 through our internet and social media presence. Through our membership we support over 120 support groups across the country creating an environment where prejudice and discrimination are eliminated and where individuals are valued, respected and supported through their own personal recovery journey.

How we are constituted

We are a leading national membership charity, our work is governed by a Board of Trustees; many of our Trustees have lived experience of mental illness and the distress and devastation it can bring. Our governance structure comprises of Regional Committees, National Committees and a Board of Trustees. Board Members take responsibility for the development of a clear mission and strategy. The Chief Executive Officer reports directly to the Board, a Senior Management Team manages the day to day operation of the business.

A brief history

Since 1972 we have brought people together to support each other. We run services and support groups that change people's lives and challenge attitudes. We support 60,000 people every year across England to get through crises, live independently and realise they are not alone.

Our services are designed and delivered with passion and vision. We are an experienced national provider and operate over 250 diverse services including instructed and non-instructed Advocacy. We are committed to supporting people with complex needs, our IMCA services effectively meet the needs of people with a wide variety of communication difficulties. We deliver successful community based advocacy services as well as providing advocacy into acute hospitals and secure units. We deliver Employment and Training services, Psychological Therapies, Housing and Accommodation, Registered and Residential services, Criminal Justice and community / day services for young people and adults.

We work collaboratively across the private, statutory and community sector to deliver services in the community and secure settings that identify and address local need.

Our achievements

Our annual Service User Satisfaction results for 2014 are very rewarding and demonstrate that Rethink Mental Illness staff are committed to providing person–centred services which focus on the issues and goals of the people who they serve;

- ✓ 99% of respondents feel that they are respected and treated with dignity and actively listened to by staff.
- ✓ 97% of respondents feel that they have been involved in deciding on the support that they have been given
- ✓ 97% think that the service has supported them towards achieving their goals.

The response from people using our services suggests that we are doing an excellent job to empower people through involving them in deciding on the support they are given, we will continue to work hard to achieve even better next year by continuing our co-production approach to support and service development.

> **'I have found the staff who have supported me have done so in a very collaborative manner. I have always been asked what type and in what manner I wish to receive support and involvement. This was particularly evident at a Care Program Approach (CPA) meeting'**
>
> ***Female service user, PiC Eastern Advocacy***

Our high performing Manchester service delivers IMHA and IMCA services in the community and within semi-secure and secure settings, a contract we have retained since 2007. We deliver IMHA services to people in eleven secure settings through a national contract with Partnerships in Care and we have a contract to deliver inpatient advocacy to people in three Bury and Equilibrium Healthcare hospitals and in Sheffield. We have supported over 1,732 cases across our North West and West Yorkshire services.

We provide a flexible model of 'spot purchase advocacy' to Local Authorities and the NHS in the North West, Commissioners have purchased our services to add additional capacity to their existing advocacy contracts or to provide specialist input for more complex or out of county cases.

We retain and develop our staff by ensuring they have a framework of support and continuous professional development, opportunities for self development and appropriate training.

We campaign nationally for policy change, influencing the reform of mental health services and we are a lead partner in the Schizophrenia Commission. We are also delivery partners in the Time to Change campaign to tackle stigma and improve service provision.

1.	Performance management information across the three boroughs consistently highlights that IMCA's are least engaged in adult protection cases despite being the only befriended area of involvement of IMCAs. Why do you think this is and how would you go about addressing this? We will be taking into consideration amongst other things: • Reference to, and consideration of, SCIE Guide 32 • An example(s) of where you have encountered and addressed this in your practice **Guideline 500 words**

Response:

Safeguarding referrals in all of our IMCA services have been historically low whilst referrals generally have consistently risen. In some areas, the low rate of referrals can be identified as coinciding with reduced rates of safeguarding locally. However, data from the Department of Health shows this is unlikely to form a trend as numbers appear to be rising yearly.

We believe that referrers need to be continually reminded and supported to make appropriate referrals. Anecdotally we understand that some of the low rate of referral activity especially in our North East services was around referrers not fully understanding the role and scope of the IMCA service.

To address this, IMCA's regularly attend team meetings to raise awareness of the service and host 'question and answer' sessions with key staff and other stakeholders. Our Advocacy staff spend as much time as possible promoting the service in the community, in key points of referral e.g. hospital wards, the criminal justice system and care homes.

We are currently re-designing the advocacy area on our national web site www.rethink.org to improve the depth and breadth of advocacy information available to commissioners, potential referrers and self referrers. We will include a 'frequently asked questions' (FAQs) section and highlight free access to our advocacy related publications, information and fact sheets, visitors will be able to make online enquiries, online referrals and can find contact details for our Rethink Information and Advice Service (RIAS), a national local cost helpline for people who need information but do not need a formal advocacy service.

We know from our experience the following issues will have an impact on referrals and will plan to address them in our mobilisation and communication plan:

- Referrers believing that an IMCA should only be instructed if the client is un-befriended however this is not the case with safeguarding referrals.

- Poor case screening and assessment, often resulting from poor publicity and awareness raising, leading to inappropriate referrals being sent to the IMCA team often more appropriately taken by generic advocacy services.

- Improved local knowledge of IMCA eligibility criteria.

- Referring to the IMCA for safeguarding is a discretionary power rather than a duty which makes good publicity, increasing understanding locally and close working relationships with partner agencies is essential.

- Raising the understanding of SCIE Guide 32 locally with referral agencies, ensuring local authority and NHS staff clearly understand how they can instruct an IMCA in safeguarding cases where the individual lacks the capacity to consent to at least one of the protective measures which they are deciding upon. Our IMCA's work closely with local Safeguarding Teams to ensure that referral/review pathways are clearly understood and publicity is made available to the clients involved in safeguarding cases where appropriate.

We know, from experience in our IMCA services, that many of these issues can be successfully resolved to increase the number of safeguarding referrals by;

- Building strong working relationships with potential referral agencies

- Using staff flexibility to meet individual need

- Proactively raising awareness in local communities

- Providing clear, accessible publicity for service users and carers.

502/500

2.	What challenges do you envisage encountering in the expansion of the IMCA role to incorporate that of Litigation Friend? How will you address them? We will be taking into consideration amongst other things: • What you understand the role to involve • An example(s) of where you have encountered and addressed this in your practice

	Guideline 500 words

Response

The Litigation Friend (LF), a role traditionally undertaken by a parent or guardian appointed by the court to act as a Representative for a claimant who is under 18 years of age, or who lacks capacity to litigate must;

- Be able to competently and fairly conduct proceedings on behalf of the person
- Have no interests that conflict with the person
- Agree to take on the role

Increasingly IMCA's and Relevant Persons Representative's are taking on this role as part of their wider remit.

Our IMCA's are well placed to take on this role as they have a good working knowledge of the Mental Capacity Act and often have an existing relationship with the person. The work does cause us some challenges as an organisation as it requires an element of autonomy, more frequent supervision and sometimes additional costs to cover increased travel especially for individuals in Out of County/Borough Placements.

The Department of Health has recently commissioned the development of a guidance document for those wishing to act as a LF in order to promote and inform best practice, our advocacy teams in the North West have had early sight of the document and believe our current practice is in line with the proposed guidance.

We foresee a number of challenges in the expansion of the role including:

- The LF role has not traditionally been an extension of the IMCA role and instead constitutes a separate responsibility. The current approved IMCA training course does not prepare IMCA's to take on this role, additional training will need to be sourced depending on the requirements of the best practice guidance. Our IMCA's who are currently providing LF services are highly trained and very experienced but will need to be re-trained to comply with the new guidance when it is released.

- Our Professional Indemnity Insurance will also need to be reviewed to ensure it encompasses this extended role.

- As individuals have to be willing to take on the role it is unclear to what extent an individual could be compelled to do so by their employer if they express a wish not to. The possibility of corporate bodies taking on the role is still being explored. The IMCA's in our existing service have taken on the responsibility of this role successfully in several cases for over twelve months but we will build in contingency to meet the demand in our structure.

- The role can be very time consuming, and as such requires adequate resourcing and staffing including regular supervision, especially when there is conflict between the relevant person's wishes and what is deemed to be in their best interests and what the IMCA chooses to instruct on.

- The role has a large influence on what is the best interest for the client and involves a level of confidence, skill and training that requires LF's to influence, work alongside and advocate against law practitioners including Solicitors and Barristers. This level of work requires significant coaching, supervision and support from the organisation.

- Potentially high un-budgeted costs where the role of the LF requires considerable travel, the length of time some cases are in court and also the unknown costs of instructing experts

- Management and support issues of the LF if they decide to leave the organisation while still actively working on a case.

For the purpose of this contract we plan to employ a trained IMCA to undertake LF work on a flexible zero or annualised hours contract to concentrate on longer cases and who have the required level of independence required to fulfill the role. An LF on a flexible contract will also ensure that the IMCA's in the team are not tied up in long-term litigation work and can concentrate on their primary role.

631/500

3.	What training provision – both in-house and external - do you have in place to ensure the continuous professional development of your workforce? **Guideline 500 words**

Response:

We recognise the high level of training and support required in order to deliver a quality IMCA service and as a result, all advocacy staff in this service will have access to a comprehensive Advocacy Manual that provides guidance and informs how our services should operate. Regular online information bulletins will update knowledge and information about developments and current case law that will affect practice.

We have a national Advocacy Forum where Advocates share good practice, local policies and procedures and reflect on difficult cases. Each advocate also has supervision, an annual appraisal with their line manager who will be an experienced Lead Practitioner, group supervision and case management meetings to reflect on difficult areas of work. We also have a Learning and Development Team who ensure that all identified training needs are met.

Training needs are identified in a variety of ways:

- Recruitment and Selection process
- Probationary Review
- Supervision/Appraisal
- Training identified to work with particular clients based on needs arising from their care/support plan
- Contractual requirements

Within six months, all new and transferred staff will have completed and passed sections of all mandatory training. New staff cannot pass their probationary period without successful completion. These courses include Equality and Diversity, Mental Health Awareness, Safeguarding Adults and Children, Information Governance/data protection, Code of Conduct and Professional Boundaries training. Other training required/identified for the service contract such as Managing Difficult Behaviour would be delivered at this time as well as any specific learning identified in supervision.

During the induction period, new staff will shadow existing staff in our existing Manchester or Calderdale Advocacy services. They also have the opportunity to be mentored by experienced Peers as well as a Lead Practitioner.

We use a number of external providers for the National Advocacy Qualification modules so that we can provide training quickly. All staff commence training for IMCA and IMCA/Dols to enable them to complete the required modules as quickly as possible. While doing so they will be supported and supervised by qualified advocates from their service. All advocates in our North West teams are qualified in IMHA/IMCA and IMCA DoLS to improve flexibility of the service.

We utilise experience within our large advocacy teams to complete our in-house training program which is developed and delivered by all the team. This gives the opportunity for experienced staff to share their own advocacy skills. It also allows staff to familiarise and practice their skills in delivering training in specific fields.

All of our IMCA's are experienced in concluding issues within expected timescales in a person centred way and have experience in documenting their case activity including writing reports to satisfy decision making needs or in a legal context where this is necessary. Training and opportunities for shared learning are available across all of our advocacy services.

Staff are encouraged and supported to take advantage of local external training opportunities appropriate to their role, a key example of this is where staff access Local Authority training around Safeguarding Adults and Children. We ensure that our services are an integral part of the local mental health pathway allowing us to access joint training events hosted by Health, Social Care and the Voluntary/Community Sector.

We have developed an e-learning platform that allows staff to access training from remote sites at flexible times that suit them, our e-learning portfolio hosts formal training and awareness raising tutorials on a diverse range of subjects including Mental Capacity Act and Safeguarding.

Our Learning and Development Team will work with experienced Advocates and Training Providers to source/develop training to meet the needs of the LF role once the national guidance has been released.

605/500

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<td>4.</td>
<td>What will be your approach to awareness raising, across all three boroughs, both immediately post-award/contract commencement and over the intervening year's?

We will be taking into consideration amongst other things:

• Reference to examples of your approach elsewhere
• Use of site visits, website, social media etc</td>
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	Guideline 500 words

Response

We will work collaboratively across the three boroughs to raise awareness and publicise the service to ensure that individuals get fair and equal access to advocacy support, recognising that the service is client generic and needs to be culturally appropriate. We understand the requirements of the Mental Capacity Act are broad and relate to diverse groups of people.

Immediately post tender award, we would agree a local implementation and communication plan with commissioners and other key stakeholders. This is a process we regularly carry out in our Advocacy services and ensures that all parties are clear on service development milestones, outcomes and expectations through the mobilisation process. Communication and awareness raising are key elements of this plan and will include;

- Service Users and Carers
- Voluntary/Community Sector Providers
- Statutory Mental Health Teams
- Hospital Inpatient Units
- GP's/Primary Care Services.
- Private Sector Care Providers

Understanding the local patient pathways, service provision and networks are key to Advocates working effectively, during the induction period new Advocates will be encouraged to make links to Care Homes, Hospitals and Statutory Teams to familiarise themselves with those organisations and to publicise and raise awareness of the service and how the referral process will work. Staff will deliver training as required to NHS, Social Care and other referral agencies.

Promotion of the service is an on-going process, as the patient population changes, our Advocacy Teams across the country build culturally appropriate promotion and publicity into their team work plans. Building on our experience in other areas the team will make full use of resources in the local community to raise awareness including:

- 'Pop up' Advocacy Awareness Events in diverse locations including Hospitals, Clinics, Primary Care locations and in Residential and Nursing Accommodation.
- We monitor where referrals are received from so that we can target publicity and raise awareness in areas and communities that appear to be more difficult to reach.
- Regular presentations to Service User and Carer's groups
- Active use of social media and use of the Rethink Advocacy web pages that will support people to refer and gain more information about the service.
- Promoting the service to local people through our national Rethink Information and Advice Service and Rethink Mental Illness web site www.rethink.org
- Staff visits to key local community organisations including faith organisations, emergency services and legal representatives
- Providing training to key referral agencies so they are clear on how to refer, clear on how the service fits within the local mental health and safeguarding pathway and ensure that organisations are fully aware of the eligibility criteria for the service.
- We use branded IMCA specific promotional items including Referral Pathway Flowcharts, Mouse Mats and Coasters in our Calderdale service which are distributed to local teams and partners at presentation and awareness events throughout the year.

We are committed to encouraging the development of Peer Support and recognise the benefits well trained Peers can have in providing informal advocacy and support, to build resilience and access community facilities. We will recruit and train Volunteers and Peer workers to publicise the service in the local community primarily to Service User/Carer Groups but also, in discussion with Commissioners, offer Group Advocacy Sessions in Hospital/Residential Home settings adding value to the current contract.

548/500

5.	There is regional disagreement on the issue of the automatic appointment of 39D IMCAs for all un-paid RPRs. If this were to become standard practice it would precipitate a substantial increase on the demand for IMCAs involved in DoLS cases, over and above the increase in demand following the Cheshire West judgment. With the workload continuing to grow, how would your organisation manage an additional increase in demand on top of the continuing growth? We will be taking into consideration amongst other things: • Understanding of the issue • Contingency plans • Relationship with Commissioners **Guideline 500 words**

Response:

We understand that the Cheshire West/Surrey judgments have significantly broadened the accepted definition of what is a Deprivation of Liberty resulting in an expectation that more people will be entitled to be assessed, which will drive up referral numbers within Advocacy Services.

We will monitor referral rates with Commissioners to ensure that our model of service has sufficient capacity to meet the expected needs of referrals. We will agree a contingency plan at an early stage to manage demand, should we receive unexpectedly high numbers of referrals.

We manage demand in all our Advocacy Services, demand management and contingency plans are drawn up with the full involvement of all key stakeholders in the Service Advisory Group meetings.

We map all performance data, client records and progress towards meeting KPI’s on our bespoke Rethink Information System (RIS). RIS is a powerful client record management system that allows managers to generate real time reports around service performance, client progress towards agreed outcomes and provide information for commissioners to support the contract monitoring process.

Our contingency plans for this service will include options to:

- Recruit and utilise locally trained Advocates who form our own local ‘bank’. These

Advocates are staff employed by Rethink Mental Illness but have chosen to work on flexible employment contracts. They are subject to the same support, training and management as our permanent contract Advocates but can be called upon at short notice to add additional capacity to the service. Our bank Advocates also allow us to help meet individuals specific needs and cultural requirements if they are not met by the core team.

- Recruit an experienced Advocate to perform the Litigation Friend (LF) role across the service on a flexible employment contract. This will ensure that our IMCA staff can concentrate on providing the core service instead of working on providing potentially long term or complex legal support.

- Dual, train all Tameside Advocates. All of our Advocates working in the North West are trained in IMHA, IMCA and Dols giving us a very flexible workforce across the region. Our contingency plans may involve offering additional hours to Manchester based IMCA's who are working part time to support this service if referrals peak. This facility will also help manage any recruitment, annual leave or sickness absence issues in this service.

- Depending on TUPE actuals and associated costs we anticipate there being a surplus in our budget for the second year of operation which will allow us to restructure the service, increasing capacity to meet any anticipated additional demand for IMCA services. This restructuring will have the full involvement of commissioners and form part of our normal positive contract management relationships and service annual report.

- Recruit, train and support Volunteers and Peers. Whilst not providing front line advocacy services our experience in other areas shows that Volunteers and Peers can be used to support access to information, advice and guidance, build resilience and support access to universal services. Volunteers and Peers can reduce contact time with trained Advocates and free up capacity by supporting non-essential tasks. Volunteers and Peers also play a valuable role in supporting staff to promote the service across the local community.

530/500

6.	What challenges might you encounter delivering an advocacy service across three different boroughs? Using examples from your practice, demonstrate how you would address these with regard to Oldham, Stockport and Tameside. **Guideline 500 words**

Response:

Immediately after tender award we will develop a detailed and comprehensive development and mobilisation plan in partnership with Commissioners and other key stakeholders highlighting actual and potential challenges in the development and implementation phase, mitigating risks and challenges in day to day service operation/provision.

A number of challenges are immediately apparent and include:

Ensuring equity of service across Oldham, Stockport and Tameside – It is important that people from all three boroughs get equal and fair access to the service and that clear referral protocols are in place to ensure an appropriate response to the timescales and targets required by IMCA's in their role.

We propose to allocate an individual Advocate to each of the three areas but will manage these posts flexibly to reflect service demand at any one time.

Nominating Advocates to localities cuts down on travelling, provides continuity and raises the profile of the service with the result of improved response times. However, using them flexibly across the three boroughs we will ensure that the named Advocates continue to provide an on-going link for organisations and teams in their area building up valuable local relationships and knowledge.

Where possible we will co-locate those IMCA's in their nominated area through negotiation with local teams. The Service Lead will have a reduced advocacy caseload but will work flexibly across the service concentrating their time on more complex or longer term cases increasing capacity for the IMCA's.

Recognising that there is an element of choice in whether staff wish to undertake the LF role, we propose to recruit an IMCA to undertake this role on a zero or annualised hours contract to ensure that this work, which is generally longer term, can be delivered without adversely affecting workflow and capacity in the IMCA service.

The development of a local Service Advisory Group with representation from Rethink Mental Illness, Commissioners, key Health and Social Care Teams, Service Users/Carers and in some cases significant local Care Providers will be tasked with ensuring referral protocols are in place and agreeing mechanisms for prioritising workload to achieve an equitable service across the three boroughs. If successful we would develop this group in the period of time between contract award and the date agreed for service launch to ensure these issues are addressed at the earliest possible opportunity.

Ensuring an equitable service across the culturally and ethnically diverse boroughs
Linked to access and a flexible service response we need to ensure that we can offer a quality IMCA service to all citizens of Oldham, Stockport and Tameside whatever their cultural, ethnic or communication needs.

The community as a whole is diverse and differs between the three boroughs, with a small IMCA team we will need to ensure we have appropriate links with other key local organisations, targeted staff training and support and also access to external professional support where assessed needs fall outside of the scope and skills of our IMCA team. We recruit staff locally wherever possible to reflect local demographics and have resources in our budget that can facilitate the purchase of additional support into the team to help with peaks in demand or where we need specialist cultural or communication support. In addition to this resource we also have an Asian Mental Health Service in Trafford who are available to the team for advice around the particular needs of the Pakistani and Bangladeshi communities. We also have a team of Advocates across the North West who are on flexible contracts and have been delivering our Spot Purchase Advocacy Support to local authorities in Greater Manchester and Sheffield.

587/500

7.	Using at least one example for each, demonstrate how your IMCA's have the necessary skills to practice non-instructed advocacy when working with people who: • Do not have English as their first language • Need specialist communication tools • Communicate through informal methods **Guideline 750 words**

Response:

All of our Advocates provide a person centered holistic service to the person they support, we encourage our experienced IMCA's to be creative when understanding and making an individuals wishes known.

Our IMCA's use the 'Watching Brief' approach taking time to build relationships with professionals, family members and all stakeholders who have an interest in the persons needs. Our IMCA's build a picture of the individuals likes, dislikes and preferences holistically and then use diverse communication methods to check out those assumptions with the person concerned.

We use translation services, if necessary, when working with people who do not have English as their first language but we understand the limitation and risks of solely relying on translators to accurately communicate important issues. Our IMCA's always use translation services as one tool of many, our Manchester team use picture boards and study responses and reactions to questions to back this up. Our Trafford BME service shares the same office as Manchester Advocacy, other local staff regularly approach our team making use of their experience and knowledge.

Example 1 - A clear example where our services have supported clients who do not have English as their first language comes from our [redacted] service where we supported an individual who had never had verbal speech. The client's family were [redacted] as their first language, the IMCA attempted communication in English [redacted] and with visual tools to give the client the best opportunity to respond.

The case concerned consent to serious medical treatment. The client could only respond by laughter or crying and even that response was limited. The IMCA reported that although the client had never had the capacity to choose to follow Islam a reasonable person would probably assume that if she did choose a faith [redacted] and therefore the beliefs of this faith should be considered in making the decision.

In this faith, because she lacks capacity, she is considered to be exempt from "sin" and would not be required to "fast". Personal care should always be carried out by a female as male support would be seen as inappropriate and the fact that the treatment would sustain life and did not conflict with faith.

The recommendation from the IMCA was to proceed with the treatment.

Example 2 – Shows where IMCA's have communicated using informal methods and was within the [redacted] Service where we had a person living in his own home and staff required support to help this individual build a list of likes and dislikes around food so that he could be adequately supported to cook meals.

The IMCA worked alongside the individual, his family and floating support staff to offer samples of food, encouraging the individual to taste, smell and touch the food. All the time the IMCA was asking direct questions and monitoring verbal and physical responses to the choices offered until the individuals likes and dislikes were understood.

Example 3 - Our IMCAs use a diverse range of tools and flexible processes to help individuals make decisions. An example where our staff had to work very flexibly was with an individual with [redacted] on a hospital ward. The individual would only communicate using 'yes' and 'no' and also had assessed risks around violence resulting in the ward being partitioned to safeguard other patients.

Our IMCA worked with the individual in a non-instructed way to discover his preferences and help him make decisions around moving to more appropriate accommodation where his needs could be met more effectively. The approach required considerable joint working and co-operation with hospital staff to deliver the positive outcome which allowed the individual to move out of hospital. The IMCA used a range of techniques which included:

- Using simple speech
- Keeping visits short to lower anxiety for the individual and comply with agreed risk assessments.
- Direct questioning so that the individual could answer "yes" and "no" as this helped lessen his frustration and levels of anxiety.
- Sitting at a distance from the individual that was acceptable and also safeguarded the IMCA as she carried out her role.
- Using picture boards and other visual aids.

698/750

8.	How will you manage service demand, including 'gate-keeping' decisions around the 'appropriateness' of referrals and the sign posting on of referrals that do not fit with the IMCA brief? **Guideline 500 words**

Response:

Rethink Mental Illness is a national provider of advocacy services and we understand the issues around managing demand in this type of service. Building on the experience of delivering similar IMCA services in Manchester and Calderdale we are confident our team of IMCA's can meet historical demand for the IMCA service along with adding additional capacity to meet expected growth or unexpected peaks in service demand.

There will be times when we have to prioritise access to the service; to manage prioritisation effectively we would work with Commissioners and key stakeholders from contract award to draft clear protocols and procedures around demand management.

One example where we had to do this was in our [redacted] Advocacy service where we received numbers of referrals that were considerably higher than anticipated in the generic element of the service. We negotiated methods for prioritising referrals with Commissioners to safeguard capacity for the statutory IMCA/DoLS/IMHA elements of the service whilst increasing resources to map services in the local community who could provide information, advice and guidance to clients wishing to access the community advocacy element of the service allowing us to work through this and future spikes in demand.

High priority groups identified in the contingency plan included:

- IMCA/DOLs/RPR
- Safeguarding concerns
- Court of Protection Referrals
- Child Protection/Child placement cases

Other referrals were assessed by the Service Lead against the following criteria:

- Potential impact of the issue presented
- Potential timescale for advocacy required. For example, in some IMCA cases where the issue was a change of accommodation a degree of forward planning allowed IMCAs to be scheduled in
- Availability of other sources of support e.g. Citizens Advice Bureau, debt advice, other voluntary and community organizations.

A fully functioning Service Advisory Group is essential in partnership working bringing all stakeholders together and this has been invaluable in Manchester, Calderdale and Sunderland.

Key decisions around referral priority and assessment methods are all agreed in the Advisory Group with the Service Manager feeding performance data back to the group and as part of the regular contract monitoring cycle.

The service advisory group will monitor data relating to KPI’s, trends in referrals and outcomes, working relationships with other partners or stakeholders required to produce the annual review/report.

All Rethink Mental Illness services carry out an ongoing process of community mapping to ensure they are well networked, staff understand local patient and mental health pathways and are fully aware of other organisations in the local community who can offer complementary services, should the IMCA service not be appropriate. A full understanding of all the options available to people within a locality are key in enabling the service to concentrate on its primary goal of delivering an IMCA service whilst carers and referrals who do not meet the service criteria are supported to access more appropriate services in the local community.

Good communication links and effective publicity ensure that teams, residential accommodation and Hospitals are clear around the service referral criteria and staff will build up good working relationships through day to day contact. These close working links will ensure, as far as possible, the service may get advance warning of peaks in demand e.g. early notice that a Residential Home might be closing.

Each of the IMCA's in the team will be designated to one of the three boroughs and be responsible with the Service Lead and the Service Manager for making links with teams and providers in the locality. In our other services Advocates carry out presentations at Community Mental Health Team meetings and ward meetings at inpatient units.

The team will work across the three boroughs meeting demand where it arises, the service lead with their greater experience and reduced caseload will concentrate their efforts on supporting longer-term or more specialist advocacy cases. We have contingency support from our other North West services and our spot purchase team if demand spikes are identified through staffing issues such as long term sickness.

629/500

9.	Using examples, demonstrate how the advocacy support your IMCA's will provide will be culturally sensitive and relevant across age, gender, religion, race, sexual orientation and disability? **Guideline 500 words**

Response:

As a provider of Independent Mental Capacity Advocacy we will receive referrals from all residents of Oldham, Stockport and Tameside whatever their age, gender, religion, race, sexual orientation or disability. Our IMCA staff are highly trained and experienced at working with all potential client groups and will prioritise networking within their local communities to ensure the service is accessible and meets the diverse needs of the population.

Appropriate and accessible publicity is vitally important in ensuring that local people and potential referral organisations are clear on the scope of the service and how to refer and also that people are fully aware of their rights.

We always respect the needs of all people referred to the service working in a person centered way, working holistically with clients and as such hold Allocation Meetings twice weekly where the Service Lead meets with the team of Advocates to look at referrals and to ensure they are allocated appropriately between the team.

In one of our services we found out that referrals to the service were not representative of the BME profile of the locality. We worked in partnership with Commissioners and Statutory Teams to identify other providers working with BME groups, we promoted the service heavily to those organisations but surprisingly this had little impact on the numbers of referrals. Real change occurred when we advertised and recruited a bi-lingual Advocate who worked closely with the local community to generate an understanding of the role of the service. After a relatively short period of time the service noticed a significant increase in referrals from those targeted communities.

Wherever possible we will attempt to match Advocates to individuals in terms of gender/culture to ensure our service is culturally appropriate. We recently managed to achieve positive outcomes working with a young woman with significant needs around identifying her [redacted]

We recently supported a man from [redacted] around his advocacy needs. [redacted] Had the advocate not had an understanding of the particular cultural needs of the client he would have gained that understanding through research and where appropriate involving other professionals or organisations to ensure that the client was supported to express his wishes. Advocates will often request the assistance of interpreters if there are language barriers, make use if basic sign, Makaton, communication boards, pictures and symbols, we can be very creative on how we communicate. Advocates will liaise with those they believe will be appropriate in assisting them in their role, this may include speech and language therapists, church elders, community based staff in roles particular to that clients needs and clinical staff. We are aware of some of the limitations of using interpreters and all of our advocates are trained to back up interpretation services with the visual and communication tools listed above. In addition we have used: • Easy read extensively • Drawings • Talking mats • Community languages • Widget • British Sign Language. When our advocates work with clients we make sure that we place the information in the context of the outcomes that we are working towards, speaking directly to the person so that we can pick up any facial expressions or useful body language that may not be available through the spoken word. **573/500**

10.	Edward is a 67-year-old man accommodated in a residential home due to his dementia. His care needs are such that he needs staff support and intervention 24 hours a day. He lacks the capacity to consent to his accommodation in the home and so a DoLS authorisation has been sought and granted. The BIA was not able to contact his brother during the initial assessment, despite every reasonable effort being made, and so a paid Representative has been appointed from the IMCA service. Two months into a six month Standard Authorisation, Edward's brother presents at the home when the paid Representative is visiting and demands to know why he hasn't been involved in any of the care planning or decision making about his brother. He demands that the paid RPR relinquish their contact with Edward and allow him to take over the supportive role. What issues might the paid Representative seek to address when confronted with this situation? **Guideline 500 words**

Response:

We would initially talk to the brother explaining our role and ensure that he understands we are working in his brother's best interest and that it is the responsibility of the supervisory body on the evidence of the BIA to decide who is invited to act as the RPR. We would provide the brother with information around Edward's rights to ensure he is better informed about the nature of the RPR role. We would ask if he wishes us to continue with the RPR but with clear lines of communication and involvement in his brothers support.

If Edward's brother is unhappy about the process or the attempts to contact him prior to the RPR appointment our advocate would ensure that he has information on how to make a formal complaint.

We would explore if Edwards brother is a Deputy as they can request the termination of an RPR appointment. If that was the case we would meet with his brother to hand over the case in a professional manner explaining the decision to Edward at each stage. If the RPR is discharged we would have a full handover with the brother (if he was to take on the role) sharing our experience of managing the case so far and offering any future support that would be appropriate.

The IMCA would have a conversation with Edward at an early stage to understand what his views are and whether he would or would not want his brother to act as his representative. Depending on Edwards capacity to understand and make the decision the IMCA may use a verbal approach or alternatively other tools such as sign language or picture boards to help make his wishes known.

A review may also be requested to look at whether the brother is an appropriate person to act as the RPR. The responsibility for this decision lies with the Best Interest Assessor to determine the RPR, alternatively the issue could be raised as a safeguarding case but this option may be an overreaction if a decision could be made without going down this route.

228/500

11.	Finally, please provide an outline of your organisation's proposed management and staffing structure for the IMCA Service in Oldham, Stockport and Tameside. In particular, please identify: • The number of IMCA's in your proposed service • Recruitment and relevant safeguarding checks • Management and supervision arrangements **Guideline 750 words**

Response:

The IMCA role is challenging and requires staff who are highly trained and motivated, possess the correct values and have the experience and confidence to work in a challenging multi-agency environment.

Our proposed team for this tender includes three part time trained and experienced IMCA advocates to cover the three boroughs. As with all our advocates these IMCA's will ultimately be dual qualified as we would encourage them to qualify for the IMHA elements as well which will add value to our model. The three advocates will be supported and supervised by a part time Service Lead post that will also be a qualified IMCA but will carry a reduced caseload.

To provide additional flexibility, support demand management and allow us to offer some specialist support to people with specific needs we have added a number of additional hours to the budget to allow us to buy in specialist support as the need arises e.g. translation services, communication support and where we need to meet an individuals particular cultural or support needs. The Service Lead and Service Manager will allocate the additional hours as required with feedback on how they are utilised given to Commissioners and other key stakeholders through the Service Advisory Group.

Our management and team structure

[Deleted diagram]

Recruitment and Safeguarding

We have a robust recruitment policy which is used across all services with the clear intention to:

- Appoint the best person for each position
- Ensure equality of opportunity for all applicants
- Ensure compliance with our Equal Opportunities policy and the National Minimum Standards prescribed by the Care Quality Commission and relevant employment legislation.
- Meet the organisations operational aims and requirements
- Support the career development of existing staff and aid retention.

We have a dedicated Human Resources department who support staff recruitment and we have extensive experience of managing TUPE for both incoming and outgoing staff. We are sensitive to the concerns and rights of staff in this process and support with regular information and consultation to enable a successful transition for staff.

All of our mangers are recruitment trained and we advertise positions locally as well as online and in the press to ensure we target recruitment in local communities where we are working.

On appointment, all candidates are required to provide two satisfactory references one of which must be their current or most recent employer. DBS checks are completed on all staff to the appropriate level required for the role and all certificates of the qualifications applicants claim to have are checked. No staff will commence work with the organisation until all the checks have been confirmed.

Any concerns or risks highlighted in checks are followed up by our HR department e.g. risk assessment of minor historical convictions and assessed by a senior manager before being signed off by the Director of HR. Advocacy positions require candidates to be a person of ‘integrity and good character’ and as a result and in line with the code of practice we would discuss any such appointments with appropriate commissioners or their representatives.

All new staff are required to successfully complete an induction and probationary period including completing all mandatory face to face and E-learning training including training around safeguarding children and adults.

Management and Supervision

Rethink Mental Illness services in the North West are overseen by an Area Manager who directly supervises an Advocacy Service Manager based in our central Manchester office. The Tameside service will be managed in the locality by a part time Service Lead post who will report to the Service Manager.

Both the Service Manager and Service Lead will be qualified Advocates with a high level of skill and experience. The Tameside Service Lead will provide line management, supervision and appraisal to the IMCA’s whilst continuing to carry a reduced caseload of more complex cases.

Staff will have individual one-to-one supervision and also have access to group supervision sessions with other advocacy staff which assist team development and aid reflective practice. All staff have an annual appraisal which measures personal achievement throughout the year and identifies goals and training needs for the following year.

683/750