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

VoiceAbility

Tender submission prepared by:

Name: [redacted]

Position held: **Regional Development Manager**

Organisation: **VoiceAbility**

Date: **13th 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)
£85,939

Hourly Rate
[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:
587/500 words

VoiceAbility is a national charity, providing specialist advocacy in 75 local authority areas and IMCA in 35 of those. We acquired Advocacy Experience Ltd, the current IMCA provider, in 2011. In the last year we have more closely aligned Advocacy Experience's policies, procedures and infrastructure with VoiceAbility's, but it has remained a wholly owned subsidiary. We are now beginning to incorporate Advocacy Experience's work within VoiceAbility more fully.

If our proposal is successful, the service and its advocates will be wholly managed by VoiceAbility, combining the skills, experience and local knowledge of its advocates, with the infrastructure, oversight and performance management of the second largest, specialist advocacy provider in England.

VoiceAbility' Mission is strengthening voice, championing rights, changing lives. We do this by providing Independent Mental Capacity Advocacy, Independent Mental Health Advocacy, NHS Complaints Advocacy, Looked-After Children's Advocacy and Independent Visitor Services. We also provide community and generic advocacy, and active voices and participation services (such as the DH National Forum for People with learning Disabilities) locally, regionally and nationally.

In 2013 we worked with 21,189 advocacy issues, experienced exceptional growth and became the largest provider of NHS Complaints Advocacy in England (a fact that won us the 2014 Fundraising Team of the Year). We work with older people, carers, young parents, people with learning disabilities, mental health problems, substance misuse problems, acquired brain

injuries, dementia, physical and/or sensory disabilities, carers and young people.

In January 2014, we completed the pilot phase of our Total Voice Suffolk Service (building on similar experience in Wandsworth, Northamptonshire and Lincolnshire), successfully tendered for the service for a further 3 years and were nominated for an innovation and best practice award by Suffolk County Council for our partnership working to support people with complex needs. We continue to develop partnerships across the country to ensure we reach the most vulnerable people and offer value for money to our commissioners.

We delivered the Experts by Experience Programme as a consortium member with Choice Support and provided Post Winterbourne View Experts by Experience, attending 35 of the 150 inspections. Our Experts were well regarded by the CQC. Since that time, we have developed our experience and provide Quality Checkers Services in 4 local authority areas.

We employ a team of people with learning disabilities to provide a range of training and consultancy services to organisations across the country, and we have supported the Learning Disability Partnership Board in Lincolnshire to establish a Community Enterprise and provide training and Easy Read Translation Services.

In 2013/14 we have worked closely with the Department of Health and the House of Lords, as lead partner for the Care and Support Alliance, to draft guidance on Advocacy, Information and Advice as part of the Care Act, so more people can access advocacy support to help them to be involved in decisions regarding their health and wellbeing.

We are a registered charity and company limited by guarantee. Our Chief Officer and Board of Trustees, including people with lived experience, have ultimate responsibility and oversight for the organisation. Operational responsibility rests with our National Services Director, Colleen Humphrey, and our Executive Management Team.

VoiceAbility was formed in 2010 following the merger of long-standing charities Speaking Up and Advocacy Partners. Together, we have over 40 years' experience of advocacy and participation work across England. We merged with ESAN (Suffolk) in December 2011, HUBB (East London) in September 2012 and Loud and Clear (West London) in May 2013. We have a projected annual turnover of £8 million with significant levels of reserves.

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:
598/500 words

Our analysis:
SCIE Guide 32 and the 6th IMCA Report suggest that approaches to safeguarding taken by Supervisory Bodies directly influence Adult Safeguarding IMCA referrals and highlights a continued reduction in Adult Safeguarding referrals (12% of total referrals) year on year.

Oldham, Stockport and Tameside have experienced an overall increase in safeguarding alerts, but annual reports show little connection with IMCA services. IMCA instruction is made by the local authority/NHS. IMCAs can only influence referrals. Our IMCAs can, and often do, suggest a safeguarding IMCA referral for people they work with or through informal discussions with referrers. For VoiceAbility (and Advocacy Experience) nationally the proportion of IMCA Safeguarding referrals are:

- 14% (1st October 2013-31st March 2014)
- 12% (1st April-30th September 2014, where post Cheshire West DoLS referrals have significantly skewed referral percentages)

Referrals to Oldham, Stockport and Tameside IMCA service compare favourably at 15% of total referrals between 1st April and 30th September 2014 across the 3 local authorities, so we are performing above organisation and national averages. But this masks variations within each LA area. As current providers of IMCA in Oldham, Stockport and Tameside, we know that, between 1st April and 30th September 2014, the proportion of IMCA Safeguarding referrals were as follows:

- Oldham 10%
- Stockport 12%
- Tameside 20% (we believe this to be a direct result of pro-active referrals from the recently appointed DoLS Lead in Tameside)

Cheshire West and Surrey Supreme Court rulings heralded a 75% increase in IMCA referrals across Oldham, Stockport and Tameside. This means the number of safeguarding referrals has increased, but the proportion in relation to total IMCA referrals hasn't.

Proposals:
We are proposing establishing a joint **IMCA steering group** work with MCA Leads across all 3

local authorities to. This strategic group will include the Service Manager (and Managing advocate as appropriate) will review performance data and trends, and ensure clear and embedded:

- Referral practices
- Multi agency safeguarding policies which include IMCA guidance
- Multi agency IMCA/DoLS training and awareness-raising campaigns with those who can instruct an IMCA and those who prompt referrals.

In **Oldham** we will be involved in:

- Health and Wellbeing Board (HWB) GP Governing Body training re. MCA and IMCA and training of GPs and practice nurses in safeguarding adults
- Oldham Adult Safeguarding Partnership Board training sub group and dignity task group through Introduction to MCA, DoLS and Level 2 MCA courses

In **Tameside** we will provide quarterly awareness and training sessions to:

- Dignity Champions around the role/function of IMCA
- Tameside Adult Safeguarding Panel (TASP) Training Panel recipients around IMCA, and safeguarding

We will also include questions about IMCA in the Annual Adult Social Care Survey to develop understanding of local gaps in knowledge re. IMCA

In **Stockport** we will:

- Develop IMCA involvement in DoLS and MCA training for Care Homes and Care Managers
- Work with Stockport NHS Foundation Trust through training to support CEQUIN target on safeguarding
- Develop strategic links with Pennine Healthcare NHS Trust Adult Safeguarding Operational manager to increase referrals from NHS professionals

As the current provider, we have already started to address this by working with:

- Tameside Hospital Safeguarding Manager and DoLS lead, training Consultants, Senior Nurses, Ward and Discharge Managers
- Andy Holt, Mental Capacity Act and Deprivation of Liberty Safeguards Co-ordinator in Tameside to generate an increase in IMCA (and especially DoLS) referrals, referrals.
- Safeguarding professionals at Stepping Hill hospital to ensure adults who lack capacity on surgical wards are represented
- Mental health professionals at Cheadle Royal hospital to raise awareness of IMCA

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:
603/500 words

The Mental Capacity Act Code of Practice makes no reference to IMCAs acting as Litigation Friends (LF), however demands on IMCAs in this role have increased as the Official Solicitor becomes the LF of Last Resort. The role can also be fulfilled by RPRs (un/paid) who can be well placed to understand the individual's needs, preferences and wishes. We have reservations about using unpaid RPRs.

The role carries significant responsibilities. The LF must determine how best to support the individual in all respects, and if they fail in this duty, are accountable to a judge. We have addressed this organisationally through:

- Making LF a voluntary opportunity for advocates
- Appointing two Senior IMCAs to supervise LF cases regionally.
- Written organisational guidance and training, including DH Guidance
- Weekly catch-ups on LF cases, in addition to supervision
- Peer support through our online IMCA Practice Forum
- Support from our national Head of Policy
- Training 80% advocates in the North West to understand the LF role
- Ensuring advocates are covered by our Professional Indemnity Insurance in the LF role.

Litigation Friend can be expensive/time consuming and currently demands on our IMCAs are exceptionally high. The Court of Protection is stretched to capacity, creating further delays, but if an LF is not appointed, court cases can last several months (or years) with significant costs. SCIE Guidance recommends LAs set aside funding for this purpose, but in an environment where authorities are cutting core services, this is challenging.

In Oldham, Stockport and Tameside, we will provide 2 Litigation Friend cases per annum, within the contract price, based on demand from 2012-14. We are happy to provide additional LF work at an inclusive price of £30 per hour.

[redacted], *26, has* [redacted]. *When* [redacted]*'s dad moved in, Social Workers and her landlord became concerned about financial abuse: bills were left unpaid and she began withdrawing savings. A Safeguarding referral was made and an IMCA appointed. Through conversations with* [redacted]*, her friends, family and carers, the IMCA felt that* [redacted] *lacked capacity and the safeguarding alert was upheld*.

But discussions with [redacted]*'s father, mother, brother and paternal grandfather didn't resolve the situation and the landlord was unable to remove the father from the property. Our Senior IMCA*

Caseworker, experienced in LF, discussed the case with peers and their manager who agreed LF may be beneficial. The IMCA researched case-law to find similar LF cases and suggested this option to the Local Authority, explaining the role and the process involved. The Local Authority asked the Court of Protection to invite our IMCA to be LF because [redacted]'s family were hostile to her father and there was concern that he might challenge their lack of neutrality. Our IMCA sought legal representation for [redacted], approaching 3 solicitors (to ensure objectivity/transparency) with a case outline. The appointed solicitor and the IMCA made regular visits to [redacted] to support the case to progress and help [redacted] understand what was happening.

Her father received an eviction notice and left. Neither he nor his girlfriend could contact [redacted] without permission or come within 100 yards of the property. If [redacted] wanted to see her father, a Risk assessment and a Best interest decision was required. [redacted] also had 28 hours of care and support each week and these restrictions meant the barrister requested Deprivation of Liberty assessment, which is ongoing.

[redacted]'s mother became her Financial Deputy. Her father is challenging this. The case is unresolved, but without a LF, [redacted] would still be risk of financial abuse and may have lost her flat.

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:
(546/500 words)

Learning and Development Manager (and Training Manager of the Year 2007), Alison Lloyd, co-ordinates training and development across VoiceAbility, reporting to our HR Director, Debbie Moore, a member of the Executive Management Team. She recently reviewed our learning and development policy and processes so all staff and volunteers can access the training they need to do their job.

New/transferring employees have a formal **induction,** covering VoiceAbility's values, health and safety, equality and diversity, the service they work in and their role. Within their first week, advocates have:

- First supervision with line manager to confirm understanding of service standards and responsibilities.
- Introduction to supervision /appraisal process.
- Personal development/performance objectives started (completed within 2 weeks).
- Orientation to stakeholders.

After three months of employment, staff create a **Personal and Professional Development Plan** (PPDP) with their manager. Advocates update the PPDP with their training achievements, (including refresher training) and review it quarterly with their line manager.

Employees are expected to complete the following training within 12 months of employment:

- Independent Advocacy Qualification (IAQ) and unit 305 (IMCA) (all certificates are scanned and stored electronically for quality assurance)
- Non-instructed advocacy practices
- Cultural awareness
- Training to support specific user groups e.g. those with dementia, substance misuse, Acquired Brain Injury
- Communication methods

Advocates identify and access further training opportunities through discussion with their Line Manager, and based on need for that training/learning as evidenced through case-work (e.g. DoLS module).

Our rigorous approach to **safeguarding** exceeds statutory requirements and is informed by evidence, policy, legal and practice issues. Nicola Youens, Head of Quality, oversees safeguarding policy, practice and training and reports directly to a governance team chaired by our CEO and supported by the Ann Craft Trust.. Advocacy plays such as important role in safeguarding vulnerable adults that we have invested significant resource in developing our policies, procedures and training programme, to include:

- Our policies and enhanced safeguarding protocols
- Case Studies/practice based training around different types of abuse and 'grey areas'
- Making a safeguarding alert

- Management arrangements for escalating a safeguarding alert
- Local Safeguarding policies, procedures and specialist professionals to maximise the number of safeguarding alerts which are upheld
- Safeguarding for managers non-advocates

Managers must complete accredited Advocacy Supervision for Supervisors training; demonstrating the core skills, knowledge and competencies to provide advocacy specific supervision.

6-weekly, formal **Line Management Supervision** focuses on performance, case reviews, specific issues and goals for the coming period. Confidential notes are signed by the advocate and their line manager. **Annual Appraisal** is a chance for staff and managers to reflect on the previous year, consider 360 degree feedback, review goals and the PDPP.
6 weekly **Casework Supervision** provides peer support to discuss and work through cases and suggest improvements to the service.
Practice Audits take place at least quarterly (more frequently for new staff). Managers meet with advocates to analyse case work, using our internal audit tool (based on Advocacy Principles, person-centred practice, equality and diversity, safeguarding and the Advocate's Code of Practice). The process includes observed casework and informs training, development and organisational best practice.
Online in-house IMCA, IMHA and NHS Complaints Forums are well utilised, accessible by all employees and promote the sharing of good practice and discussion of complex issues between practitioners.

4.	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 **Guideline 500 words**

Response:
(633/500 words)

We will target awareness-raising and training activity based on local priorities in order to increase eligible referrals, and reduce ineligible ones. This approach is at the heart of ensuring IMCA services genuinely protect the rights of the most vulnerable in society. s
The re-establishment of an **IMCA Steering Group** will:

- Help identify local priorities for awareness-raising across the 3 boroughs
- Review our **Stakeholder Engagement Plan** for the contract duration (this might initially focus on increasing safeguarding and SMT referrals and referrals from GPs for example), and
- Monitor our success in reaching those who need an IMCA.

An annual **e-survey** of referrers/decision makers will identify what information they need about MCA, IMCA and the new service. The results will inform the Steering Group and our training, awareness-raising and service literature.
Our **IMCA Services Manager** will:

- Have a lead role in the IMCA Steering Group
- Develop strategic relationships to increase access to IMCA (e.g. Health and Wellbeing Boards, CCGs, GPs, MCA, DoLS and Safeguarding Leads)
- Agree Engagement Protocols with referrers, local advocacy providers and organisations such as Healthwatches
- Provide 1 x awareness-raising session/month.
- Monitor referrals by referrer, issue type and support need each month to establish the effectiveness of awareness-raising and adapt accordingly.

The **Managing Advocate** will dedicate 10hrs per month (1/2 a day in each area) to awareness-raising sessions and site visits, including:

- Safeguarding and MCA training for NHS Trusts/CCGs, to increase GP and Practice Nurse awareness
- Informal discussions with referrers and those who prompt referrals (e.g. 3rd sector organisations, Carers Groups and Issue based organisations)
- Targeted information to Learning Disability, Older Adults, safeguarding and Healthcare Professionals
- Working with Healthwatches so carers, informal support groups and key local stakeholders understand IMCA and to improve links with NHS Complaints
- Awareness-raising with Managing Authorities (e.g. DoLS Surgeries) to increase appropriate DoLS referrals and manage demand

Team members will have **specific geographical responsibilities**. The Managing Advocate will

have the awareness-raising lead for Oldham, whilst the Advocate will focus on Stockport and Tameside. This will include **site visits** and **awareness-raising/training** to hospitals, care homes and Adult Social Care Teams.

Equal Voices Plans for each local authority ensure a close a match between referrals and local demography. We will look at data (e.g. ethnicity, gender) and presenting needs (e.g. age, referral source) to address possible under-representation and target resources. We also benchmark this against data from other IMCA services.

Communications and Marketing Manager, [redacted] will support the team in devising, developing and implementing our local Marketing Plan (a toolkit of resources and guidance and templates on our intranet, *VoiceAbility World*). Our **website** will include:

- How to contact/refer in Oldham, Stockport and Tameside
- A downloadable referral form
- The RPR self help guide
- Links to useful information on SCIE, Department of Health, Care Quality Commission, etc.
- Information about other advocacy services

In addition, we will ensure that other organisations have **web links** to our referral information. This will include, as a minimum, each local authority, hospital, Healthwatch and advocacy provider in the area.

[redacted] IMCA Service
Established in 2007, the IMCA steering group attracts high levels of engagement from health and social care. Meeting quarterly, it has been instrumental in leading changes in practice, for instance: securing hospital management board support to increase SMT referrals; more appropriate IMCA DoLS referrals from social work teams; increased referrals by their dentists and with GPs.

Cambridge IMCA Service
Referrals from [redacted] IMCA service were lower than expected. We met with statutory stakeholders and decision makers and increased information and training, working with professionals at to understand how IMCA fitted into their practice, processes and procedures. As a result of this collaborative approach we saw a 30% increase in referrals over 3 months.

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:
(652/500 words)

39D IMCAs, unpaid RPRs and growing demand:
As a national provider, we know local approaches to IMCA and 39d referrals differ and the Cheshire West ruling has served only to accentuate the fact. Shortages of Best Interest Assessors, backlogs of DoLS Authorisations, and too many urgent DoLS referrals can all lead to IMCA capacity issues.

Oldham, Stockport and Tameside referrals in **the last 6 months** have exceeded those for the whole of the previous financial year, making demand management a key issue.

Referral Category	**Oldham**		**Stockport**		**Tameside**	
	1/4/13-31/3/14	1/4/14-30/9/14	1/4/13-31/3/14	1/4/14-30/9/14	1/4/13-31/3/14	1/4/14-30/9/14
Serious Medical Treatment	14	13	16	9	11	21
Changes in Accommodation	23	21	24	25	20	28
Adult Protection	11	17	5	1	10	7
Care Reviews	8	4	1	3	9	9
DoLS	3	12	6	15	0	13
Total	59	67	52	53	50	78

Irrespective of the demand pressures, unpaid RPRs have a major role to play. Often they can best represent the individual because (depending on their relationship) they can understand what that person would want for themselves. Problems though can arise because the unpaid

RPR might:

- Feel under pressure to accept the role.
- Struggle with the responsibility/time commitments placed on them
- Feel overwhelmed and un-supported.

Automatic 39d IMCA referral however means support is available, as needed, for the individual and their RPR. 39d IMCA promotes self advocacy and can save money by avoiding the need to go to court. And if for some reason the RPR withdraws a 39d IMCA must be appointed anyway, and if already supporting the process, transition can be smoother and more effective.

Contingency Planning

Our service is designed to address increased demand and future growth as follows:

1. **Paid RPR** working 7.5 hours/week (minimum) across Oldham, Stockport and Tameside. This regional role, successfully implemented in Liverpool, is non-IMCA qualified (offering value for money) and works with individuals from the start of the DoLS process, avoiding the subsequent need for a 39d referral.

2. **Social Work Students** will support the Paid RPR and provide non-statutory non-instructed advocacy at venues such as care homes, across the 3 localities. Based on our pilot in Liverpool, SW students are cost-neutral and can add real social value.

3. **Developing a downloadable RPR Self Help Guide** (including easy read, non English versions) for unpaid RPRs, to understand the process, responsibilities and duties better. It will be shared across services, developed by our Marketing and Communications Team, at no cost to commissioners, with local targeted awareness.

4. **DoLS Surgeries** at key sites (e.g. Care Homes) prioritise DoLS referrals and improve Managing Authority awareness to make earlier, appropriate DoLS referrals so that we can better manage demand.

5. **Casework Prioritisation.** IMCAs with a geographic remit will develop relationships to increase/improve referrals locally and reduce travel time. IMCAs will allocate one day/week to non-urgent referrals, so more eligible individuals can access IMCA.

6. **Pool of Local IMCAs.** We provide IMCA services in 10 North West local authority areas in the North West, with 12 DoLS-qualified IMCAs, a pool of sessional workers to prioritise urgent cases across the region and 4 IMHAs who will be IMCA qualified by January 2015. This will help us to manage unusual peaks in demand and provide contingency for annual leave/staff absence, meet urgent timescales and maintain referral levels.

Data and Discussion with Commissioners

Communicating with commissioners (and MCA/DoLS leads, Supervisory Bodies and referrers) about service demand will help us maintain a responsive and locally relevant service. MAAVIS (Managing Advocacy and Active Voices Information System) is our bespoke, cloud-based casework management system. It allows us to monitor referrals by issue type, support need, location and individual advocate. We **benchmark casework times**, activity and recording accuracy individually and service wide to quickly identify/address performance/capacity issues. We will provide a **monthly summary report**, alongside quarterly contract monitoring reports to commissioners/ throughout the contract, to identify and find solutions to capacity issues quickly

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:
633/500 words

We must ensure IMCA is **accessible**, regardless of where people live and where they receive care/treatment. With a contract which covers 3 local authority areas, we also need to ensure individual commissioners get value for money and a service which reflects **local need/diversity.** Cheshire West has led to an **overall increase in demand**. DoLS referrals alone in Oldham, Stockport and Tameside increased by 413% in the 6 weeks following Cheshire West, and the trend has continued, so there is an even greater challenge to **predict and manage demand across 3 authorities**.

Local Approaches to IMCA vary across local authorities, so d**eveloping local relationships** is crucial. The **Steering Group** will be key to this and evidence [redacted] highlights how well this can work. Advocates will have **specific geographical responsibilities** ensuring a known name/face for referrers. Our Managing Advocate will have operational responsibility for referrals in Oldham, to provide dedicated focus to improve referrals and relationships where there has traditionally been least engagement in awareness raising. The IMCA will focus on referrals from Stockport and Tameside. Both work peripatetically, using laptops and smart phones to maximise casework and minimising travel time.

Because Advocacy Experience, the current IMCA provider, is a wholly owned subsidiary of VoiceAbility, we know the transferring staff team, their specific skills and experience. We have oversight of the current contract and specific local issues, have kept our commissioners informed about increases in demand and already **adapted our approaches** to manage this within existing resources.

We can also make reasonable **predictions about future demand**. Within the contract price we can work with 197 referrals/annum (including two Litigation Friend cases). However, we predict demand in 2015-16 to be c.396 referrals. Our **service model** offers flexibility, efficiency, scope for **spot purchase** or overall increase in investment as well as a local focus for Oldham, Stockport and Tameside:

- The **paid RPR** will work across Oldham, Stockport and Tameside, where there is no relative or friend. As a non-IMCA qualified role, on a lower salary, it offers value for money. Feedback from services in Liverpool suggests that it may reduce urgent 39d referrals.
- **Social Work placements** offer additional RPR resource and non-statutory Non Instructed Advocacy at venues such as care homes, to improve referral rates and reduce inappropriate referrals through awareness-raising.
- **Sessional workers**, available 7.5 hours per week and a **regional pool** of DoLS qualified advocates will support fluctuations in service demand
- **The IMCA Helpline** increases casework capacity and frees IMCAs to develop operational relationships and raise awareness. It is a shared national resource, offering value for

money, responding to more enquiries, more of the time, regardless IMCA availability.

- **MAAVIS** (our casework database) is cloud-based and accessible by any advocate with permission, from any location with WiFi. We monitor demand, capacity, IMCA practice and casework times by a range of variables, in real time, to provide **up to date information** about service capacity, ensure our advocates remain **issue focussed**, predict demand and inform referrers, commissioners and strategic partners.
- We will ensure appropriate **management and strategic oversight**. The Managing Advocate will line manage service staff, whilst the Service Manager will devote 1 day per week (minimum) to contractual matters and strategic relationships

Case Study

When [redacted] IMCAs reported an increase in referrals from [redacted] residents at [redacted]. Our commissioners were able to discuss this unintended consequence of the hospital closure and negotiate local arrangements accordingly.

Case Study

IMCAs traditionally struggled to engage with [redacted]. When a new Safeguarding Manager and DoLS Lead were appointed, we arranged for IMCAs to be involved in compulsory training for hospital staff. Because Consultants, Ward and Discharge Managers attend the training, it has contributed to a 100% increase in Serious Medical Treatment Referrals in [redacted]

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:

761/750 words

[redacted] lived with his mother until she died, after which he had lived in a series of institutions, including the specialist **assessment and treatment unit** where our Advocate, [redacted], worked with him to be involved in meetings about his future. J[redacted] had **mental health** problems, an [redacted] and staff described his behaviour as **challenging**.

When [redacted] first approached him, [redacted] was **uncommunicative**. [redacted] understood that communication is about **making a human connection**, so he began by making several short visits, showing his identity badge, always **smiling,** being **open** and **friendly**, and explaining his role in **simple language**. [redacted] often stood in the corner or was too unwell/refused to see [redacted]. But [redacted]'s **consistent friendliness and kindness** helped build trust.

[redacted] also contacted an advocate who had worked with [redacted] in his last home, to find out more about how he communicated and reacted to certain situations.

Eventually [redacted] sat with [redacted] and nodded to show that he wanted [redacted]'s help. [redacted] began to understand [redacted]'s **behaviour**, **facial expressions** and **language** and when [redacted] was happy, sad, worried or angry. [redacted] also worked with [redacted]'s **Psychologist**, who had developed a series of **picture cards** to help [redacted].

[redacted] was able to agree the support he needed and the kind of home he wanted. Staff reported that [redacted]'s behaviour was more stable and he was communicating more.

At first [redacted]I attended Multi Disciplinary Meetings on [redacted]'s behalf, agreeing beforehand what he would say. [redacted] then attended a meeting but [redacted] represented his wishes. Eventually [redacted] attended meetings and answered direct questions from professionals about his future accommodation and support. As a result, several options were rejected and [redacted] moved to long term accommodation which he had been involved in choosing.

[redacted], a 73 year old [redacted] man, suffered from [redacted] The hospital made a **Serious Medical Treatment** referral because [redacted] required an endoscopy but professionals couldn't explain the procedure and [redacted] became distressed every time it was discussed. [redacted] preferred to communicate in [redacted] so our IMCA, [redacted], appointed a **translator**. [redacted]'s dementia made it hard to understand information about the endoscopy, even in [redacted]. Helen, with the help of the translator, explained her role and talked to [redacted] about how he was feeling. [redacted] talked fluently about his **past experiences** and life in [redacted] and this helped [redacted] to

understand his preferences and to **build up trust**.
[redacted] found herself intuitively **miming** actions to [redacted], whilst the translator explained in [redacted], tracing the progress of the endoscopy tube from her mouth, down across her throat towards the stomach. [redacted] indicated that he did understand and agreed, in [redacted], to the procedure.
But [redacted] knew that, because of his dementia, she needed to look for **consistency** in [redacted]'s responses by **asking the same question in different ways**. She **drew a picture** to explain the procedure and checked several times that [redacted] fully understood. The endoscopy went ahead and [redacted] experienced little if any distress.

[redacted] was recovering from a **stroke**. Upon discharge from hospital she was placed in a care home temporarily, to assess her longer term needs. A **Change of Accommodation** referral was made to our IMCA Service.

Staff at the home said [redacted] wouldn't talk to them or answer their questions. They felt she didn't understand them and doubted her capacity to be involved in decisions about her accommodation.

During the first visit, our IMCA, [redacted], asked [redacted] open questions about her wishes and feelings. Rita's replies seemed **muddled**, but [redacted] realised that, with enough time to respond, [redacted] could communicate. [redacted] accessed [redacted]'s **care files** and spoke to her **GP**, discovering that [redacted] had seen a **Speech Therapist** in hospital as part of her rehabilitation.

[redacted] telephoned [redacted]'s niece, who lived in [redacted], to find out more about [redacted]'s life before her stroke. Her niece described her as fiercely independent and very house proud, feeling that [redacted] would want to stay in her own home for as long as possible.

[redacted] met the speech therapist, who advised her to use **multiple choice questions**, for instance "Are you feeling happy, or sad?" The therapist also advised us to use an **Alphabet Board** so that [redacted] could communicate independently.

Using the techniques suggested by the Speech Therapist, it became obvious that [redacted] had very strong feelings indeed about her future accommodation. [redacted] used the Alphabet Board to point to the letters she needed and [redacted] wrote the words. [redacted] simply needed **time** to participate in discussions about her future and eventually returned home, with a package of care and support.

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:
(642/500)

The challenge is to ensure everyone who is entitled to can access an IMCA. Our proposed **IMCA Steering Group** is important in determining the approach of referrers and statutory gatekeepers, such as Supervisory Bodies, Managing Authorities and Mental Capacity Act Co-ordinators. Demand for IMCA across Oldham, Stockport and Tameside in the last 6 months has exceeded that of the previous financial year. **We predict demand for 2015-16 will be approximately 396 referrals/annum.**

IMCAs are appointed by statutory referrers and don't control the referrals they receive. We see this in different local authority responses to Cheshire West, SMT and Adult Protection referrals. But we can **influence referrer behaviour**, through operational and strategic relationships and awareness-raising. We don't advocate 'gate keeping' by local authorities, of referrals and will work with professionals to understand the benefits of IMCA involvement. Internally, the helpline and informal discussion with advocates helps us to understand the issues locally and ensure that we receive fewer inappropriate referrals.

The Care Act, places statutory duties on local authorities to make advocacy available to more people. This will increase demand for advocacy and may create additional confusion for referrers because of overlap between Care Act, IMCA, IMHA, (and community-, NHS Complaints- and in some cases Looked After Children's advocacy).

A **co-ordinated approach** is needed locally, **streamlining** processes to ensure people get the service they need when they need it, including people with complex needs. We will develop **engagement protocols** with providers such as Cloverleaf, Stockport Advocacy and local Healthwatches, engage in joint awareness-raising and develop a common **advocacy referral pathway**, including a simple online checklist.

Our **IMCA helpline** answers more calls so IMCAs can concentrate on casework, and has an important signposting function. Helpline Advocates receive locality training to signpost people to a service wherever possible and we **monitor unmet need** (and share it with commissioners) to inform future developments priorities.

Case Study
[redacted] *Vulnerable Adults Advocacy is a small service with specific criteria for referrals. We were turning people away from the service, with no real local alternative. We used data to evidence unmet for parents involved in child protection proceedings and agreed with commissioners to amend referral criteria.*

Our service will manage 197 referrals/annum (including two Litigation Friend cases), but can easily expand, through spot purchase or by increased investment overall. The Managing Advocate and IMCA have **specific geographical remit**, and **work periptatetically**, maximising

casework time, minimising travel time and developing local relationships and knowledge.

We have calculated service capacity using local data and national benchmarks of 12 hours/case. The **5**means advocates spend 85% of time on casework and contractual tasks like awareness raising and 15% on awareness non casework tasks, such as training and organizational meetings. We expect advocates to accurately record 95% of their working time to reflect this split and will monitor this throughout the contract and address capacity issues promptly.
The **Paid RPR**, enhanced by **Social Work placements**, supports people without friends/family. We believe it will **reduce urgent IMCA DoLS** referrals. **Sessional staff** and a **pool of regional IMCAs** support fluctuating demand and offer flexibility in the first months of the contract.

Specific features will improve referrals. Social Work placements will provide non-statutory **Non Instructed Advocacy** at key venues such as care homes. We know from services in Liverpool that this is useful in raising awareness among Managing Authorities to make more appropriate IMCA referrals.

Advocates will provide **DoLS surgeries** at venues where demand indicates it is useful. Services in Bolton were inundated with DoLS referrals following Cheshire West but many were from the same Managing Authority. We allocated half a day at those care homes, working through referrals, many of which were inappropriate. This helped us manage capacity and informal discussion with care homes helped them make timely and appropriate DoLS referrals, impacting positively on MCA Co-ordinators, Supervisory Bodies, Best Interest Assessors and the IMCA service.

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:
(581/500 words)

Equality, diversity and anti-discriminatory practice is a compulsory part of our Induction, Supervision, Appraisal, Casework Review and Practice Audit, stakeholder feedback and an agenda item at local, regional and national meetings.

As an organisation we value diversity and want ensure that our working environment is as inclusive as possible, both to staff and service users alike. Our **Equality and Diversity Training Programme** is designed to provide a rolling programme of focused learning around the main protected characteristics under the Equality Act 2010. These sessions include DVD scenarios with guided group discussion and last between 2 and 3 hours per module. It is mandatory for everyone to attend.

L**ocal voluntary sector networks** help make our services accessible to people with protected characteristics. We will raise awareness across each authority with issue based groups, BME Community Groups and LGBT groups, so that they can prompt a referral to our service as appropriate.

Some communities, who might rely on informal support networks, may not access advocacy. We will work with **community leaders** to **change perceptions of advocacy** through training and awareness-raising. Written information isn't always the best format for some people whose first language is not English, so **word of mouth** an **awareness raising events** will be important.

Equal Voice Plans will help us to ensure as close a match as possible between the demography of local areas, and the people we support.

We get to know the person's preferred method of communication and use the skills of all of our advocates to offer a sensitive service, for instance by making a male/female advocates available. Oldham, Stockport and Tameside have access to a sessional IMCA who speaks 4 relevant languages, an Acquired Brain Injury specialist IMCA and Becky Bradley, IMCA Services Manager is Makaton and BSL level 3 qualified. All of our MCAs are trained in a range of Non-Instructed Advocacy techniques. We also use:

- Makaton
- Widget/graphic communication systems
- Access to SALT
- Audio and video stimulation
- Picture cards
- Photographs and objects, including those with particular meaning to the person
- Communication boards and talking mats
- Observation
- Staff/carers with greater awareness of individual communication methods
- Translators

Online Practice Forums mean that, as advocates confront challenging issues, they can access an organisation-wide pool of colleagues who can reflect on and help guide their response.

Case Study

[redacted] is 19 and has [redacted]. His social worker referred him to our service. He lived with his mum and wanted to go to college, but his mum wouldn't allow this and restricted his daily activities. We visited [redacted] and his mum at home. [redacted] and [redacted] spent time talking but his mum was very wary. [redacted] approached a local [redacted] Group, because he felt there were some cultural barriers. The Group's leader suggested [redacted]'s mum might prefer to have a woman present and offered to support us with the case and any language issues. We checked with [redacted]'s mum and arranged a second visit.

[redacted]'s mum really opened up to us on the second visit. She was very worried about the people he would meet at college, that people would make fun of him and that it wasn't culturally appropriate. [redacted] visited a local college with his mum, the IMCA and the Women's Group leader. We spoke with [redacted] beforehand to help him prepare a list of questions and his mum talked to college staff. [redacted]'s mum was reassured and he was able to attend college.

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:

(594/500 words)

To support Edward in the Paid Relevant Persons Representative (RPR) role, our Representative would spend time with Edward, observing him in different situations, talking to him and people who care for him, using different communication tools and techniques to understand:

- His needs and preferences
- What level of involvement he might have in decisions regarding his care and support
- The least restrictive measures for caring for Edward.

Edward's brother is upset about the perceived failure to involve him. This may be directed towards the RPR, requiring patience, understanding and empathy from her/him in explaining the law, their role, and exploring how they might support Edward's brother to become involved while always ensuring that Edward's best interests are upheld.

It is the Supervisory Body (SB) which determines who can best represent Edward's wishes. Generally a relative would rarely be considered inappropriate, and there are clear advantages to appointing a relative. They are likely to know more about the individual's personality, likes, dislikes and history and can be well-placed to consider what the individual might want for him/herself.

The RPR role is complex, time consuming and carries considerable responsibility. There is a requirement for the RPR to visit every 4-6 weeks to check DoLS conditions are being met. Friends/relatives often struggle to fulfil this because of work/personal commitments, geographical distance and travel costs and their emotional involvement can make it harder to be detached and objective.

Additional problems for unpaid RPRs are:

- Volume of paperwork
- Language/terminology can be hard to understand
- Requirement to be assertive, exerting the right to view care plans, speak to care staff and to Edward

- The duty to report anything untoward to the SB requires observation (sometimes it's the little things), assertiveness and resilience.

In this case, the Brother couldn't be contacted at the point of Appointment. So the paid RPR might suggest several options:

1. Our continued involvement to the end of the 6 months, to help Edward's brother engage and teach him the RPR role should that role be needed longer-term
2. Recommending the SA is rescinded in Edward's brother's favour, or
3. Option 2, but making a 39d referral for Edward and his brother. In this case we might argue we now have a relationship with Edward, know the case and can explain the RPR role and duties in detail to Edward's brother so he can determine if he needs support, either immediately, or at any time in the future.

Clearly however it is only the SB who can make this decision and we would ensure that Edward's brother appreciated this fully.

Regardless of our continued involvement, we would ensure Edward's brother had the information he needs to act as RPR and the SB is informed of our suggestions to avoid further delays. Handover would focus on the 39d checklist of DoLS conditions, checking Edward's brother can fulfil his role and handover of Edward's case.

In all cases, our IMCAs seek guidance from their Line Manager and peers, through informal discussion and peer supervision, or our online IMCA Practice Forum. We provide IMCA in 35 Local Authorities, each with different approaches to RPR, DoLS and the 39d role. Some MCA Co-ordinators appoint a 39d IMCA as a matter of course. In other areas we have developed a Paid RPR role to pre-empt the need for a 39d IMCA, and we are offering this role in Oldham, Stockport and Tameside. In each case, we work flexibly with our commissioners, MCA Co-ordinators and Supervisory Bodies to ensure that the needs of the individual are upheld.

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:
Guideline 784/750 words

VoiceAbility will provide a new service, with capacity for 197 referrals/annum, including 2 Litigation Friend cases. We expect advocates to spend 85% of that time on casework and contractual activities and 15% on training, team meetings, etc.

Proposed Staff Structure

[Deleted diagram]

Regional Director-Ruth Ingamells
[redacted], our organisational IMCA lead, has worked for VoiceAbility for 8 years, 4 of which as a Regional Director. From 1st December [redacted] region will include the North West. She will lead service implementation from award of contract.

IMCA Services Manager
The IMCA Services Manager will devote 7.5 hours/week (1 x working day) minimum to this service, managing the Managing Advocate, playing a lead role in the IMCA Steering Group, and developing strategic relationships. [redacted], our IMCA Services Manager, will implement the contract and manage the transition of staff to VoiceAbility. She is an experienced Manager, a qualified IMCA/IMHA and has BSL level 3 and Makaton training

She will be available throughout the working week, via mobile phone/email. An on call system for **Safeguarding** issues ensures staff can contact a manager about a safeguarding issue, at any time.

Managing Advocate (30 hours per week)
The Managing Advocate will dedicate 22.5 (3 working days) to IMCA casework, with geographical responsibility for Oldham, where IMCA is least engaged in awareness-raising. They will manage all service staff and placements and lead on Litigation Friend cases, with additional resource from a Senior Caseworker in Liverpool and Sefton.

IMCA (30 hours per week)
The IMCA will focus on casework, with responsibility for referrals, awareness raising and operational links in Tameside and Stockport

Paid Relevant Persons Representative (7.5 hours per week)
This new role, adopted across several services, has had a positive impact on caseloads and reduced demand for urgent DoLS referrals. The RPR will complete the IAQ within 12 months of recruitment, working regionally, with 7.5 hours/week minimum for Oldham, Stockport and Tameside.

Social Work Placements (15 hours per week)
Working with Salford and Manchester Metropolitan Universities, we will support 2 x annual Social Work Placements, offering Non-Instructed Advocacy and additional RPR support.

IMCA Helpline (Monday to Friday, 9-5pm, 8pm on Thursdays)
This national resource, provided by qualified advocates, will allocate email, telephone and fax referrals, inputting them onto MAAVIS, and notifying advocates via email. Helpline advocates receive locality training and local IMCAs will be available to referrers via mobile phones.

The helpline answers more enquiries than a standalone referrals administrator and provides value for money by sharing the cost across participating services. Oldham, Stockport and Tameside IMCA service successfully adopted the helpline in September 2014.

Sessional Advocates (up to 7.5 hours/week)

Sessional advocates, available from Day 1 of the contract, allow us to assess demand during the first 6 months and meet fluctuating demand thereafter. They receive full induction, supervision and casework supervision. 3 sessional, qualified IMCAs work flexibly to meet demand regionally and we are training 4 local IMHAs to complete the IMCA qualification.

Supervision and Management
MAAVIS is our bespoke, cloud-based casework management system, accessed from any location with WiFi. Advocates have smart phones and laptops, reducing the need to be office based, and supporting **peripatetic working**. Advocates attend their first appointment from home and have allocated geographical areas to maximise casework time, minimise travel time and develop local relationships.

Our Managing Advocate will make weekly checks of MAAVIS casework activity and average casework times to **benchmark performance**, inform Practice Audits and manage demand.

Staff agree written objectives with their line manager, informing supervision, **appraisal** and **personal development plans**. Line Management Supervision is 6 weekly, focussing on performance, case reviews, specific issues and goals for the coming period.

Casework Supervision is a 6 weekly opportunity for peers (usually by discipline, such as IMCA, IMHA, Forensic, etc) to share cases, seek advice, review practice and case law and support colleagues.

Practice Audits are conducted quarterly, as a minimum, but more often during **6 month probation**, or where there are performance issues. They include observed casework, a review of casenotes and MAAVIS reporting accuracy.

VoiceAbility ensures communication/accountability through a **structured meetings timetable**, including: **Monthly IMCA team meetings**; Regional Manager-; Heads and Regional Director-; Executive Management Team-; and Board Meetings.

Recruitment
Fair and open TUPE consultation processes will facilitate smooth transfer of staff from Advocacy Experience to VoiceAbility, with dedicated HR resource and access to an Employee Assistance Programme. When recruiting new staff, we do so based on candidates' ability to meet Person Specifications, their performance at two interviews co-assessed wherever possible by people who have used our services.
We seek enhanced Disclosure and Barring Service Checks and two written references for new and transferring staff. We ask candidates to declare convictions that would otherwise be spent, and request DBS checks again every three years.