Equality Impact Assessment (EIA)

This document demonstrates how the council is meeting its duties under the Equality Act 2010, by giving due regard to the requirement to: eliminate discrimination; advance equality of opportunity; and promote good relations.

1. Background

Directorate	Integrated Commissioning
Service area	Adult Social Care – Independent Statutory Advocacy, Autism and Mental Health Children and Young People's Advocacy – Children & Families Hub
Title of the activity being assessed i.e., the strategy, plan, policy, or service	Procurement of independent adult social care advocacy and children and young people's advocacy in Gloucestershire
Brief outline of the proposal(s)	Independent advocacy can assist individuals to understand their choices, make decisions and have their voices heard. The National Advocacy Charter defines advocacy as*: "taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice".* The Care Act statutory guidance further defines it as *"supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need"*. Advocacy can take several forms depending on the individual's ability and capacity to instruct an advocate. The objective of this project is to re-commission advocacy services for both Children and Young People and Adults in Gloucestershire to meet both statutory obligations and afford individuals their rights. The aims are to: • provide advocacy services that ensure compliance with the statutory requirements • secure future funding for advocacy services • ensure service continuity

	• re-commission services that fit with the commissioning of information and advice services • commission services that fit with the wish to promote independence and active communities.
Who is affected by the proposals?	Service users [x] Workforce [x] Other, please specify: Referrers & Carers
Decision to be taken and decision maker	**Adults** - Cllr Carole Allaway-Martin & Cllr Kathy Williams **Children** – Cllr Stephen Davies
Person(s) responsible for completing this assessment	Bernadette Cuddy & Nina Verle
Date of this assessment	06.10.2021

2. Information Gathering

Briefly outline your approach to consultation and engagement, together with details of any other information and data sources you have utilised:

Research, Consultation and Engagement	
Service users	**Adults Research and Engagement.** Our current provider submits data on their clients as part of ongoing contract monitoring which is reviewed on a regular basis to enable us to identify where there are gaps in service provision and where action needs to be taken. There has also been consultation and engagement in the form of a survey and online discussions with staff that refer into the services to gain their feedback. Survey sent to all referrers, carers and recipients of advocacy services and discussions held with the following: - • Carers Hub • Gloucestershire Deaf Association • Adult Social Care (ASC) 37 responses received: 18 of these from individuals working within Adult Social Care. 26 of respondents were referrers into the

	service Feedback from ASC - there needs to be more focus on the referral process regularly. This was also the case with Age UK, and the Deaf Society, as they felt that staff turnover meant that new hires didn't fully understand their obligations to provide information on advocacy services. Co-production of advocacy in Black Asian and Ethnic Minority groups will be a key focus for our provider going forward to address feedback in our survey that indicated that we need to develop cultural competency in our advocacy services. We are currently developing a role with our current provider - an appointed Equality and Inclusion Officer who will work in all our communities and with our partners and charities to develop a greater understanding of individual's rights to an advocate and for their needs to be met. This will be done in a co-produced way and volunteers will be developed and educated to perform as culturally competent advocates, or advocates that are experts by experience. Some quotes directly from our survey mention: - Q: 'How easy was it to make a referral to Advocacy services for either yourself, someone you care for/support or a client/member? Please tell about any difficulties you may have encountered? *'The lack of cultural knowledge in assessing the need of the Advocate I was advocating for'.* Q: 'Were your individual needs or the needs of another you referred or supported met?' *'Better knowledge of cultural needs and assessment.'* *'Better cultural Assessment of vulnerable people at risk with mental Health'* Q: 'Did the person providing advocacy support/advice explain the services and support provided in a way that was easy to understand? If you answered 'no' to the above question, please explain further' *I am a deaf British Sign Language user and your website, and services I can't access.'* Q: 'In your opinion, are there gaps in the services we offer for advocacy?' *'Because Autistic people need social translation, they need advocates often for example in the diagnostic process they don't see the point of the questions, so they mask'*.

	Q: 'Have you had any challenges referring anyone from specific groups? If you answered, 'yes' to the above question, that you have faced challenges, what were they?' *'An issue is that advocacy for people in hospital seems to end the second they are discharged, a period of following up would be helpful, particularly relating to concerns around care'.* A hospital discharge pilot is also underway and will be extended. Report from survey below. For respondent comments – see Appendix 1  1_Statutory_Adults_ Advocacy_Services S
Workforce	We have consulted with professionals who refer clients into the advocacy services via an online survey and face to face. Engagement was undertaken with the Gloucestershire County Council's Adult Social Care Team through on-line meetings. The key messages from the team indicated that further training and development sessions are required as part of the development of the service to ensure all staff are fully aware of their statutory obligations around offering advocacy.
Partners	We have consulted with a number of providers of advocacy services around the country plus the providers currently providing advocacy services for GCC regarding the client data collection. We have also discussed different commissioning options with other local authorities. Survey sent to GHC and other partner organisations
Other	There are ongoing contract monitoring meetings with the service providers, to develop the service now and to feed into the re-commissioning process. Provider Market Engagement Event - 22 September 21 We appeared on Gloucester FM Radio on the 11th of October 2021, to discuss the recommissioning of the contract and held a question-and-answer session live on air.

Research, Consultation and Engagement	
Service users	**Children's and Young People's Advocacy Service.** A clear distinction needs to be made between both the adults service and the children's service. Children's Advocacy is very much a small niche service, commissioned for the purpose of supporting children in care. Therefore, extensive research across multi-agency and our partners does not apply. Our Social Worker team are our key referral point. **Children's and Young People's Engagement.** Regular engagement is embedded in the Children's and Young People's Service. We adhere to the Commission Cycle, 'review, plan do' of the services that we Commission for Advocacy and Engagement is part of this cycle. This information informs how we move forward and support outcomes for Children and Young People who engage with and benefit from Independent Statutory Advocacy. Children's and Young People's Independent Statutory Advocacy is only available to looked after children (Children in Care) and Care leavers- this is a very small cohort of children. Therefore, it differs greatly in scope and size in comparison to the Adults Service- which targets all age cohorts and individuals who may be incapacitate or have special characteristic that requires support to have their voice heard. Therefore, the approach to engagement has been adapted to our cohort of children. Safeguarding and how we engage with children differs also. Due to the size, age, and cohort of children that we support, a decision was made by senior management that engagement should rely on our tried and tested methods that we use to understand the voice of our most vulnerable children. The structure of our engagement is as follows: • Young Ambassadors • Direct and ongoing 1-1 engagement with Children's Social Workers who refer children to our incumbent provider

	• Engagement with Advocates. • Case study review. • Quarterly review and meetings with our incumbent provider. **Engagement and Review of Case Studies with Advocates.** We believe the best way to capture the voices of children and young people is to work closely with the advocates who are supporting our most vulnerable children and care leavers- their expertise helps to amplify their voice in a way that enables the child to feel secure and supported to have their voices and wishes and feelings heard. Engagement is embedded within the regular review of Children's and Young People's Advocacy Service. We have identified that children are satisfied with the service we currently provide. Budgetary constraints do not enable transformation at present; however, we do review needs regularly and any changes in the future will be informed by demand and any legislative changes. We do place an emphasis on gathering feedback and reviewing this each quarter. The value of advocacy is that it is intrinsically led by the wishes and views of children and young people- which is at the heart of Children's Services. The online survey the Children's Advocacy Service provide, has been rigorously and independently evaluated by our own Young Ambassadors. We have Case studies capturing stories of young people who have used the service and the outcomes. In the last Quarter 62 young people have received Advocacy in total 319 Young people have had the support of an advocate. **Sample Feedback** • The feedback from Children and Young people is positive and reflects that 'They feel listened to.' • Young people have said they feel. 'Having an involvement of an advocate, has helped to have their views listened to' • the direct result we heard from they are that it has had 'a positive effect on their emotional wellbeing.'

	Areas to Improve. For those children and young people who feel that their outcomes have deteriorated further, this is usually due to a child or a young person being unhappy at the outcome of their Child Protection meeting, rather than a reflection on the work achieved with their advocate. Therefore, we will work together to ensure that children understand the decisions that are made in their best interests and seek to continue to build strong relationships with our Advocates and Children's Social Care Practitioners who are involved in the decision-making processes. Regular meetings will occur to look at outcomes for children in care and care leavers and their feedback. We will ensure that we have regular meetings with both Advocates and Decision Makers, to review how to support and enable children to understand the decision-making process, and how better we can communicate and work together to ensure that children feel. • that we understand their voice and can demonstrate how their voice has been heard. • their wishes and feelings have been considered in the process, and, • the plan in place is there to ensure their best interests are met. Our incumbent provider submits data for our children and young people on a quarterly basis, this supports the work we do with ongoing contract monitoring. This regular review enables us to identify where there are gaps in service provision and where action needs to be taken. There has also been consultation and engagement in the form of a survey which has been issued by our current provider and reviewed independently by Young Ambassadors in Gloucestershire. The survey was sent to Children and Young People who are recipients of the service.
Workforce	In Children's and Young People's Service, we meet regularly with social workers who make referrals for looked after children (children in care) to identify what areas are of most concern. The

	key concern was that the referral process needed to improve, and a pilot is now in place with the provider to ensure greater speed, accuracy, and acknowledgement that the referral has been made, and has been acknowledged with the provider and an advocate allocated.
Partners	As Advocacy for Children and Young People in care is a 'niche area' in comparison to adult's services which spans wide and far across the County. Referrals will go to the provider and via Adult Social Care and their many partners across county. How we differ is that we have one referral point- our Social Workers make these referrals to our Advocacy Provider. We have reviewed the survey completed by our current provider independently with Young Ambassadors who have approached the review of the survey in a robust manner. In addition, we sought information from Young Ambassadors to identify if they as individuals had accessed Advocacy, and as experts by experience none of the members of Young Ambassadors had done so.
Other	Engagement is embedded in our practice with social workers and via the ongoing contract monitoring meetings with the service providers. We listen to the voice of the child from our feedback and case studies to understand their wishes, feelings and ascertain if Advocacy helps to amplify their voice. We look at ways to improve and develop the service on a regular basis via quarterly review and discussions with social workers and this model of continuous improvement forms the basis for future service specification modelling.

3. Equality Assessment

Briefly explain your assessment of the **impact of the proposed activity** on the protected characteristics below. This section evidence how the council is giving due regard to the three aims of the general equality duty, which are to: eliminate discrimination; advance equality of opportunity; and promote good relations.

Protected Characteristic	Service Users	Workforce
Age	Adults with serious mental ill-health, substantial difficulties	

	in engaging in discussions about their needs or lack capacity will be able to benefit from advocacy services who will work to have their voices heard. All the services in scope are intended to empower the individuals and ensure that their voice is heard. The ageing population and increasing isolation may place extra demands on the advocacy services, as individuals may not have appropriate individuals in their lives to help them express their views. We plan to review the referral patterns to the services. We will use contract monitoring with providers to understand the reasons for the age profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding, and linking to expected trends. **Children & Young People** Children and young people who are in care, leaving care or in the child protection system will benefit from the support to have their voices heard and participate in decisions that affect their lives. Advocacy support will enable disabled children and young people to have their own voices heard separately from their parents, guardians, or Carers.	
Disability	As above. In relation to disability this will ensure views across all disability	

	groups are captured in a person-centred way and therefore will have a positive impact across disabilities. It will allow for any learning and gaps in provision to be identified and used to ensure development of the current and/or future provision. The engagement exercises carried out with those who represent some of community with disabilities indicate that there are barriers to easily accessing the service. Therefore, we intend to work closely with our current provider to support the development of a new role- Equality and Inclusion Community Development Office whose duties are not limited to; • Developing an engagement strategy in Gloucestershire to ensure we are reaching all our resident representative groups, and those with protected characteristics. • This new role (funded outside of the current contract for a term of 1 year) will seek to develop relationships with organisations that represent individuals from both Black Asian and Ethnic Minority Groups, and people with protected characteristics. The purpose is to further improve digital and	

	human resources to meet individual needs. • When strong links have been established with organisations and the voluntary sector in County, our aim is to develop volunteers with lived experience or those with comparative protected characteristics and from Black, Asian and Ethnic Minority Groups, who will be skilled and accredited advocates. • In addition, the responsibilities of the role will aim to ensure that advocates employed are working in a Culturally competent manner. • Our aim is to raise the profile of Advocacy and help organisations understand the supports that are available for the individuals they represent, and to develop internal staff with greater proficiency in meeting the needs of those with protected characteristics. A workforce that is diverse, with an embedded culture and practice that focuses on meeting the cultural, and individual	

	needs of all our residents. All the services in scope are intended to empower the individual and ensure that their voice is heard, and this applies to disabled people meeting the relevant eligibility criteria. The commissioning will ensure that the contracted providers are experienced in working with disabled people and working with people with communication support needs. We plan to use contract monitoring with providers to understand the reasons for the age profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding. We also plan to hear more from people about their experiences of these services in the future. We continue to follow the Accessible Information Standard introduced in 2016 to make it easier for individuals to get the information they need to inform their decisions. Majority of those accessing advocacy services have either Learning disabilities/difficulty, a long-term illness/condition or mental health issues. As age increases the proportion of respondents reporting a limiting long-term health problem increases and with it the likelihood of	

	needing an advocate. The proportion of residents with long term conditions is significantly higher than the national average, a likely reflection of our older population. **<u>Children</u>** Disabled children will particularly benefit from using advocacy services to have their voice heard	
Sex	All the services in scope are intended to empower the individual and ensure that their voice is heard, and this applies to people of both genders meeting the relevant eligibility criteria. We plan to use contract monitoring with providers to understand the reasons for the profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding. Transgender equality variant identities – we will follow internal guidance and adhere to the equality legislation – Equality Act 2010 and have sought to meet with Prism - the council's internal LGBT+ staff network to enable us to review how we can best support this cohort of individuals.	
Race	All the services in scope are intended to empower the individual and ensure that their voice is heard, and this applies to people who meet the relevant eligibility criteria, regardless of ethnic origin. The future providers will be	

	expected to be accessible to all sections of the community and culturally competent in their engagement with Black Minority and Ethnic groups. We plan to analyse referral patterns and to use contract monitoring with providers to understand the reasons for the profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding. National research undertaken around inequalities provides evidence of a disparity of access and outcomes for Black and Minority Ethnic users of health services[1]. Older people from black and minority ethnic groups continue to receive poorer treatment from health and social care services; they are also often underrepresented among those using services. Barriers to accessing services include lack of information, language difficulties, and differing expectations about how services can help. Advocacy services will help address these disparities by ensuring that engagement and support is provided to meet the needs of those with a protected characteristic to ensure that we enable their voice/opinion to be heard regardless of any physical or mental disability. The profile of individuals	

[1] "Better Health Briefing Paper 9" *Race Equality Foundation (2008)*

	using advocacy services is very dependent on staff referring appropriately. It is important that advocacy services can engage suitable interpreters to work with individuals as this is not an advocate's role.	
Gender reassignment	We believe that currently none of the service providers collect this information from individuals. The future providers will be expected to be accessible to all sections of the community. We plan to use contract monitoring with providers to understand the reasons for the profile of their clients and what actions may be needed as a result, including filling any gaps in knowledge and understanding with the advocates.	
Marriage & civil partnership	People without either a partner/friend or relative who can adequately and appropriately support them are more likely to use advocacy services than people with partners who can take on this role. We plan to analyse referral patterns and use contract monitoring with providers to understand the reasons for the profile of clients and what actions may be needed as a result, including filling any gaps in knowledge and understanding. Individuals who are married or in a civil partnership may be able to benefit from their partner involving them to	

	participate in decisions affecting their lives or speaking on their behalf if the appropriate legal arrangements have been put in place. Individuals without partners and without arrangements in place may need to call on some advocacy services more as a result.	
Pregnancy & maternity	We plan to use contract monitoring with providers to understand the reasons for the PM profile of their clients and what actions may be needed as a result, including filling any gaps in knowledge and understanding. We will expect providers to do more to hear from people about their experiences of these services. It will be particularly important to provide a timely service to pregnant women and those recently giving birth. Women with mental ill-health relating to their pregnancy are likely to benefit too from advocacy services.	
Religion and/or belief	We plan to use contract monitoring with providers to understand the reasons for the profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding. This will include understanding how well advocates are supporting individuals to practise their religion and or beliefs.	

Sexual orientation	We plan to use contract monitoring with providers to understand the reasons for the age profile of their service users and what actions may be needed as a result, including filling any gaps in knowledge and understanding.	

4. **Completed Actions & Proposed Actions.**

Set out how the proposed activity has already been amended following the equality assessment, to maximise the positive impact or minimise the negative impact:

Change	Reason for Change
More robust data gathering for protected characteristics, for staff commitment to encourage clients to populate it. POhWER- our current provider, have been asked to explain to each client the benefit to themselves and others of completing the necessary segments when working with individuals.	Without this information it prohibits us from understanding the profile and associated needs of the clients accessing our advocacy services. Further contracting arrangements will also include the necessity to have a greater understanding of our residents and their protected characteristics to meet current and future needs of all our residents.
Cultural Competency – training staff to be able to engage in a manner appropriate to the needs of individuals from ethnic minority communities and those with protected characteristics.	From a recent report from Noor Al-Koky and David Pugh it identified a gap in culturally competency and on us as a Local Authority to raise awareness and understanding of Black and Minority Ethnic Groups right to advocacy. Key findings from the Report. 2.5.4 Culturally appropriate advocacy was another recommendation proposed by the review which it suggested could help increase engagement with services among ethnic minority groups. It found generic advocacy was ‘poor at proactively engaging ethnic minority’ individuals. 13 Implications of the Wessely Report on the use of the MHA in

	Gloucestershire, D Pugh, P Southam, September 2019 14 Reply to open letter by 166 members of the Royal College of Psychiatrists published in the Guardian on 14 July 2020 3.12 The Wessely report has a section on 'Culturally-appropriate advocacy' pointing out that a lack of cultural understanding can make poorer outcomes worse for patients from ethnic minority communities, and potentially reinforce barriers to earlier engagement with services. They further point out that advocates are well placed to help patients voice their individual needs and can be crucial to establishing a better foundation for appropriate care and treatment – 'The provisions of culturally-appropriate advocacy are key to reducing additional stresses and anxieties that could exacerbate a patient's mental condition'. 6.7 Review quality of culturally appropriate advocacy, with a view to engage in a national pilot Gloucestershire's Mental Health Services | Have Your Say Gloucestershire (engagementhq.com)
Workforce - Communication and Training Strategy. Outcome Manager to meet with POhWER to develop this further.	If we educate individuals from each community and have volunteers and professional advocates that understand and represent them, we believe that people will feel understood, their individual needs met, and we will achieve better outcomes.
Partners – as above.	
Other – a greater need to engage with charities, the voluntary sector across Black and Minority Ethnic communities within Gloucestershire. The purpose of this is to co-produce and develop a talent pipeline and representation within all our communities of volunteers that	

represent and understand the diverse needs of our residents and clients of advocacy. In addition, we are currently developing a role of an Equality and Inclusion Community Development Worker who will develop a strategy and plan to further our aims and ambitions of developing cultural competency and a greater understanding of the needs of our clients and residents who have protected characteristics. We are currently engaging with cultural competency experts to pilot cultural competency training and advocacy has been selected to spearhead how we move forward in a more inclusive way.	
Protected Characteristics - there is a plan to extend to cover Menopause and Carers by those who are Lobbying for those changes.	Flexibility to provide support to those who are experiences challenging life changes and for Carer's is currently in place and will be reviewed when we see these changes implemented.
Review of data once Findings of latest Census published in 2022	In April we will review and act appropriately. We do believe that we are now putting in place the necessary changes in a proactive manner.

1. Planned Actions

Set out improvements that will be undertaken, following the equality assessment, to further maximise the positive impact or minimise the negative impact:

Potential impact (positive or negative)	Action	By when	Owner
Positive	Ensure consultation findings and consideration of impact of people with protected characteristics informs the service specification	Service specification to be complete by the beginning of January 2022	Contract Managers and Project Team
Positive	Ensure due regard is given by the appointed providers to equalities implications that	Intended timescale for tendering	Contract Managers

	relate to the service workforce, either from the service specifications or TUPE requirements	and award process – January – September 2022	and Project Team
Positive	Investigate referral patterns to the individual services Ensuring all clear who can access service	Ongoing	Contract Managers and Project Team
Positive	Monitor protected characteristics through the contract management arrangements, taking proportionate steps to improve the collection of data relating to those protected characteristics where there is a data gap. Addressing no. of instances where response 'prefer not to say'. Need to review data collection process and ensure clients understand why we ask for this information and how their data will be used.	From October 2022 – through the term of the contracts.	Contract Managers and Project Team
Positive	Ensure consultation findings and consideration of impact of people with protected characteristics informs the service specification	Service specification to be complete by the beginning of January 2022	Contract Managers and Project Team

2. Monitoring and review

The following processes/actions will be put in place to keep this 'activity' under review:
Progress will be reported to the sponsors using the corporate project management system. The quality of provision will continue to be monitored by Officers, including: -.

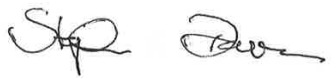
- Ongoing quarterly reporting and monitoring meetings will take place to review who is using the service in terms of protected characteristics and where there are gaps which need addressing.
- Bernadette Cuddy is engaging with current provider who have completed a scoping exercise on how we can engage communities.
- Review of data collection processes are being reviewed with the current provider. Ongoing equality monitoring will be a requirement of the new contract and engagement/review of engagement.

3. Officer / Decision-maker Sign off

Officer: By signing this statement off as complete you are confirming that 'you' have examined sufficient information across all the protected characteristics and used that information to show due regard to the three aims of the general duty. This has informed the development of the activity

Signature of Senior Officer	
Name of Senior Officer	Sarah Scott
Date	9.2.22

Decision maker: I agree that sufficient information and analysis has been used to inform the development of this 'activity' and that any proposed improvement actions are appropriate, and I confirm that I, as the decision maker, have been able to show due regard to the needs set out in section 149 of the Equality Act 2010.

Signature of decision maker	
Name of decision maker	Cllr Stephen Davies
Date	9.2.22

Signature of decision maker	

Name of decision maker	Cllr Carole Allaway-Martin
Date	9.2.22

Signature of decision maker	
Name of decision maker	Cllr Kathy Williams
Date	9.2.22

4. Publication

If this document accompanies a Cabinet report or an Individual Cabinet Member (ICM) decision report it will be published, as part of the report publication process, on the GCC website. If this statement is not to be submitted with a Cabinet report or an Individual Cabinet Member (ICM) decision report, please maintain a copy for your own records that can be retrieved for internal review and in case of future challenge.

Appendix 1 – Service User Data

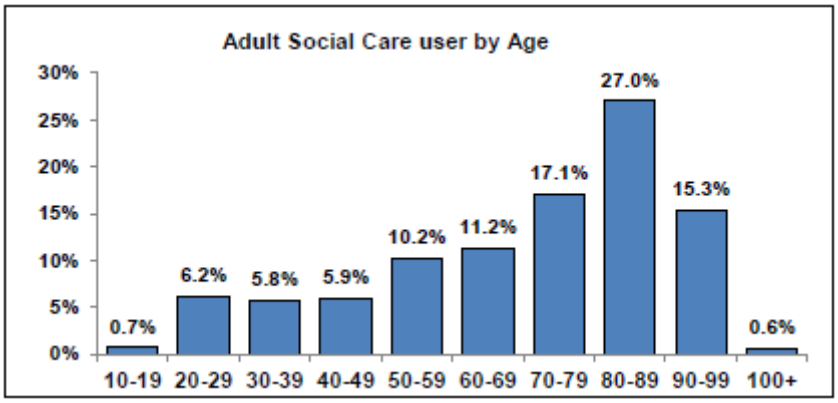
Details of service users affected by the proposed activity

Protected Characteristic	Service User Data and Information
Age *percentage/profile of service user ages*	Gloucestershire's aging population will have an impact on the number of people requiring advocacy services and this has been considered in the re-commissioning of relevant services. The proportion of people aged 65+ exceeds the national average and is expected to rise to 20% by 2021. In 2020 mid-year estimate the resident population of Gloucestershire was estimated to be 611,332 people of this: • 20.2% are aged 0-17 • 58.0% are aged 18-64 • 21.8% are aged 65 and over There is considerable variation at district level:

	• At 22.2% Gloucester has the highest representation of children and young people and exceeds the county and is just over the national average. • At 60.7% Gloucester also has the highest proportion of people aged 18-64, exceeding the county and national average. • All districts in the county except for Gloucester have a higher proportion of people aged 65+ when compared to the county and national average. At 26.2% Cotswold has the largest proportion of people aged 65 and over. [2]- need reference All population figures are taken from the following sources: • Age and Sex: https://www.gloucestershire.gov.uk/inform/population/population-figures/county-and-district-data/ • Ethnicity: Census 2011 - Ethnic group by sex by age • Long term health problems or disability: Census 2011 – Long term health problems or disability by sex, age, and disability (day to day activities are limited) Key Demographics from 2011 Census • In 2011 50.9% of the Gloucestershire Population were female • In 2011 49.1% of the Gloucestershire Population were male • In 2011 21.6% of the Gloucestershire Population were aged over 65 • In 2011 22.4% of the Gloucestershire Population were aged 19 or under • In 2011 95.6% of the Gloucestershire Population were from a white ethnic group • In 2011 4.4% of the Gloucestershire Population were from BAME ethnic groups • In 2011 16.1% of the Gloucestershire Population were registered as having a long-term health problem or disability The Census is carried out every 10 years and the 2021 Census day was Sunday 21 March 2021 with results expected to be published in 2022. In March 2020 there were 10540 adult social care users: • 58.0% of adult social care users were female. • 65% were over the age of 65 and 51.9% were over the age of 75 • 13.3% were adults with a learning disability • 2.7% were adults with a mental health problem

- 50.5% were 'older people'
- 6.8% were adults with a physical disability

Glos. Diversity Report – ASC (2020-21)



- *The highest age bracket of users was those aged between 80-89 with 27% of users. This was also the highest category in 2019 with 26.5% of users.*
- *The proportion of users aged under 50 has fallen slightly to 18.6% from 20%*

Adults Monitoring Data – Qtr. 4 (2020-21)

Data supplied from the incumbent providers shows that the contracted advocacy services are being accessed by people in all the age bands reported.

Age Range	IHCA	IMHA	RPPR	IMCA DoLS	IMCA	ISCCA	ICAA
0 - 24	4%	8%	0%	4%	3%	0%	6%
25 - 64	74%	70%	31%	33%	35%	80%	46%
65+	22%	21%	68%	63%	64%	20%	48%
Prefer not to say	5%	5%	0%	0%	0%	0%	0%

Children

Historically, Local Authority (LA) responsibilities for tracking extended from ages 15 to 19, and to 20-25-year-olds with a statement of educational need or disability (SEND). However, LAs are now only required to track and submit information about young people up to the end of the academic year in which they have their 18th birthday i.e., academic age 16 and 17-year-olds.

Gloucestershire has a lower proportion of 0-19-year old's and 20-64-year old's when compared to the national average. At 31/01/21 there were 800 children in care and 717 children on child protection plans and 2001 Children in Need. The largest proportion of Children's Social Care users (35.5%) are aged between 10-15. This was an increase of 0.9% points in comparison to March 2020.

[2] Equality and Diversity Interactive Report 2021

Under 11	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	Over 18 years
Q3 7 Q4 11	Q3 8 Q4 15	Q3 6 Q4 4	Q3 8 Q4 6	Q3 5 Q4 9	Q3 9 Q4 10	Q3 8 Q4 10	Q3 5 Q4 7	Q3 6 Q4 1	Q3 1 Q4 2

Disability *percentage/profile of service users who have a disability*

In 2014 there was an estimated 38,231 people aged 18-64 with a severe or moderate physical disability living in Gloucestershire and an additional 22,861 people aged 65+ who are unable to manage at least one mobility activity on their own. In Gloucestershire 18.3% of people aged 50-64 reported a limiting long-term health problem, this increased to 49.0% of respondents for the 65+ age group

Sensory impairments

There are an estimated 63,000 deaf and hard of hearing people in Gloucestershire[3]. Of these, 630 (1%) have a severe- profound hearing impairment and 160 of these (25%) are Deaf Sign users[4].

Estimated prevalence (%) of hearing loss of 25 dBHL or more in the adult population (people aged 18 and over)

	2015	2020	2025	2030	2035
NHS Gloucestershire	23	25	26	28	29
England	21	22	23	24	25

Source: NHS Hearing Loss Data Tool

Visual and hearing impairments[5]

	Gloucestershire			England		
	2018	2019	2020	2018	2019	2020
% Reporting blindness or partial sight	1.6	1.4	1.4	1.6	1.6*	1.5
% Reporting deafness or hearing loss	7.0	6.8	6.9	6.6	6.2*	6.2

Vision and hearing impairments affect people from all sections of society and across all age groups. In 2020 approximately 1.4% of the 16+ population in Gloucestershire reported blindness or partial sight. During the same period 6.9% of the population aged

[3] Hospitals Hearing Services database
[4] Gloucestershire Deaf Association (GDA)
[5] https://fingertips.phe.org.uk/profile/general-practice/data#page/4/gid/2000004/pat/46/par/E39000043/ati/165/are/E38000062/iid/355/age/164/sex/4

16+ reported deafness or hearing loss[6]. As people get older, they become increasingly likely to suffer from hearing and vision impairments; given the ageing population this means the number of people affected by these conditions is likely to increase in the future.

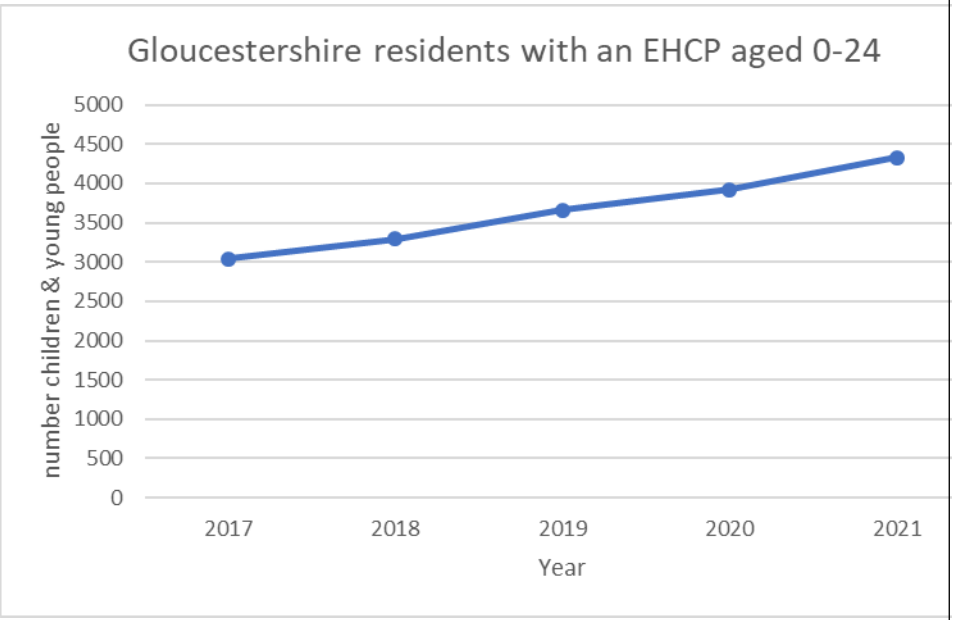
Adults Monitoring Data - Qtr. 4 (2020-21)

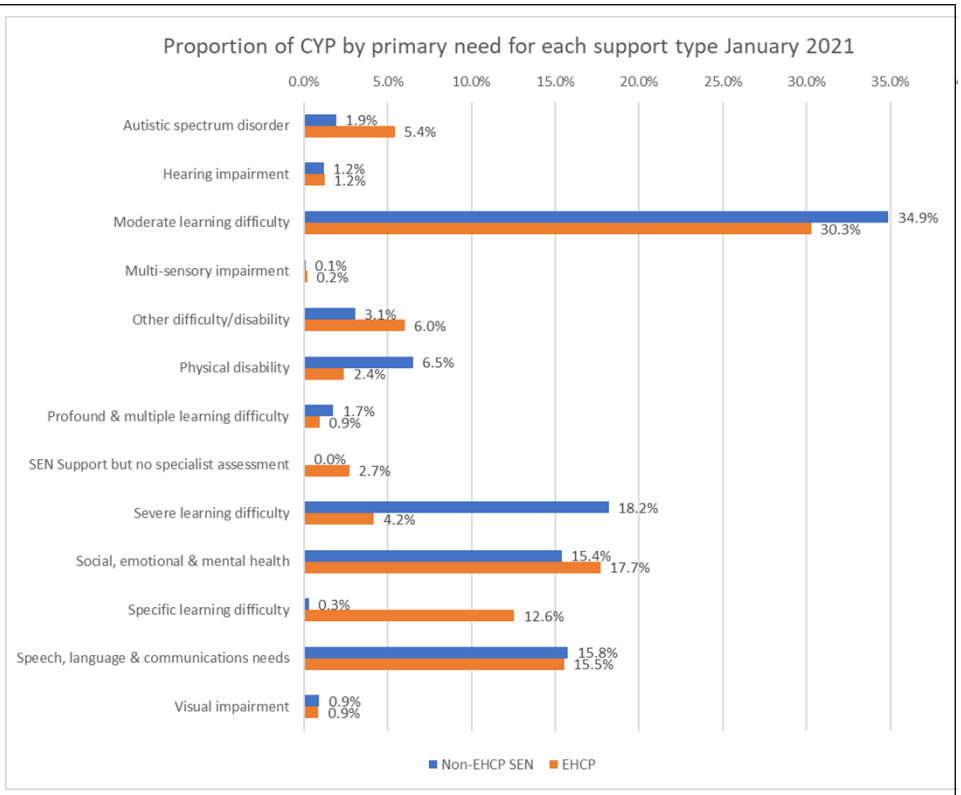
Data supplied by the present service providers shows that the advocacy services are being accessed by people with a range of disabilities. Given the eligibility criteria for the services, the large proportion of people categorised as mental health/dementia and learning disability is expected.

Client Group	Total
Acquired brain injury	2%
Autism/ Asperger's Syndrome	4%
Awaiting additional category	0%
Cancer	1%
Cognitive Impairment	3%
Dual sensory disabilities - deaf and blind	0%
Hearing – Deaf – Severe hearing impairment	0%
Hearing – Hard of hearing	8%
HIV/ Aids	0%
Homeless	0%
Learning disabilities/difficulty	10%
Long term illness/condition	53%
Marriage or Civil Partnership	0%
Mental health	36%
Mental Health - Dementia	9%
Mental Health - Older Peoples'	32%
Physical Disabilities	4%
Pregnancy/Maternity	0%
Returning Citizen Ex Offender	0%
Sensory Impairment - Learning	2%
Stroke	1%
Substance misuse	2%
Substantial Difficulty	7%
Unconscious	0%
Vision – Blind – Severe visual impairment	0%
Vision – Partially sighted	2%

Children and young people

[6] National General Practice Profiles (data from GP Patient Survey), Public Health England, https://fingertips.phe.org.uk/profile/generalpractice/data#page/4/gid/2000004/pat/46/par/E39000043/ati/165/are/E38000062/iid/355/age/164/sex/4 Accessed 25/01/2021

	In the Pupil Wellbeing Survey, 2020 6.2% of children & young people reported a disability. 56.5% of those specified the type of disability - 36.3% of those reported a physical disability and 69.3% reported a learning disability. The number of CYP with an EHCP has been rising steadily in recent years, from around 3,000 in 2017 to almost 4,500 in 2021 and represents 3.6% of the school pupil cohort.  Children and young people can also receive non-EHCP SEN support in schools. In 2021 11,750 children received SEN support (13.1% of pupils). The primary reason for support varies and is child specific.

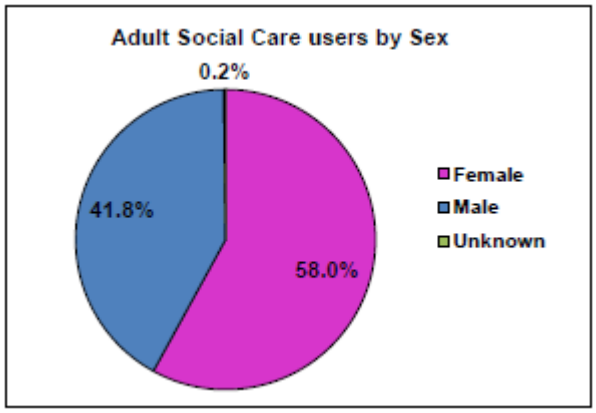


Sex *percentage/profile of service users who are male and who are female*

<u>Population Profile 2020/21</u>[7]

The overall gender split in Gloucestershire is 51% female: 49% male. As age increases the gender difference become more significant where women account for 63.4% of the population aged 85+. Women are also more likely to head lone parent households with dependent children. There is a higher proportion of women accessing and receiving social care services.

Glos. Diversity Report – ASC (2020-21)



58% of the users were female, in comparison to 57.9% for the previous period.

<u>Adults Monitoring Data – Qtr. 4 (2020-21)</u>

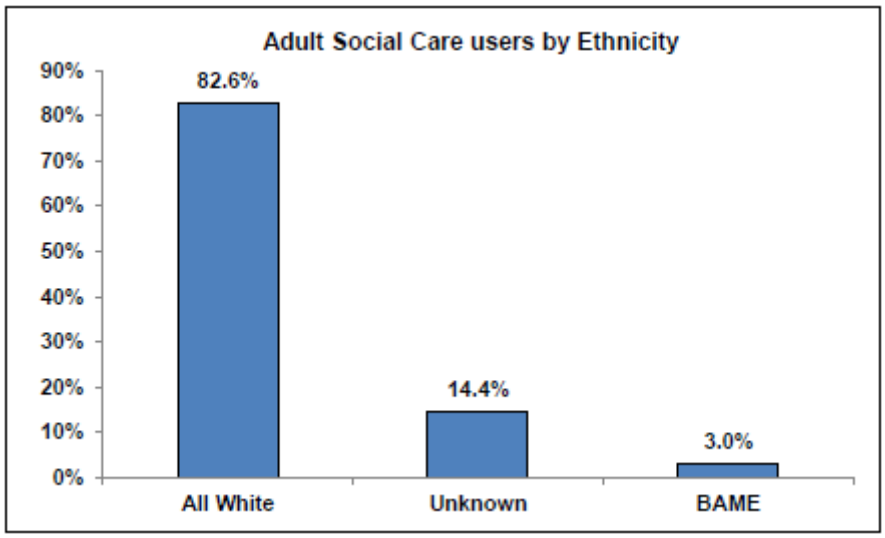
[7] https://www.gloucestershire.gov.uk/media/2105981/equality-profile-2021.pdf

	Data reported by the current providers shows that the advocacy services are being accessed by both men and women but predominantly by women with 52% of all services users registering as female, 47% as male; 2% prefer not to say **Gender** / **IHCA** / **IMHA** / **RPPR** / **IMCA DoLS** / **IMCA** / **ISCCA** / **ICAA** Female / 65% / 52% / 53% / 44% / 54% / 78% / 49% Male / 35% / 48% / 47% / 56% / 46% / 22% / 51% **Children and young people** The council's latest published Service User Diversity Report (2020/21) tells us that 52% of all Children's Social care users are male, this has decreased from 53.4%. This has seen an increase of 2.2% of female users over 12 months. Unborn/Unknown were recorded at 2.4%, up from 2.2% last year. However, the data from the CYP advocacy services show that the general CYP advocacy has a breakdown in the calendar year 2015 of 50.7% female and 49.3% male. There is a different pattern for the gender breakdown of the advocacy service for disabled children and young people. In this case the gender breaks down to 33.3% female and 66.6% male, but the numbers are very low. **Male** / **Female** Q3 21 / Q3 42 Q4 32 / Q4 44
Race *percentage/profile of service users who are from black and minority ethnic backgrounds*	According to the 2011 Census 7.7% of Gloucestershire residents were born outside of the UK. The percentage of Black and Minority Ethnic (BME) population rose from 2.8% to 4.6% (this figure is low compared to the national level of 14.1%) and significantly the 'White Other' population in the county more than doubled between 2001 and 2011, from 9,000 to 19,300, now accounting for 3.2% of the county population. Most of this increase has been linked to inflow from Eastern European countries. GGloucester City and Cheltenham have the largest proportion of BME communities in the county; however, there are also pockets of diverse communities in rural parts of the county. According to the 2011 census around 10,300, (7.6%) of 0-19-year-olds in Gloucestershire were from a Black or Minority Ethnic Group. This is an increase of 3% from 2001 and is more diverse than other age groups in the county. This proportion is still considerably lower than the national average of 21.1%. The number of 0-19-year-olds classed as" white other" which includes migrants from Europe, has also increased from 1,725 (1.3%) in 2001 to 3,600 (2.6%) in 2011. These % may reflect improved disclosure and recording rather than an actual rise. Overall, for Gloucestershire, 98.6% of the 65+ population is White and 1.4% of the 65+ population are from BME groups.

	The latest statistics on the number of overseas nationals registering to work in Gloucestershire show that the number of migrant workers to the county has decreased from 4,400 in 2006/07 to 2,800 in 2013/14. It is difficult to predict future patterns of immigration into the county.[8] Gloucestershire had more deaths than births overall between 2019-20. The main driver of population growth in the county was internal migration as more people moved into the county than moved out. Internal migration increased Gloucestershire's population by 0.51%. There were also more people immigrating to Gloucestershire than emigrating, which increased the population by 0.16%. Gloucestershire's components of change were like the Southwest. In contrast, England had more births than deaths (0.8% natural change) which is opposite to Gloucestershire. Also, whilst most of Gloucestershire's population growth was attributed to internal migration, England's population growth was mostly contributed to by international migration (0.41%) (from inform Gloucestershire Current Population of Gloucestershire mid 2020 https://inform.gloucestershire.gov.uk/media/2108954/mid-2020-population-estimates-final.pdf **Glos. Diversity Report - ASC (2020-21)** • 82.6% of adults receiving community and residential services identify against White British • 3% of adults receiving community and residential services identify against Black and Minority Ethnic populations • 14.4% of service users' ethnicity has not yet been obtained [9].

[8] JSNA, "Understanding Gloucestershire" - A Joint Strategic Needs Assessment (JSNA) - Inform

[9] Service User Diversity Report 2020/21



Adults Monitoring Data - Qtr. 4 (2020-21)

Data supplied by current providers of advocacy services for adults show that most service users are white British, with several other ethnic groups also being represented. A significant number 'prefer not to say'.

Ethnicity	IHCA	IMHA	RPPR	IMCA DoLS	IMCA	ISCCA	ICAA
White	70%	73%	75%	67%	68%	50%	72%
Of ethnic origin	5%	8%	7%	12%	13%	0%	13%
Prefer not to say	26%	20%	19%	24%	22%	50%	18%

Children and young people

The council's latest published Service User Diversity Report (2020/21) states that that there has seen increases in the number of children accessing services across all ethnic groups, with proportion of children from Black and Minority groups increasing from 9.6% to 14.6%.

The number of white children accessing services has also increased by 5.2% over the same period

	White British	White other	Asian	Black African	Black Caribbean	Mixed ethnicity	Other
Q4	64	3	0	1	1	2	0
Q3	53	2	3	1	1	3	0
Q2	66	2	3	2	1	16	1

Q1	77	4	2	2	1	6	2

80.4% of pupils in maintained Gloucestershire schools were recorded as being white British in the January 2021 Census a further 17.6% were from Black, Asian and minority ethnic groups and 2% did not have their ethnicity recorded. The percentage of pupils from BAME groups was highest in Gloucester district (30.6%) followed by Cheltenham district (21.3%). In Gloucester district a quarter of pupils were from Mixed ethnicity (8.8%); White other (8.2%) or Asian (8.1%) groups. In Cheltenham these ethnic groups represented around a fifth of pupils; White other (9.7%), Mixed ethnicity (5.6%) and Asian (4.1%).

20.8% of pupils who lived out of the county but attended Gloucestershire maintained schools were of BAME ethnicities, the largest BAME group represented being pupils of Asian ethnicity.

Ethnicity of Pupils on roll in Gloucestershire maintained schools - January 2021 Census								
	Cheltenham	Cotswold	Forest of Dean	Gloucester	Stroud	Tewkesbury	OOC	Total PC
White British	76.5%	87.2%	90.1%	67.5%	87.6%	84.5%	76.8%	80.
White other	9.7%	4.8%	4.2%	8.2%	4.3%	6.4%	3.3%	6.
Asian	4.1%	1.1%	1.7%	8.1%	0.8%	2.2%	9.7%	3.
Black African	0.7%	0.3%	0.2%	2.6%	0.3%	0.6%	2.3%	1.
Black Caribbean	0.1%	0.0%	0.0%	1.2%	0.1%	0.1%	0.0%	0.
Mixed ethnicity	5.6%	3.5%	2.2%	8.8%	4.0%	3.6%	4.3%	5.
Other	1.2%	0.6%	0.5%	1.6%	0.5%	0.7%	1.1%	0.
Refused/not obta	2.2%	2.3%	1.2%	1.9%	2.3%	1.8%	2.4%	2.
BAME	**21.3%**	**10.4%**	**8.7%**	**30.6%**	**10.0%**	**13.6%**	**20.8%**	**17.**

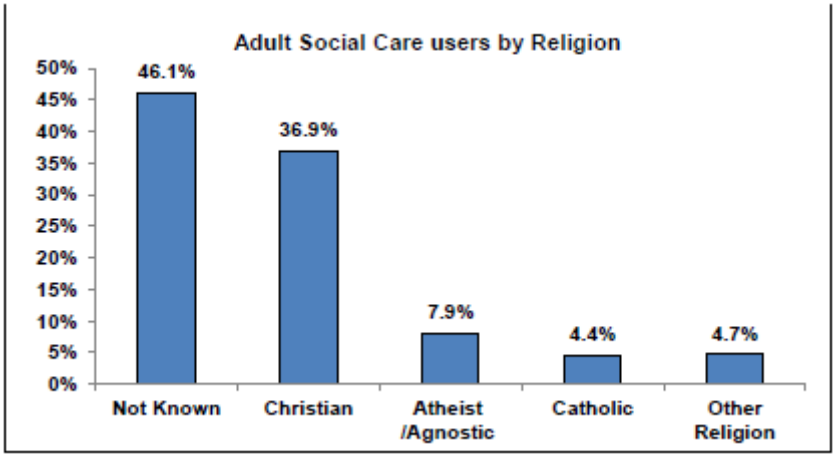
In our CiC cohort children from some BAME groups are over represented compared to the pupil population. This is particularly evident in the Black Caribbean and Mixed ethnicity communities.

Gender reassignment *percentage/profile of service users who have indicated they are transgender*	There are no official estimates of gender reassignment at either national or local level. In the next Census (2021) there will be a new question around gender, asking "is your gender the same as the sex you were registered at birth?" It is directed only at people aged 16 and over, and answers will be voluntary. A separate, individual form can also be requested and submitted by any household member, should confidentiality be a concern. It is hoped that more accurate data around gender will help equality monitoring in the future[10]. Currently the best estimates on gender reassignment come from the Gender Identity Research and Education Society (GIRES). GIRES estimates that there are approximately 650,000, 1% of the

10 https://www.ons.gov.uk/census/censustransformationprogramme/questiondevelopment/genderidentity/guidanceforquestionsonsexgenderidentityandsexualorientationforthe2019censusrehearsalforthe2021census#guidance-for-the-sexual-orientation-question-for-the-2019-rehearsal

	population in the UK, who are experiencing some degree of gender diversity. By applying the same proportion to Gloucestershire's 16+ population, we can estimate that there may be approximately 5,220 adults in the county who are experiencing some degree of gender diversity. Numbers of people identifying as transgender across the country appear to be increasing. According to the LGBT Foundation, "an increasing number of trans people are accessing Gender Identity Clinics; it is unclear if this represents an increase in the trans population or an increasing proportion of the trans population accessing Gender Identity Services"[11]. **Glos. Diversity Report – ASC 2020-21** Unknowns and Transgender account for less than 0.2% of the users **Children and Young People** 0.6% of young people reported identifying as transgender in the Pupil Wellbeing Survey 2020, this is in line with previous surveys.
Marriage & civil partnership *percentage/profile of service users who are married or in a civil partnership*	Among residents of Gloucestershire: • 30.5% are single and have never married or registered a same-sex civil partnership • 50.2% are married. • 0.3% are in a registered same-sex civil partnership • 2.3% are separated but still legally married or still legally in a same sex civil partnership • 9.5% are divorced or formerly in a same sex civil partnership which is now legally dissolved • 7.2% are widowed or a surviving partner from a same sex civil partnership (**Source:** Census 2011) Gloucestershire has a lower proportion of people who are single or separated when compared to the national figure. In contrast the proportion of people who are married, divorced, or widowed exceeds the national figures.
Pregnancy & maternity *percentage/profile of service users who are female and who are pregnant or*	There were 6,124 live births in Gloucestershire in 2019. The highest proportion of deliveries were to women aged 30 to 34 continuing the trend of later motherhood. Births to mothers in all age bands between the ages of 25 and 44 account for a slightly higher proportion of total births in Gloucestershire than they do nationally, whilst those to mothers aged under 25 account for a lower proportion.

[11] LGBT Foundation (2017), Transforming Outcomes: A Review of the Needs and Assets of the Trans Community http://lgbt.foundation/transformingoutcomes Accessed 12/02/2021

on a maternity leave	In the year 2019/20 0.5% of all deliveries were for young women aged under 18 and 1.8% for those aged 18 or 19 years. In 2020/21 this has remained stable with 0.4% and 1.8% delivering aged under 18 and aged 18 or 19 respectively. However, deliveries by women known to Social Care has increased during the pandemic rising from 1.2% to 2.1% of all deliveries. Many women have good mental health during pregnancy. Some women may already have a mental illness when they get pregnant. Others worry about mental health problems they have had in the past. They fear of getting ill again during pregnancy or after childbirth. Some women have mental health problems for the first time in pregnancy. Unfortunately, pregnancy does not stop people from having mental health problems. Women who stop medication when they get pregnant have a high risk of getting ill again (e.g. 7 out of every 10 women who stop antidepressants in early pregnancy become unwell again).
Religion and/or belief *percentage/profile of service users' religious beliefs*	Nationally Christianity is the largest religion, with 33.2 million people (59.3 per cent of the population). The second largest religious group were Muslims with 2.7 million people (4.8 per cent of the population), (**Source**: Census 2011). Gloucestershire has many diverse faith groups including a large number of Christian churches catering for those from different religious backgrounds. In addition, both Gloucester and Cheltenham have significant populations from the Muslim and Hindu community. In Gloucestershire 63.5% of residents are Christian, making it the most common religion. This is followed by no religion which accounts for 26.7% of the total population, (**Source**: Census 2011) **Glos. Diversity Report – ASC (2020-21)**  • *Christian was the highest religious group with 36.9% of users followed by Catholic at 4.4%.*

<table>
<tr><td></td><td>

- *Other religious groups accounted for 4.7% of users in 2020. However, the true number might be greater as nearly half (46.1%) of users did not record a religion*

Adults Monitoring Data - Qtr. 4 (2020-21)
Almost ¾ of clients recorded as 'Prefer not to say'; Christian/Catholic – 14%; 3% 'other' and 8% as having 'no religion'.

<table>
<tr><th>Religion</th><th>Total</th></tr>
<tr><td>Prefer not to say</td><td>76%</td></tr>
<tr><td>Christian/ Catholic</td><td>14%</td></tr>
<tr><td>No religion</td><td>8%</td></tr>
<tr><td>Another incl. Muslim/Jewish/Buddhist Hindu/Sikh)</td><td>3%</td></tr>
</table>

Children
We haven't asked this in Pupil Wellbeing Survey since 2012, and it is not collected as part of the School Census
</td></tr>
<tr><td>Sexual orientation percentage/profile of service users who are lesbian, gay, bisexual, heterosexual</td><td>

There is no definitive data on sexual orientation at a local or national level. In the next Census (2021) there will be a new question around sexual orientation, asking "which of the following best describes your sexual orientation?", and providing a list of options. It is directed only at people aged 16 and over, and answers will be voluntary.

Estimates on sexual orientation used by the Department of Trade and Industry in 2003, and quoted by Stonewall, suggest around 5-7% of the population aged 16 and over are lesbian, gay, or bisexual[12]. If this figure were applied to Gloucestershire, it would mean somewhere between 26,100 and 36,500 people in the county are LGB. A more recent estimate from the 2018 ONS Annual Population Survey (APS) suggests that 2.3% of the England population aged 16 and over is LGB[13]: if this figure were applied to Gloucestershire, it would mean that there are approximately 12,000 LGB people in the county.

Adults Monitoring Data – Qtr. 4 (2020-21)
30% of clients identifying as 'heterosexual'; almost 70% as 'prefer not to say'; 1% as other. IMHA/IMCA DoLS & Care Act where majority 'prefer not to say'.
</td></tr>
</table>

[12] Department of Trade and Industry (2003), Final Regulatory Impact Assessment: Civil Partnership Act 2004, http://webarchive.nationalarchives.gov.uk/+/http:/www.berr.gov.uk/files/file23829.pdf Accessed 08/02/2021
[13] ONS (2018), Sexual Orientation, UK:2018 https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018 Accessed 08/02/2021

Sexuality	IHCA	IMHA	RPPR	IMCA DoLS	IMCA	ISCCA	ICAA
Heterosexual	49%	23%	48%	31%	45%	50%	31%
Prefer not to say	50%	76%	52%	69%	55%	50%	69%
Other	1%	1%	0%	0%	0%	0%	0%

Children

The Pupil Wellbeing Survey (formerly Online Pupil Survey) shows the proportion of young people reporting non-heterosexual sexual orientation has been increasing over the previous 5 years.

OPS/PWS Secondary and FE young people			
Sexual/gender identity	***2016***	***2018***	***2020***
Heterosexual	72.0%	70.0%	77.9%
Lesbian/Gay	1.3%	1.5%	2.0%
Bisexual	3.9%	4.9%	5.8%
Don't know/figuring it out	7.8%	7.4%	7.4%
Asexual	1.8%	1.5%	1.4%
Transgender	0.5%	0.5%	0.6%
Refused	12.7%	14.2%	4.9%
LGBT	*5.7%*	*6.8%*	*8.5%*

Appendix 2 – GCC Workforce Data

Details of Gloucestershire County Council staff affected by the proposed activity

Protected Characteristic	Total number of GCC staff affected:
Age	None affected
Disability	
Sex	
Race	

Gender reassignment	
Marriage & civil partnership	
Pregnancy & maternity	
Religion and/or belief	
Sexual orientation	

COMMENTS - ADVOCACY SURVEY 2021

How easy was it to make a referral to Advocacy services for either yourself, someone you care for/support or a client/member?
Please tell about any difficulties you may have encountered?
None
I can't comment on any of the above - the main issue is the number of families and Autistic people who say they need advocates who understand but don't fall under the statutory criteria
Lack of responsibility but get an answer with threatened measure
Not the difficulty in getting to the service, us the lack of cultural knowledge in assessing the need of the advocate i was advocating for

How long did it take for the service to respond?
Tell us more about the duration and your experience.
Automated answer
The experience was that proper management and assessment was not put in place.
I did threaten the agency to make a public show if my concern was not treated as an emergency. We were very satisfied with the support and advice that we received. This lasted about 6 months until we realised that we were wasting our time in trying to convince the consultant that he had got it wrong and so we gave up because the next step would have been to go to the GMC

Was the response or contact from the provider within the agreed timeframe?
If you were dissatisfied with the response time, please tell us about your experience.
.it was not a matter of time frame but of proper assessment of a case that was not given priority of mental health.
No, the response was good however the person's need was not totally managed because there were mental health issues

Were your individual needs or the needs of another you referred or supported met on the following:
If not, how could have met your needs better?
Better knowledge of cultural needs and assessment
The ability of the person I advocate for was not assess well due to the mental health of the person. There is a need for better cultural assessment of vulnerable people at risk with mental health
I am deaf BSL user - your website and services I can't access.
pointless exercise- look after your own

Did you feel any of the following, when your voice was heard by the advice/service provided to you?

Please tell us about your experience:
A good responsive service
The allocated person supported us well and arranged interviews with the person about whom we were making the complaint. They also attending that meeting to support us.
Some arrangement was made but I did not think that was proper, so I had to get others to raise my concern and lack of mental need follow-up which was the cause of lack on assessment needs.
If I did not get the attention for the person, I would expose the cause to the public by getting the News media to intervene
As I said above, we felt well supported in taking our complaint forward. The problem was not with the advocacy service but the intransigence of the consultant that we were complaining about.
I am deaf BSL user - your website and services I can't access.
the best patient is the one you don't hear from

Did the person providing advocacy support/advice explain the services and support provided in a way that was easy to understand?
If you answered 'no' to the above question, please explain further:
Explaining the service is different to taking responsibility to the needs in question or as an emergency.
The person I was advocating for was in the mental health system, but from my point of view he did not have the capacity to do the right thing and I feel the assessment was not done with a positive outcome
I am deaf BSL user - your website and services I can't access.
ticking boxes to look good

In your opinion, are there gaps in the services we offer for advocacy?
If you answered 'yes' to the above question please, tell us why?
Just not enough capacity to respond to increase demand
Because Autistic people need social translation. They need advocates often (for example) in the diagnostic process. they don't see the point of the questions, so they mask. This is what Autistic people in Glous tell me.
People are not culturally knowledgeable or take the time out for good assessment or seek to do referral culturally for help
Assessment ought to be for "a person" and every effort should be made to give more positive approach even when it is another culture that maybe in question.
I am deaf BSL user - your website and services I can't access.
Lots of people need advocacy beyond the very specific offer POHWER is commissioned for
Where is the access for Deaf BSL users?
all about ticking boxes and looking like you care to gain brownie points, when you actually don't

To ensure that we provide services that meet your needs now and, in the future, tell us how we can improve?
Build capacity
Where there is difficulty, please seek to find help in the different community

There is a need for cultural interpretation. If that service is not in place, then I would have gone other route with the case.
Not sure really as I don't even know whether I am legible to complete this questionnaire. If that's the case this form has been different to answer.
I click "Likely" if your website and service become more accessible - I am deaf BSL user - your website and services I can't access.
Please provide BSL access and Deaf advocate services
no providers, no care, keep it in house, do what you can do to the best of your ability, expect nothing from no-one

Did you experience any difficulties finding information about Advocacy Services?
Please tell us more:
I have knowledge of some of the department and know someone to contact if I was not sure
I was aware of the service prior but never use the service. This was an emergency case and maybe a one off. if your website and service become more accessible - I am deaf BSL user - your website and services I can't access. the subliminal message is that the most "vulnerable" people bother you, the rest know what you're like and don't bother you so you can get on with your job by appearances

Is there anything else you would like to share about the services/support provided?
Why isn't this questionnaire accessible?
PEOPLE ARE TO BE SUPPORTED AS "PEOPLE" and culture comes after Caring as people.

Would you have any additional needs/requirements to take part in such Forums/Groups?
Depending on the topic
Provide a British Sign Language Interpreter
Please provide BSL Interpreters (they can be booked via GDA)
no, it's all people-pleasing and politick making so we don't care, you can do what you what to feel better about yourselves and tick the boxes, we look after our own

Are there any particular times that suit best?
Pm not Wednesdays
During school terms

If you have not made a referral, is there a reason? Please select some of the barriers or obstacles to referring to advocacy service.
Previous experience, not sure if advocacy was appropriate, Insufficient information or guidance available
Previous experience, Insufficient information, or guidance available

If you have not made a referral, is there a reason? Please select some of the barriers or obstacles to referring to advocacy service. (Other (please specify))
cccc

An advocate has not been required
Not applicable to direct role
Criteria is too narrow
Referral do not have Deaf BSL services
I have recommended a referral is made but a different staff member has completed the referral.

How easy was it to contact the service? If it was difficult, please explain why
Hard to find information
Service no suitable for BSL users. No access to BSL.
I am unsure of which service to refer to because of the lack of information from each service in my first language BSL.

Was the time the service took to respond acceptable in your opinion?
If no, tell us about your experience:
n/a
cccc
Delays appointing advocates Delays with advocates not contacting individual over many months
Variable response time due to waiting list pressures. Individual IMCAs / Paid RPRs are generally quick to respond.
Never accessed

Have you had any challenges referring anyone from specific groups?
If you answered 'yes' to the above question, that you have faced challenges, what were they?
It again depends on staff availability.
The client didn't qualify for the service
Service no suitable for BSL users.
A Deaf sign language user, a member of the local community was finding the end of life overwhelming for his wife, to understand the stages and funeral procedure. There was no one to contact or service locally to help them. One was found eventually in Bristol, Richard McGill Trust.
An issue is that advocacy for people in hospital seems to end the second they are discharged, and a period of following up would be helpful, particularly around issues related to concerns about care.

If you selected 'Other' to the above question, please specify:
Contacting adult services for example a Deaf British sign language user needing a PA. We have had barriers to meeting / matching the criteria required to meet their needs and the criteria the service is working to.

Outcomes If you selected 'no' to the above question, was this due to any of the following: (Other (please specify))
dddd

I invited the newly appointed advocate to meet the client at our centre - so that we could also share info and support the development of the working relationship. They told me that they weren't sure if they could do that because of their COVID restrictions and they would get back to me. They didn't get back to me.
Not always given update after referral.
No obvious British Sign Language access.

Do you feel confident about knowing when you should contact POhWER for Advocacy guidance or support services for a client?
If you answered 'no' to the above question, please tell us why
The service specifications are too confusing e.g., some self-referrals and others not. To be less confusing, they all need to be one way, so you refer in to POhWER via one route, rather than services such as IMHA or IMCA that all have varying routes. POhWER can then direct you to the right service. Unsure about criteria and when this would be helpful
Access to BSL
Not sure about all the rules - only seems to cover certain people which is confusing - why not an advocate for anyone open to MH services?

What works well with regard to advocacy services in Gloucestershire that you have accessed in the last 12 months?
When I last worked with an advocate their knowledge was good
Referral process, the support received, how timely the support is
They were able to listen to the person and support them to be heard
Easy online application and quick response
central referral point. clear reports provided by advocates.
If I am unsure, I can ring up and ask for advice before I make the referral.
Advocates allocated in a timely manner. All advocates represent the people well and support them with ensuring their health and wellbeing, views and wishes are represented
The knowledge and experience of the advocates.
regular contact/updates with advocate
Care Act Assessment Advocates
Giving individuals a voice to communicate what is most important to them in their assessment or in regard to their accommodation.
When referred have had access to advocate
Training to Carers re. self-advocacy
Advocates allocated when required.
We have positive case studies of advocates making a difference but not in the past 12 months.
The ability to refer someone on their behalf.
Adult Help Desk, Social Worker CCG
Very helpful and caring staff, really trying to get the best for a client

Are there any areas you feel could be improved around advocacy services in Gloucestershire including training offered?
Based on experiences those i line manage have had, Communication and timeliness

Training for all social care staff Using LAS to confirm receipt of referrals Being able to access an advocate for a reason not specified (Outside of normal realms should there be a cause to support adult care tasks)
I have had no training.
Training would be helpful
There are staff shortages which can affect how quickly an advocate can be appointed. Some advocates have a lot more experience than others, but it does take time to develop knowledge.
Why an advocate won't become involved when the decision is about managing finances.
Communication between advocates and professionals is poor. It can take weeks to get a response back from the advocates which can delay the entire Care Act process. Advocates also seem reluctant to resume visits after Covid which inhibits getting to know individuals with LD as they are not able to engage as well on a virtual meeting from my experience. Advocates appear to be really stretched and under resourced.
Offering nontechnical language when advertising Advocacy to the communities of Gloucestershire
There needs to be an advocacy service a step below POhWER, a community level perhaps, where lower-level advocacy is available, and it can be accessed by individuals and professionals working in the community. Many times, the individuals referred by our service are too low level for POhWER and there is nothing else.
Accessibility. Information shared about services.
Yes, face to face befriending services. BSL access, not through an interpreter.
Training for advocacy with shared funding for British Sign Language interpreters. More information of what services offer for referral purposes.
Understanding the complexity of MH difficulties and that not everything is fixable.

Do you see yourself as having an advocacy role in relation to those in your care?
As social workers we advocate needs/wants/wishes but not in the formal care act or IMCA sense as that would be biased as we commission services
My "advocacy" role would be limited to trying to support them to live the life they want and trying to make sure providers are working towards that, making sure that providers are not placing restrictions on my individuals and reminding providers and others about the rights of my individual, and ensuring these are respected. But as I am in a position of "power" the relationship is unequal, and I cannot actually be an advocate. As a decision maker, I cannot be an advocate. The advocate is solely there for the individual, and to represent the individual and to help them put across their views. They need to be separate from the decision maker/funding organisation, and not influenced by those concerns.
I may support an individual to have their views and wishes expressed to a partner agency
It depends on the individuals that I am working with whether or not an advocate is required.
As a Social Worker it is my role to ensure those who I support have access to the services they need.
I work for the DoLS team and advocating for the people I am assessing is part of the role.
not always appropriate for social worker to act as advocate, especially if my views conflict with clients
Although not an advocate we support the individual with voicing their wishes and concerns and goals which is evidenced through our assessment.

I advocate for individuals and family who I work with, but good practice means an independent advocate should be sought to avoid conflict of interest as a local authority employee

We work with people and encourage them to take control of their goals. However, for those very much in need we can help coordinate care.

Supporting people to make decisions about their care and support needs.

For some of our clients we are their main/only source of support, are trusted and feel that we know them well. We understand the principles of a provider having a conflict of interest in advocating for the client - but often there actually isn't a conflict because it is alternative needs/services that are being explored. It would be useful to have a 'test' for the management of conflict and let the client have some choice in their advocate. Our clients tell us they don't always feel understood by others - and I am not sure that the advocates used are able to access any training in complex cognitive issues.

Advocating for children

Regularly get Deaf service users asking to call on their behalf, or translate letters sent to them.
My role is working with Deaf and hard of hearing people, to advocate and refer on to counselling and other services that support their wellbeing. I encourage positive thinking by setting up events and arranging time to mix and meet friends to reduce their mental decline.
I also refer to other services such as Sign Health Charity.

Solicitor

It's my job to listen to people and understand their experiences, and sometimes to improve their well-being I recognise their need for someone to speak up for them and do so where I can - this can be difficult when teams are very split on the best way forwards, and an independent person can be helpful in this situation.

Appendix 2

Children's Advocacy Case Studies

	CASE NOTE	Themes and Lessons Learnt
Case Study 1	2021 01 12 Q3 NIA Case Study.doc	A non-instructed advocacy - young person was not able to provide verbal instruction. The skills to **understand the needs** without hearing his words and getting to know him as a person. Areas found which could be explored to further fulfil YP needs: His methods of communication needed to be reviewed, Mum needed more communication from speech and language regarding his progress to understand his needs to diminish anxiety, his regular trips with Mum could be enhanced if she had her own set of familiar PECS. This will help Mum to communicate more effectively with the young person while out on their car trips. PECS is the Picture Exchange Communication System - a visually presented method for teaching children with autism to comprehend language.
Case Study 2	CASE_STUDY_JAN_2021.odt	Because the Advocate was independent of the YP's placement, he felt able to speak honestly and earnestly about how he felt, the Advocate wrote down his words, worries and frustrations. The Advocate spoke for the young person at his review and delivered his words to the meeting. The professionals at the meeting were able to hear the young person's thoughts and feelings and respond with empathy and understanding, thus the young person felt that he was being listened to and that his words had been heard. The knowledge of the **independent status** of an Advocate can be an important factor in the interaction between the Advocate and young person.
Case Study 3	Case Study April 2021 Child in Care C	Professionals at the meeting were able to hear the young person's real feelings (which the young person believed she had been told to keep to herself). Her true feelings were heard and

		considered, and there was a realisation that she may appear to others to be ok when, she was unhappy. Recognition of the child's feelings has improved, and appropriate support is now being offered within the care placement. Because the Advocacy Service is **independent of Social Services** the young person felt able to talk about her negative feelings.
Case Study 4	Case Study April 2021 Initial Child pr‹	To get the young person's views for an Initial Child Protection Conference **independently**. To gain the young person's views on lived experiences at home as she has found it hard to speak to the social worker. The young person was able to express her views openly through an advocate; opinions that would have been hard for her to express herself, as she was not happy with her social worker due to current circumstances which she held them responsible for. The young person had their rights upheld and was able to **actively take part in an important decision about their life**. The young person felt heard and listened to.
Case Study 5	Case Study April 2021 Initial Child Pr‹	Request for advocacy support to gain the young person's view for an upcoming initial Child Protection Conference Young person was going out late at night, hanging out with older people and getting intoxicated, putting herself at significant risk of harm. Police had also stated real concerns about the young person carrying a knife in the community. There was also a concern regarding the young person carrying a knife at home and hiding it in her room in a teddy where her younger niece sleeps, as it is a shared room. Young person had expressed concerns to social worker that she didn't feel safe when she was left in the home with mum's boyfriend in afternoon and evenings when mum had to work. The Young person did **engage with the advocate** and was able to put across her views and opinions which was written up into a report for Initial Child Protection conference.

Case Study 6	Young person in care 2021-07-21.doc	Young person doesn't trust his social worker and residential staff. Social worker wanted him to have someone **independent who he could trust**. The young person was feeling anxious and feeling that no one listened. Had periods of extreme upset where he felt completely unheard. Felt very let down and betrayed. The young person was able to have **someone they trusted in their corner** who was independent. He knew that his concerns would be voiced to the centre and social care. This has helped him relax and feel less anxious that no one was there for him.
Case Study 7	Case Study - Reunification 2021.(	IRO felt that the young person would like support with ensuring **his voice is heard** and represented during and outside the review process. Decisions have been made without consultation with the young person, or his family. The young person had expressed to his IRO that he is not always happy with the decision making around family time and has not been consulted on or talked about decisions. The **Advocate spoke on his behalf** at the reunification meeting and at his Child in Care Review. The young person now has a set timetable for reunification in place to return home to mum.
Case Study 8	Case Study September 2021.doc	The young person has no relatives in the UK, and she does not have the contact details of her family members back in Vietnam. Her parents went 'missing' three years ago due to debt, and she was 'kidnapped' from her house by people not known to her (traffickers). The advocate was very **mindful of the trauma** already endured by the young person, and the fact that she was very poorly due to a significant health condition. With the help of an interpreter the subject of family was touched upon, the advocate was mindful that this could potentially be a trigger for further trauma, and care was taken to ensure that she

		understood she did not need to discuss anything that she found too difficult. **She was able to voice her opinion** and share her hopes and wishes for her future. She understands that she can have advocacy support at any time whist she is in foster care, including as a care leaver.
Case Study 9	Case study October 2021.doc	Young person wants to complain about alleged abuse he suffered at the hands of foster carers in his previous placement. Advocate advised the young person she could write a complaint on his behalf asking for the alleged abuse to be investigated. The advocate also asks for clarification from his IRO and social worker about the plan with contact with his Mum and **will help facilitate** this. Following his disclosure of suicidal ideas, the Advocate immediately raised a safeguarding concern Not all children and young people will see that they are being heard until their advocate has actioned what they have said, and young people see it being done.
Case Study 10	December 2021 ICPC 16 year old YP f	Young person's relationship was giving cause for concern about abuse and coercion, the safety of young person and her understanding of the dangers of her boyfriend's behaviours. The Advocate ensured the correct words and wishes were read out and were understood by all at the meeting; Advocates were able to support and represent her wishes **without being part of the decision making.** The young person said after the meeting that **she felt more confident having had an advocate** read out her wishes. She said that it was exactly what she wanted to say and was 'perfect'. Several other points raised by the young person regarding her support from Social Care were all discussed.

Case Study 11	December 2021 ICPC 16 year old YP r	Both younger siblings say they are terrified of the young person and what he might do next. They are living in fear in their own home and do not feel safe. The advocacy spent time with all three children independently from each other, which allowed them to be open and uncover some of what they have witnessed at home. The Young Person's lived experiences and the reports from his siblings demonstrated the need for further regular help and intervention which was not at that time in place. The young person was keen to make steps to improve his behaviour and was informed this would be included in the report. At the conference the young person's views were read out. They were very well received, with his needs being acknowledged and forming part of the new action plan to help him and the family.