

March 2014

**KENT COUNTY COUNCIL  
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)**

**You need to start your Equality Analysis and data collection when you start to create or change any policy, procedure project or service**

**When developing high-level strategies under which other policies will sit, if those policies are jointly owned by KCC and partner organisations, they will need to take the partnership approach to EqIAs,**

Please read the EqIA GUIDANCE and the EqIA flow chart available on KNet.

**Directorate:**

Social Care, Health & Wellbeing

**Name of policy, procedure, project or service**

Re-commissioning Advocacy and addition of Learning Disability Community Advocacy – updates are highlighted in blue.

**What is being assessed?**

Provision of statutory and non-stautory (community) advocacy services

**Responsible Owner/ Senior Officer**

Emma Hanson – Head of Strategic Commissioning Community Support

Sam Sheppard – Commissioning Manager

**Date of Initial Screening**

January 2015 (DivMT reports)

Updated November 2016

**Date of Full EqIA :**

Updated 20/01/2017

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| <b>Version</b> | <b>Author</b>          | <b>Date</b> | <b>Comment</b> |
|----------------|------------------------|-------------|----------------|
| V.01           | Sholeh<br>Soleimanifar | 08/04/15    |                |
| V.02           | Sholeh<br>Soleimanifar | 13/05/15    | Janice Hill    |
| V.03           | Sholeh<br>Soleimanifar | 08/07/15    | Sam Sheppard   |
| V.04           | Sarah Challiss         | 17/11/15    |                |
|                |                        |             |                |

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Screening Grid

| Characteristic    | Could this policy, procedure, project or service, or any proposed changes to it, affect this group less favourably than others in Kent?<br>YES/NO<br>If yes how? | Assessment of potential impact<br><b>HIGH/MEDIUM</b><br><b>LOW/NONE</b><br>UNKNOWN |          | Provide details:<br>a) Is internal action required? If yes what?<br>b) Is further assessment required? If yes, why?   | Could this policy, procedure, project or service promote equal opportunities for this group?<br>YES/NO - Explain how good practice can promote equal opportunities  |
|-------------------|--|--|----------|---|---|
|                   |  | Positive   | Negative | Internal action must be included in Action Plan   | If yes you must provide detail  |
| <b>Age</b>        | Yes  | High   |          | a) Yes. Further assessment through process of co-production to identify need, impact and outcomes<br>b) Assessment of needs through review of current provision, gap analysis, and ongoing co-production with all relevant stakeholders (experts by experience or practice) to truly understand the scope and impact of the service, and to determine the best options to provide a high quality consistent advocacy across kent. | Older persons may require advocacy, if due to degenerative age related health problems, such as dementia, or general frailty, become more socially isolated and unable to participate as fully in decisions that matter to them. This is highlighted by the Francis inquiry into Mid-Staffordshire NHS Foundation Trust. For this reason adequate and timely advocacy will have a significant positive impact on older persons.   |
| <b>Disability</b> | Yes  | High   |          |   | Disability can have an impact on people's ability to grasp concepts, or make others understand their wishes due to significant communication barriers, learning disability or mental health need. Advocacy also plays an essential role in preventing, detecting and responding to abuse. This is highlighted by reviews such as those relating to Winterbourne View private hospital and inquiry into premature deaths of people with learning disabilities. For this reason adequate and timely advocacy will have a significant positive impact on people with disabilities. |
| <b>Gender</b>     | Yes  | Medium   |          |   | There are differences and inequalities between young men and women, which often put women at a disadvantage regarding responsibilities they are given, activities they perform, access to and control over resources, or decision-making opportunities. In some cultures there may be social attitudes that   |

|                        |         |         |  |  |
|------------------------|---------|---------|--|--|
|                        |         |         |  | <p>undervalue education for women, and as a result women may bear a disproportionate burden of household duties at the expense of their education. Early marriages and unwanted pregnancies and lack of educational achievement and vocational skills can also have an adverse impact in some women’s autonomy to make their own decisions. Furthermore, women are more vulnerable to both physical and sexual violence, including domestic abuse.</p> <p>On the other hand, suicide remains the most common cause of death in men under the age of 35, with young men 4 times more likely to commit suicides.</p> <p>For this reason adequate and timely advocacy will have a significant positive impact on men and women to understand their rights and empower to make informed choices.</p> |
| <b>Gender identity</b> | Unknown | unknown |  | <p>The feelings and experiences of people with gender identity are often invisible to most people, and therefore this data has not been collated in a standard way in the past. However it is clear that any anxieties or intolerances that people with gender identity may experience can lead to social isolation and and therefore in a position to full advantage of opportunities as active citizens. Through the co-production events we aim to involve people from diverse backgrounds to ensure that advocacy services will address advocacy needs of all in an empathetic and non-judgemental way.</p>  |
| <b>Race</b>            | Yes     | High    |  | <p>Diversity of need amongst people from a black and ethnic minority background is not always acknowledged, or understood. Awareness can be poor around basic issues such as; the ethnicity of the local community, information needs, and the impact of cultural and spiritual values on decision making and service take up. People from different ethnicities often</p>   |

|                           |         |         |  |   |
|---------------------------|---------|---------|--|---|
|                           |         |         |  | <p>face the double discrimination of race and disability. Advocacy can provide a vital link to mainstream services that are not always appropriate or sensitive to their needs, allowing marginalised and disempowered individuals to speak up about their views and concerns. However, the word advocacy can be difficult to translate into some languages. What advocacy means and how it can help, can be difficult for some people from black and minority ethnic groups and their carers to understand. This will be monitored in the re-commissioned advocacy service to ensure there is proportionate referral and uptake and that providers are not only aware of their make up of the communities they support but have strategies that will actively improve involvement.</p> |
| <b>Religion or belief</b> | Unknown | unknown |  | <p>Comprehensive information regarding impact of advocacy on people from different religions or beliefs is not available. However, any intolerances or prejudices against particular religions or beliefs, can cause a feeling of isolation or disempowerment, and the advocacy service will ensure that people's advocacy needs are addressed in an empathetic and non-judgemental way.</p>  |
| <b>Sexual orientation</b> | Yes     | High    |  | <p>People of LGBT background can face discrimination and barriers to achieving their goals. Although there have been huge strides in people's attitude in recent years, there are still instances of hate crime against LGBT communities. Furthermore, due to historical biases some older people may be estranged from their relatives and lack family support, and therefore more socially isolated.</p> <p>Prejudice – current or historic – in any form - can affect how someone perceives and experiences support. The role of advocacy is to support people who are unable to articulate themselves to ensure their voices</p>  |

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|  |         |         |  |  |
|--|---------|---------|--|--|
|  |         |         |  | <p>are heard, informed of their rights and supported to make their own decisions, if they are able to, or to act in their best interest if they are not able.</p> <p>The dignity in care agenda is of growing importance, and the core values of respect and compassion will extend to anyone supported through all forms of advocacy.</p>   |
| <b>Pregnancy and maternity</b>         | Unknown | unknown |  | <p>The dignity in care agenda is of growing importance, and the core values of respect and compassion will extend to anyone supported through all forms of advocacy.</p>   |
| <b>Marriage and Civil Partnerships</b> | Unknown | unknown |  | <p>The dignity in care agenda is of growing importance, and the core values of respect and compassion will extend to anyone supported through all forms of advocacy.</p>   |
| <b>Carer's responsibilities</b>        | Yes     | High    |  | <p>Caring responsibilities can have a significant impact on the health and wellbeing of people who care for anyone with a disability or health and care needs. Outcomes for carers are generally poorer than for society as a whole, as highlighted by the Governments Equalities Review undertaken as part of work to develop the National Carers Strategy 2008. Carers are more likely to suffer health problems themselves, live in poorer areas and in households with fewer resources. They are less likely to have educational qualifications or to be in employment. Many of those with caring needs are older people and much of the help they need is provided by other older people or by those in middle age. Therefore there is greater risk for carers to be unable to know their rights and having the confidence to ensure their voice is heard. For this reason adequate and timely advocacy will have a significant positive impact on people with caring responsibilities.</p> |

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## Part 1: INITIAL SCREENING

**Proportionality** - Based on the answers in the above screening grid what weighting would you ascribe to this function – see Risk Matrix

| <b>Low</b>  | <b>Medium</b>  | <b>High</b>  |
|---|--|--|
| Low relevance or Insufficient information/evidence to make a judgement. | Medium relevance or Insufficient information/evidence to make a Judgement. | High relevance to equality, /likely to have adverse impact on protected groups |

State rating & reasons: High rating with high positive impact

### Context

Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to:

- Have their voice heard on issues that are important to them
- Defend and safeguard their rights
- Have their views and wishes genuinely considered when decisions are being made about their lives

There is a mixed economy of advocacy provision across Kent for vulnerable adults provided through grants and contracts. The Care Act has placed new duties on the local authority to provide advocacy services and changes to Deprivation of Liberty Safeguards (DoLS) have led to an unprecedented increase in demand and requirements for accountable, timely services.

All advocacy services for adults (with the exception of Learning Disability advocacy) will end in March 2016, and new model of advocacy services will commence from April 2016. The new contract(s) will include:

- Independent Mental Capacity Advocacy
- Independent Mental Health Advocacy
- Care Act Independent Advocacy
- Health Complaints Advocacy
- Community Independent Advocacy

In April 2016 the Kent Advocacy Hub contract commenced with one lead provider delivering all statutory and non statutory advocacy with the exception of learning disability community advocacy. In March 2017 that current contract ends and we are looking to vary the Kent Advocacy Hub contract to include learning disability community advocacy.

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## **Aims and Objectives**

New requirements under the Care Act 2015 and the ending of current NHS Complaints Advocacy Contract and Independent Mental Capacity Advocacy (IMCA) contract in April 2016 have provided us with the opportunity to revisit the current model of Advocacy provision and design a model in co-production with key stakeholders, including people with care and support needs, carers, providers, commissioners, and other health and social care professionals.

The aim is to ensure the Authority will meet its statutory duties in provision of independent advocacy, but also works for people who need advocacy regardless of client categories. People have told us in a series of co-production exercises what advocacy means to them and of their expectations of quality advocacy services in Kent. We will ensure the referral pathways are simple and accessible to all those who need and qualify for advocacy, and that there is consistency of supply and quality.

[By varying the current Kent Advocacy Hub contract to include the Learning Disability Community Advocacy we will have a fully inclusive advocacy contract regardless of client category.](#)

## **Beneficiaries**

People have a right to statutory independent advocacy under the following legislations:

- The Mental Capacity Act 2005 introduced the right to an Independent Mental Capacity Advocate (IMCA), which gives some people who lack capacity a right to receive support to make specific decisions.
- The Mental Health Act 2007 introduced the Independent Mental Health Advocacy (IMHA) service to safeguard the rights of people detained under the Act and those on community treatment orders (CTOs), and to enable qualifying users to understand the legal provisions to which they are subject and to exercise their rights to participate in decisions about their care and treatment.
- The Health and Social Care Act 2012 introduced the Health Complaints Advocacy Service. Responsibility for commissioning the Health complaints advocacy service transferred from Department of Health (DoH) to local authorities, from 1st April 2013. The aim of this service is to support people who want to make a complaint about the health service, delivered through the NHS or privately sourced.
- The Care Act 2014 will introduce a new statutory duty, from April 2015, for provision of Independent Advocacy to strengthen the voice of people and their carers going through assessment, care and/or support planning and care review processes, as well as those people who are being supported through the adult safeguarding process.

Beneficiaries of community Advocacy include people whose disability or frailty would make them more vulnerable or generally disempowered or marginalized, for instance people with: mental health needs; dementia; sight /

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hearing or dual sensory impairment; Autistic Spectrum Conditions, as well as adults with caring responsibilities.

### **Information and Data**

Increases in the whole population figures indicate that there are likely to be significant increases in the number of people who may need to access advocacy services. The highest needs are expected to be for older persons over 85 years old, people with dementia, Learning disability or mental health needs. Further work will be carried out to assess the need for people with sensory impairments, Autistic Spectrum Conditions, and for people in custody.

### **Kent Profile**

The Kent population in 2013 was 1,493,500. This is broken down by gender as follows:

| YEAR | MALE    | FEMALE  | TOTAL     |
|------|---------|---------|-----------|
| 2013 | 731,400 | 762,100 | 1,493,500 |

- <sup>1</sup>Men (89%) were more likely to be Internet users than women (85%).

### **Age**

Age is a key factor as to whether an individual may need to access advocacy.

- Kent has an ageing population with the number of 65+ year olds forecast to increase by 91,200 (31.8%) by 2026.
- A one person household aged 65 and over in Kent is 79,310.
- 8% of the over 65s in Kent say that a long term health condition or disability limits their day to day activities in some way
- 7,043 people are aged between 75-84
- 9,415 people are over the age of 85

### **Race/Ethnicity**

Just under 1.4 million of Kent's residents are from the White ethnic group which accounts 93.7% of the total population. This is a higher proportion than the national figure of 85.4% and the South East figure of 90.7%. The remaining 92,638 Kent residents belong to the other four broad ethnic groups which we have identified as the Black Minority Ethnic (BME) group. This

<sup>1</sup> <http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2013/stb-ia-2013.html>

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equates to 6.3% of the total population. This is a lower proportion than the national figure of 14.6% and the regional figure of 9.3%.

Out of the twelve local authority districts within Kent, Gravesham has the highest number and proportion of residents from a BME group. 17.2% of Gravesham's population, 17,494 people are from a BME group. This is much higher than the national and regional proportions. Dartford has the second highest BME population with 12,295 residents (12.6%) from a BME group. Canterbury is third with 10,525 residents (7.0%). All of these areas have a higher proportion of BME residents compared to the Kent average of 6.3%. Of the twelve local authority districts within Kent, Dover has the lowest number and proportion of residents from a BME group. 3.32% of Dover's population, 3,708 people are from a BME group.

Nearly 8% of Kent's residents do not have English as a first language. These groups experience barriers of access, skills, motivation and confidence.

KCC's policy on translation and interpreting reflects the national policy to reduce reliance on written translations and providing interpreters unless there is a statutory need or the service user or carer will be discriminated against.

## **Religion and Belief**

The religious profile of Kent is very similar to that seen nationally and in the South East. The religion question was the only voluntary question on the 2011 Census questionnaire and 7.3% of Kent residents did not answer the question. This is slightly higher than the England figure of 7.2% but slightly lower than the South East figure of 7.4%.

In 2011 Christianity remains the largest religion in Kent. A total of 915,200 Kent residents said that they were Christians. This is equivalent to 62.5% of the total population which is a higher proportion than the national figure (59.4%) and the regional figure (59.7%). The 2nd highest proportion of the population claimed to have no religion. This is equal 26.75% or 391,591 Kent residents. The 2nd most popular religion in Kent is Muslim with 13,932 people which equates to 0.95% of the total population.

## **Disability**

The proportion of total resident population who have limitations to day-to-day activities in Kent is very similar to that seen nationally and within the South East. In Kent 257,038 people stated that that they have a health problem or disability which limits their day-to-day activities.

In Kent 82,570 people claim disability benefits due to a physical disability, 15,510 due to mental health problems and 12,640 because of a learning difficulty.

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The Care Act requires us to ensure information is accessible to those with sensory needs and people who may have learning difficulties and disabilities. The Care Act specifically refers to accessibility for those with sensory needs and although use of BSL interpreting is well established, an analysis of provision for all residents for general information on universal services is required.

## **Carers**

In 2011 151,777 people, or 10.4% of Kent's total population, provided unpaid care. This proportion is higher than the regional average of 8.9% and the national average of 10.2%. 23.6% of all unpaid carers in Kent provide care for 50 or more hours a week.

- Ages 50 to 64 provide the highest proportion of unpaid care for both men and women.
- 96.0% of unpaid carers are from the White ethnic group.
- 9,197 or 6.1% of people who provide unpaid care report bad or very bad health.
- 56.9% of unpaid carers are economically active. This proportion is a lower than the regional average of 40.8% and the national average of 42.1%.

The largest BME group in Kent is the Asian/Asian British group. There are 3,440 carers in the Asian/Asian British group, which is equal to 2.3% of all carers.

In Kent, women provide a higher proportion of unpaid care between ages 0 to 64 but men aged 65 and over provide a higher percentage of unpaid care than women aged 65 and over.

Outcomes for carers are generally poorer than for society as a whole, as highlighted by the Governments Equalities Review undertaken as part of work to develop the National Carers Strategy 2008.

Carers are more likely to suffer health problems themselves, to live in poorer areas and in households with fewer resources. They are less likely to have educational qualifications or to be in employment.

Many of those with caring needs are older people and much of the help they need is provided by other older people or by those in middle age.

Carers from black and ethnic minority backgrounds and other disadvantaged groups are at risk of being doubly disadvantaged by both sets of circumstances. Minority ethnic carers were particularly likely to report they felt restricted in using services because of a lack of information, or as a result of services they perceived as too expensive, inflexible, or not suitable for their individual needs.

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## **Profile of people with care and support needs in Kent**

KCC currently support 32,303 people.

- 20,175 people are over the age of 65
- 12,128 people aged between 18-64 are supported by Adult Social Care.
- 99.8% of the total number of people aged 18-64 (12,128) have either a learning disability, physical disability or mental health issues.
  
- We support 22,750 people with a physical disability \*This figure now includes older people resulting in an increase from 4,806 in 2012-13
- 2,446 referrals were made by Sensory Services in 2013-14
- Around 19,500 people suffer from dementia
- There were 258 Autism referrals made between (March 13 to February 14)
- We support 5,324 people who have mental health issues (3,619 in 2012-13)
- We support 4,208 people with a learning disability (3,619 in 2012-13)
- The Kent County Council registers for sensory impairment show more than 7,700 blind, 9,000 deaf and 1,400 deaf/blind people as of April 2011.

## **Involvement and Engagement**

In Kent we have opted to co-produce the forthcoming tender for advocacy services, where people, family members, carers, organisations and commissioners are working together in an equal way, sharing influence, skills and experience to design, deliver and monitor services. Co-production acknowledges that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need them.

Further information about the co-production activities can be found via this link: <http://www.kent.gov.uk/social-care-and-health/information-for-professionals/events-for-social-care-professionals>

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## **Potential Impact**

Historically advocacy services have been commissioned on an ad-hoc basis to meet specific local need, or to meet requirements of legislation for statutory advocacy. A mapping exercise carried out demonstrated that the availability of advocacy support in Kent is patchy and inequitable, both in terms of client groups and locality, and are not strategically aligned.

Currently there is only ad-hoc arrangements for people with dementia, limited provision for people with physical disabilities and no commissioned provision for people with sensory impairments and autistic spectrum conditions.

It is our intention that as part of re-commissioning advocacy services, we will support adults (and children in transition) who need an advocate's support, at the point of need. We will standardise the referral to advocacy, simplify the process, and therefore give greater control and influence for the individual being supported.

This model will offer an overarching advocacy service for anybody requiring advocacy support across Kent, with access to more specialised advocacy services, if required. This may be a single point of access or multiple points, subject to further development and consultation. The difference will be that people will be supported according to need, rather than disability or client category.

### **Adverse Impact:**

The proposed model will overcome adverse impact of current delivery.

### **Positive Impact:**

Co-production of the forthcoming tender for advocacy services, has been a very positive experience for all involved. In particular people who have previously felt very much marginalised, such as people with sensory impairments and Autistic Spectrum Conditions, are now taking central role in shaping the new service. People have told us what advocacy means to them and what they expect from good advocacy. People, family members, carers, organisations and commissioners have worked together in an equal way, sharing influence, skills and experience to design, deliver and monitor services. The re-commissioned services will not put people into silos but will support people based on their needs, rather than disability or circumstance. Barriers to access will be removed to ensure that everyone will be given equal access to quality advocacy services anywhere in the County.

## **JUDGEMENT**

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**Option 1 – Screening Sufficient**

**No**

Following this initial screening our judgement is that no further action is required.

**Justification:**

The new service is going to be based on need rather than client caterories, where in the past has failed certain sectors of the community. The new contract will be monitored and reviewed, to ensure that the service reaches all individuals and groups expected to benefit from advocacy, in sufficient numbers, and to put it remedial measures where gaps are identified.

**Option 2 – Internal Action Required**

**No**

**Option 3 – Full Impact Assessment**

**NO**

**Action Plan**

**Monitoring and Review**

**Sign Off**

I have noted the content of the equality impact assessment and agree the actions to mitigate the adverse impact(s) that have been identified.

***Senior Officer***

Signed:

Name:

Job Title:

Date:

**DMT Member**

Signed:

Name:

Job Title:

Date:

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**Equality Impact Assessment Action Plan**

| <b>Protected Characteristic</b> | <b>Issues identified</b> | <b>Action to be taken</b> | <b>Expected outcomes</b> | <b>Owner</b> | <b>Timescale</b> | <b>Cost implications</b> |
|---------------------------------|--------------------------|---------------------------|--------------------------|--------------|------------------|--------------------------|
|                                 |                          |                           |                          |              |                  |                          |
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