A Standards Framework

For

Delivering Effective Health and Social Care Advocacy

for Black and minority ethnic Londoners

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Contents

Introduction

What is the advocacy standards framework?

This advocacy standards framework for black and minority ethnic communities (BMEC) is a tool that offers **a set of standards** for health and social care advocacy[1] and a **process** for implementing them. The standards can be used to meet the needs, expectations and responsibilities of:

- service users or clients

- advocacy providers

- commissioners and funders.

It is important that the advocacy standards framework is used in a holistic way within a locality or borough. This means that comments and suggested changes identified by users and providers should be fed back by commissioners and funders and used to improve services, policies and practices. These in turn need to inform any local strategy for the provision of advocacy.

The framework focuses on advocacy services that cater for black and minority ethnic communities. All the processes described in this framework have been developed and informed by the views, experiences and practices of advocacy service providers, clients and commissioners.

By using the framework you will be able to improve the quality of service you provide or commission. So, if you provide services, you could use these standards to develop, for example, a code of practice for your advocates or a charter of user rights that could be publicised in a leaflet and given to all users. If you commission or fund services, you could use these standards as part of service level agreements or contracts, or simply as a good practice checklist of things you need to think about before you develop or fund a service.

If you are thinking about developing advocacy services, the framework can guide you through key stages, prompt you to consider important questions and help you to develop appropriate methods to involve key stakeholders.

It is important that the framework is used in a way which is flexible and adaptable to the organisation, agency or group concerned. For example, we have not presented a rigid concept or understanding of advocacy, because many organisations that provide advocacy to black and minority ethnic communities use different models of advocacy simultaneously. Such an approach may be

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[1] Health and social care advocacy is defined in Appendix 1

particularly important for groups that support refugees and asylum seekers, as they may initially need to provide professional or formal advocacy and then actively encourage self advocacy through educating clients to use the 'system' effectively, providing information and developing clients' language skills.

The framework is based on the systems and methods of working that are already in place and relevant to different sectors. This is important, as a key feature of the framework is to **preserve and build on the best of what is already happening** in small black voluntary organisations and self-help groups.

The diagram below provides an overview of the advocacy standards framework.

Outline for Advocacy Standards Framework

USERS / CLIENTS	ADVOCACY PROVIDERS	FUNDERS / COMMISSIONERS
Standards	**Standards**	**Standards**
▪ Charter of User Rights ▪ User principles ▪ Code of Practice	▪ Quality Assurance systems ▪ Contracts ▪ Service Level Agreements	▪ Contracting Guidelines ▪ Contracts ▪ Service Level Agreements

WAYS TO MONITOR AND EVALUATE ADVOCACY
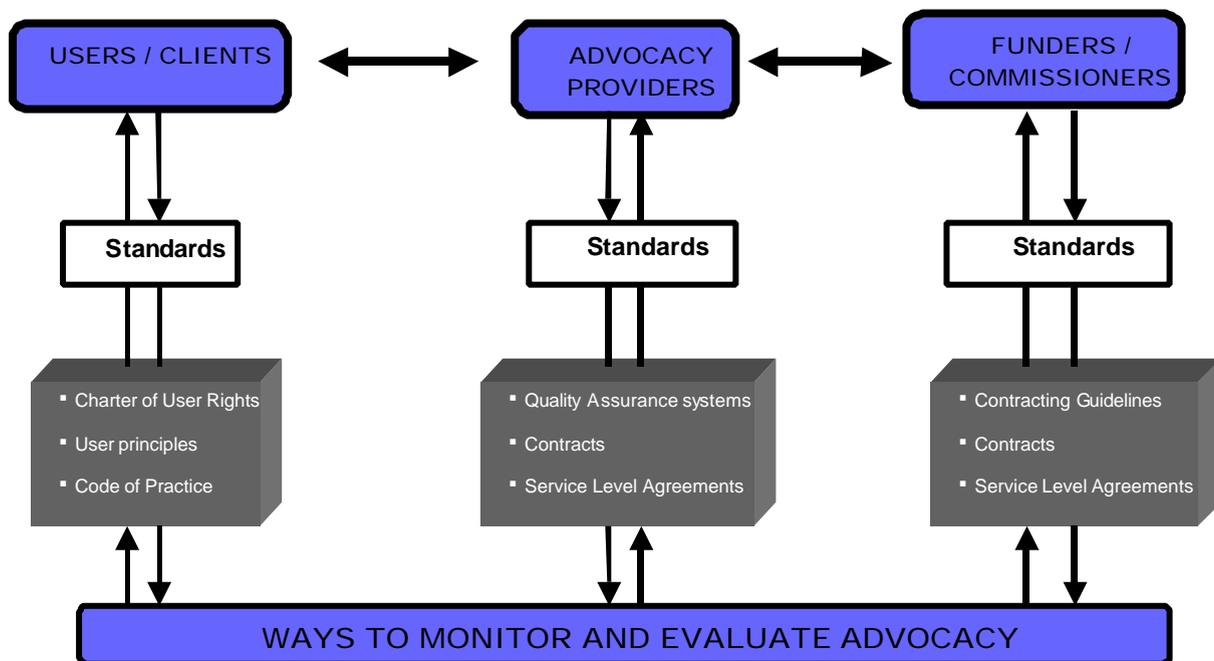
The framework has six linked stages of development that will help to clarify *why* advocacy standards are important*, what* they might look like and *how* you need to develop them. See the diagram on page 5.

Who is the advocacy standards framework for?

This framework is designed for large and small advocacy and generic organisations; commissioners; and funding bodies that either already provide health and social care advocacy or have an interest in developing and promoting advocacy. It is just as relevant for an NHS hospital or Primary Care Trust as for voluntary and small self-help groups that have no paid workers and may be providing generic, informal or specific advocacy.

Two important principles of the framework are to ensure that it:

- *is inclusive. Many organisations providing health and social care advocacy to BMEC in London are small community groups that receive little or no funding and provide an essential 'lifeline' to numerous isolated and vulnerable people (Silvera and Kapasi, 2000);*

- *brings advocacy provision for black and minority ethnic communities into the mainstream. Large and small generic advocacy providers can work through this framework to assess whether their services are accessible and appropriate to their local BMEC, as the majority of funded advocacy services are provided in this way (Silvera and Kapasi, 2000).*

How to use the advocacy standards framework

The complete framework offers a flexible approach that can be customised to the type, size and capacity of your agency or group and to the type of advocacy you provide. There are six process stages outlined within the framework, which can be followed as part of a developmental process or used individually to suit your needs.

For example, the framework could be implemented within an area, so that all advocacy services commissioned fulfil a specification agreed locally among voluntary agencies, user groups and the new NHS Patient Advice and Liaison Services.

At each stage, we have identified a number of important considerations, so that you can develop a process and standards that are right for you, and feel confident that they will be used. However, you may wish to add or omit elements, as your local circumstances dictate.

Stage 1 highlights the benefits of advocacy for BMEC.

Stage 2 sets out issues to consider and steps to take when you are setting up an advocacy scheme for BMECs.

Stage 3 helps you identify whether your service should be working to 'core' standards alone or to both 'core' and 'aspirational' standards.

Stage 4 looks at agreeing your standards framework and obtaining internal commitment and ownership.

Stage 5 describes a range of standards that relate to the expectations of users/clients, advocacy service providers and commissioners and funding agencies, and offers considerations for how these standards can be applied.

Stage 6 describes some of the methods that can be developed by advocacy providers, working collaboratively with commissioners, to monitor and evaluate advocacy services.

The framework will help providers, commissioners and users to have greater confidence in advocacy services by providing a mechanism to:

- legitimise 'informal' advocacy
- make a case for, and secure, mainstream, long-term funding
- embed good practice and improve poor practice
- develop consistent advocacy activities by staff and volunteers across the organisation
- plan, monitor and evaluate services
- review the range of advocacy activities within individual organisations and across a geographical locality or borough, and develop more appropriate services to meet the needs of local users\clients
- develop closer links between voluntary and statutory agencies, and in particular with Patient Advice and Liaison Services (PALS)
- develop a better understanding of the roles and models of advocacy being used within local areas.

Diagram of the process stages for implementing the advocacy standards framework
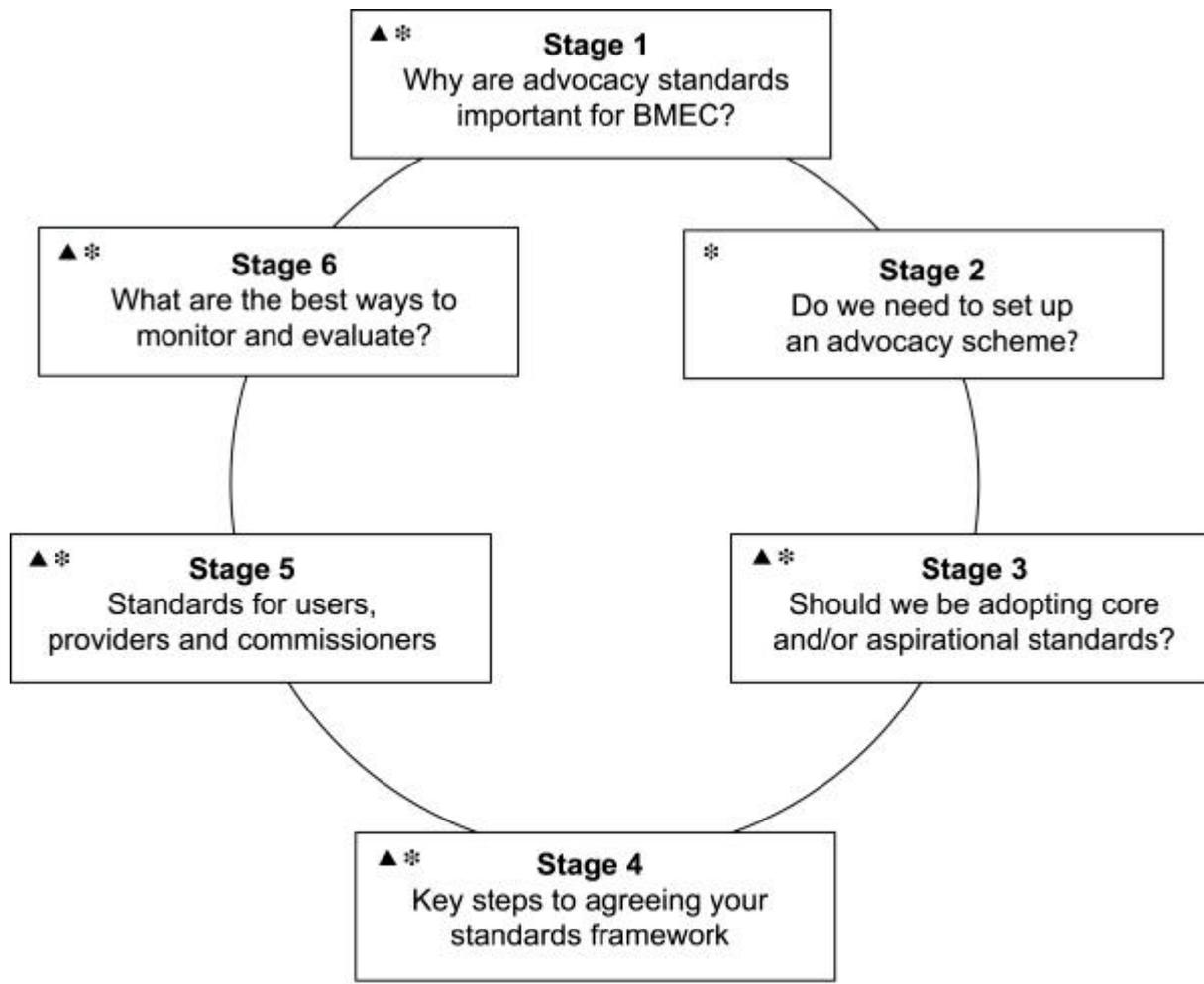
KEY

▲   This stage is appropriate for existing services

※   This stage is appropriate for new services

Stage 1: Why are advocacy standards important for black and minority ethnic communities?

We recommend that both **new and existing services** read and work through this stage.

Through extensive research[2], we know that, as a result of institutional racism, there are a number of barriers which minority communities face when accessing or using health and social care services. These include:

- Discrimination experienced in the past, together with trouble registering with GPs and negativity or even harassment from staff, deters people from attempting to access services.

- A lack of black and minority ethnic staff in NHS institutions deters potential service users.

- Feedback and complaints processes are often accessible only in English.

- Interpreting services are in short supply and are inadequately advertised; in hospitals these services tend to have inadequate needs assessment and ad hoc funding arrangements.

- Confidentiality: this can be a problem if health services are using other family members to translate.

- Language problems can lead to lack of involvement of patients and carers in assessment or treatment; this often leads to poorer care.

- Members of black and minority ethnic communities may have little confidence that services will meet cultural, linguistic or religious needs.

There are other barriers faced by all users; research studies[3] have shown that these are often compounded for certain black and minority ethnic communities, such as refugees and asylum seekers, who may be unfamiliar with health and social care provision. These barriers include:

- Lack of information about, and misunderstanding of, statutory agencies and their roles.

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[2] *What Seems to be the matter: communication between hospitals and patients*, Audit Commission, 1993; *Sick of being excluded: improving the health and care of London's black and minority ethnic communities*, The Report of the Race, Health and Social Exclusion Commission, Association of Local Government, 2000

[3] See references in footnote 2.

- Services being available only within limited hours and in particular service areas.

- Patients and carers not always receiving adequate information or services from doctors.

- Poor access to services: potential clients may be unaware that services exist, or uncertain whether they may use the services.

- Public sector providers assuming, often incorrectly, that minority ethnic communities have strong community/family support networks.

Benefits of the advocacy standards framework

The key benefits of using this framework are to achieve:

- improved access to services for users

- improvements in service delivery

- compliance with relevant legal requirements

- improvements in client and public awareness

- feedback for advocates

- better knowledge about the effectiveness and impact of the service

- improvements in working relationships across sectors

- improvements in the understanding of advocacy

- opportunities to raise funds to develop advocacy (through being better able to define services that are recognised and understood by funders and the NHS more generally).

The matrix below offers specific examples of how these apply to different sectors and groups.

	User	Provider	Commissioner or funder
Service Delivery	Confidence in using service Assurance of non-judgemental and non-discriminatory practices Good quality representation Improved communication with the service provider Greater knowledge of health and social care systems Access to individuals who can create pressure for change	Clarity about model/s of advocacy provided Consistency in the delivery of advocacy service to clients Systems for monitoring, evaluating and reviewing advocacy An opportunity to turn good practice into policy	Criteria for service development and funding advocacy Effective targeting of resources Processes and mechanisms developed to monitor and evaluate the impact and outcomes of advocacy services

	User	Provider	Commissioner or funder

Compliance with Legislation		**Relates to Provider and Commissioner**
		
		Race Relations (Amendment) Act 2000
		The standards offer pro-active ways in which organisations can tackle inequalities, promote access to services and develop a culture in which individuals do not indirectly discriminate. This is part of the *general duty* which states that public authorities must aim to:
		
		• Eliminate unlawful discrimination
		
		• Promote equality of opportunity; and
		
		• Promote good race relations between people of different racial groups.
		
		The standards also offer a way in which health and social care organisations can meet their *specific duty* under the Act to publish a Race Equality Scheme, which:
		
		• States which functions and polices they have assessed as being relevant to the general duty to promote race equality; and
		
		• Sets out their arrangements for meeting the duty by:
		
		    o monitoring their policies for any adverse impact on race equality;
		
		    o assessing and consulting on the likely impact of proposed policies;
		
		    o publishing the results of their assessments, consultation and monitoring;
		
		    o making sure that the public have access to information and services; and
		
		    o training their staff on the general duty.	

	User	Provider	Commissioner or funder
		Mental Health Act The framework offers standards to meet the requirements of The White Paper *Reforming the Mental Health Act* (2001). This identifies the need for a common criteria, a common pathway for assessment and improved and more consistent safeguards for all patients.	
		Human Rights Act Applies to all people, including children; upholds the right of individuals to have their views heard and given 'due weight'. It underlines that all people, including children, are holders of human rights.	
		UN Convention on the Rights of the Child The UK government is obliged by international law to implement the Convention. It upholds the right of children to have their views heard and given 'due weight' on any matter which affects them, and to representation in any formal proceedings.	
		Asylum Seekers and Immigration Act The changing and confusing government policies on asylum and immigration and entitlements to vouchers and benefits, in addition to the complex mental health and other health problems faced by refugees and asylum seekers, increases the need for health and social care organisations to proactively offer advocates and bilingual advocates to refugees and asylum seekers in order to : • provide an introduction to health and social care services; • raise refugees' and asylum seekers' awareness of their rights, including rights of access to free healthcare; • and help refugees and asylum seekers to negotiate various systems such as the DoH, local authorities , benefits agencies etc.	
		Health and Social Care Act 2001 Section 12 of the Act places a duty on the Secretary of State to arrange for the provision of independent advocacy services, which should be 'independent of any person who is the subject of a relevant complaint or who is involved or investigating such a complaint'. It also provides for the Secretary for State to make payments to set up such arrangements.[4]	

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[4] Health and Social Care Act 2001, Department of Health

	User	Provider	Commissioner or funder
Meeting statutory commitments of government policies		A number of government policies highlight the need to cut health inequalities, ensure fairer access for minority ethnic groups and explicitly target race equality as a focus for inequality initiatives, including: • DTLR Best Value Programme • National Service Frameworks for Mental Health and Coronary Heart Disease • The NHS Plan (see Appendix 2 for detailed implications) • ***Valuing People: A new strategy for Learning Disability (March 2001)[5]*** Government recognises that advocacy and direct payments are key to helping learning disabled people gain greater independence and control.	
Client and public awareness	Knowledge of rights and entitlements Clearer information on what to expect from advocates	Clearer and consistent message provided to clients and public about how to get advocacy services and what to expect from them.	

Stage 2: What to consider when setting up an advocacy scheme

This stage is for ***new services***. You may be considering setting up, or stimulating the development of, a local advocacy service for black and minority ethnic communities. If so, some of the issues that will affect the decision include:

• Whether you have any advocacy schemes or groups offering specific support to local BMECs.

• Whether you feel confident that the needs of your local BMECs are being met.

• Whether you have any refugees or asylum seekers in your locality or borough.

• The size and make-up of local black and minority ethnic groups. For example, you may have a large BME population or multiple small communities, which may be very isolated and have complex needs.

• Whether advocacy support is available for all sections of your local BMEC community who require assistance.

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[5] Government will invest at least £1.3 million a year for the next 3 years to develop advocacy services for people with learning disabilities in partnership with the voluntary sector; extend eligibility for direct payments through legislation; and set up a national forum for people with learning disabilities and enable them to benefit from the improvement and expansion of community equipment services now under way.

After considering the issues above, you may decide that you need to set up appropriate advocacy support in your locality or borough. This section identifies what you need to consider when you set up a scheme.

An advocacy scheme should be set up within the context of:

- an agreed local health strategy for improving minority ethnic health and access to health services

- a community development approach – working with and empowering individuals and communities

- consultation with local communities and user involvement in planning at all levels

- links between the NHS, local authorities, voluntary organisations and the wider community [6]

- feedback to communities on research findings and service changes.[7]

When assessing the requirements of an advocacy scheme, you need to consider a range of 'local intelligence' information data, such as:

- the specific area covered by the service

- which communities are present in the service's catchment area

- the geographical location and size of each community

- language/dialect skills, both spoken and written, and literacy levels

- key relevant factors, such as religion and cultural and political sensitivities

- the demographic profile of local BME communities, and future population changes

- specific health needs and issues as well as morbidity and mortality data, where available

- the socio-economic status of local BME communities

- the views of users and communities.[8]

Next steps

1. Form a multi-agency reference group so that people feel involved and have 'ownership' of the service.

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[6] Levenson and Gillam, 1998

[7] Marsha Sanders, 2000

[8] Marsha Sanders, 2000

2. Ensure that the local reference group has representatives from primary and secondary care services, local authorities, community groups and actual service users.

3. Review all existing data and information and make an informed decision about:
   − Size of the advocacy service (number of advocacy posts)
   − Funding required
   − Sources of funding available
   − Geographical boundaries
   − Implementation timescale
   − Key person to oversee the development of the service.

4. Once you have decided to set up an advocacy scheme, you need to consider the type of service you want to develop, your models of advocacy and your values and service standards. Appendix 1 briefly describes models of advocacy and gives a definition of health and social care advocacy. Stage 3 of this framework will also help you to develop a structure for the service you want to commission or provide.

Stage 3: Should you be adopting just the 'core' standards, or also the 'aspirational' standards?

This stage is for ***new and existing services*** and allows organisations to identify whether core or aspirational standards 'best fit' their organisation and stage of development.

Commissioners or funders who are also providers will need to consider both sections in this stage.

The criteria below are a basic measure or gauge to help you to decide whether you should be adopting just the core standards or also aspirational standards. You can also use the standards to act as an informal audit to 'benchmark' how you want to develop your service. Your circumstances may change even as the process develops, so we have not designed them to act as a detailed audit or assessment.

Providers

	Yes	No	Will be in place in the next 3 months	Working towards this in the next 12 months
Do you have any paid workers?				
Is your funding secure for the next 12 months?				
Do you have volunteers?				
Do you have systems and policies in place for accounting, equal opportunities, staff supervision and complaints?				
Do you have administration support (paid or unpaid)?				
Do you have a management committee or Board				

to which you are accountable?				
Do you undertake training for staff or volunteers?				
Do advocacy activities (as described in Appendix 1) account for more than 30 per cent of the work you do?				
Has your organisation been in existence for more than a year?				
Do you have any mechanisms to feed back to service users?				
Do you have any mechanisms to feed back to commissioners ?				

If you have ticked 'no' to four or more of the above questions, you should in the first instance start by meeting the core standards. Then, when you feel more confident and/or your capacity and security has increased, you can identify the aspirational standards you want to work towards next.

Commissioners and funders

	Yes	No
Are refugees or asylum seekers adequately served in your locality or borough?		
Are black and minority ethnic groups in your local population adequately served by advocacy and other support organisations?		
Does a proportion of your local population require interpreting support when using local health and social care services?		
Do all sections of your local BMEC community receive advocacy support if they require assistance?		
Do you require health and social care organisations you fund to undertake ethnicity		

monitoring?		
Do you have a strategy to commission advocacy services?		
Do you have a strategy to develop the infrastructure of local BMEC organisations?		
Do you have a strategy to co-ordinate funding provided to your local BME groups?		
Do all of the organisations you fund or refer on to have standards in place for their advocacy services?		
Do all of the BME organisations you fund which provide advocacy support as part of their work receive specific funding for it?		
Do you have any systems to collect feedback from local BMEC ?		
Do you have any systems to receive feedback from advocacy organisations and local BME organisations?		

If you have ticked 'no' to four or more of the above questions, you should in the first instance start by meeting the core standards. Then, when you feel more confident that these areas are being developed sufficiently, you can identify the aspirational standards you want to work towards next.

Stage 4: Agreeing your standards framework and securing commitment and ownership

At this stage, securing organisational commitment and ownership is vital for both *new and existing services,* otherwise the process will be a paper exercise. You should already have agreed whether you need to be working towards core or aspirational standards. Now you need to work through each section of the standards set out in Stage 5 with a team of people in your organisation.

For **providers**, this team should include:

- A member of your board or management committee
- A service user representative
- All staff or a representative from all staff groups
- Volunteer representatives.

For **commissioners and funders**, this team should include :

- All commissioners (with a responsibility for commissioning advocacy)
- Your head of commissioning or director
- Service user representation
- Representatives from local advocacy organisations, or organisations that could potentially provide advocacy.

Meeting 1

With this team, you need to agree on:

- How standards can benefit your work
- How core or aspirational standards can be used
- What you need to do or have in place in order to meet these standards (develop polices, train staff or volunteers, hold awareness-raising sessions, consult with staff and users, etc.)
- Who will take responsibility for any development work
- The timescale (if this process takes longer than 3 months, the exercise is likely to lose momentum and you may lose the confidence of any users you are involving).

Meeting 2

Once you have agreed your standards and undertaken the necessary development work, you need to decide:

- how you will monitor the standards

- how the standards will become embedded as part of your organisational culture (will they form policies, procedures, codes of practice, contracts, service level agreements, etc.)

- how you will publicise the standards

- a timescale for monitoring the implementation of the standards (it is likely that you will need at least six months to see how the standards are working)

- a date to receive feedback from the team.

Meeting 3

This is the feedback session with the team. This session needs to identify:

- what worked well

- what didn't work well and why

- what needs changing or developing

- who will take responsibility for monitoring progress (the team undertaking this should include a staff member, a board or management committee member and a service user representative).

At the end of this process, you will have a standards framework for your organisation. This framework should be reviewed annually and the monitoring and evaluation from it should feed into your annual planning cycle, AGM, annual report or other identified mechanism.

Stage 5: Developing the standards

Each section below lists *core standards* that should be met by small organisations, groups that have just set up their advocacy scheme and all commissioners. They represent a basic minimum standard that any organisation providing advocacy could be expected to meet.

The *aspirational standards* are for medium to large organisations and commissioners and funders who are jointly funding or developing projects. These standards are suitable for organisations that have met the core standards and may be meeting some, but not all, of the aspirational standards.

What to avoid when implementing standards

It is important that the standards in this framework:

- are not imposed in your organisation[9]

- are not a tick box exercise

- do not stifle and inhibit flexibility and innovation

- take account of the infrastructure and capacity limitations of your organisation

- consider any specific needs for BMEC in your locality, such as bilingual advocacy or challenging discrimination

- consider the needs of different models of advocacy you may be providing, such as citizen advocacy

- do not 'over-professionalise' advocacy activities by creating excessive formal procedures.

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[9] Working through Stage 4 in this framework is particularly important

What should users expect from advocacy?

The list below reflects the views of black and minority ethnic people who currently use advocacy services. They are basic expectations of what advocates should offer users/clients and can be used by you to guide your standards.

User expectations

BME users want a relationship with someone who:

- listens to and respects their views and opinions;

- is not judgmental (about their culture, religion, accent, dialect, political affiliation or the situation of their home country), condescending or discriminatory;

- is sensitive to their cultural and religious needs;

- is dependable and punctual;

- is honest and trustworthy;

- has high standards of personal integrity and can maintain confidentiality;

- can represent them confidently;

- has good bilingual skills;

- will give them the confidence to do things for themselves;

- offers support to help them make decisions and choices;

- can be there for them in times of crisis or vulnerability;

- will contact services to try to resolve their problems or concerns;

- can negotiate well on their behalf;

- has advocacy or other relevant qualifications;

- has good knowledge of local geography, travel routes, etc;

- has knowledge of local health and social care services and community networks (or has the ability to get this information);

- offers them continuity across service and geographical boundaries;

- improves their awareness of their rights and of the range of local health and social care services.

These standards could form the basis of:

- a charter of user rights

- user principles

- a code of practice for advocates

What standards should advocacy providers be working to?

The core standards identify baseline operational criteria, which any funding agency can reasonably expect to be in place in provider organisations. Aspirational standards are ones that services might be working towards, but have not necessarily achieved. Once you have achieved the majority of aspirational standards listed below, you will be offering a very high-quality advocacy service to all your clients and be meeting many of the accredited standards listed for PQASSO (Practical Quality Assurance System for Small Organisations) and CLS.

Core standards

- The service should have a description of the type of advocacy support it provides.

- The service should be free.

- The service should have information for users on service aims and their rights when using the service.

- The service should have a statement of equal opportunities or a statement of commitment to challenging discrimination and providing a culturally sensitive service. This may, for example, include the following standards:
  - the advocate must maintain a non-judgemental and neutral approach in the assessment and advice he/she gives. Where this is difficult, seek advice from the line manager;
  - the advocate should not present his/her own interpretation of the client's needs to health and social care professionals or allow personal prejudices to colour any dialogue he or she undertakes with professionals on behalf of the client;
  - people from BMEC, like people with disabilities, older people, etc., are surrounded by negative imagery. Advocates should draw on positive images, positive language, culturally appropriate activities and other means to portray the person as an individual deserving of respect;
  - the advocate should not discriminate against the client on the grounds of race, gender, marital status, religion, political affiliation or sexual orientation;
  - minor incidents of racism or other forms of discrimination should be dealt with by the advocate in the form of a verbal challenge; advocates will work to their own judgement in each case.

- Where the nature of the work falls outside the advocate's remit, the advocate should endeavour to refer the client to a relevant agency where possible.

- The service should be familiar with local BME voluntary sector groups and community organisations, and be able to provide clients with early contacts and on-going support.

- The service should collect information on who uses the service (this could include numbers of people using the service, their gender/ethnic group, support provided and issues dealt with).

- Users should have access to advocates with appropriate language skills.

- The service should collect feedback from users about the service and how it can be improved.

- The service should record unmet need.

Aspirational standards

Organisational commitment to advocacy

- There should be an explicit commitment to the values and principles of advocacy within the health and social care provider's publicity, promotion literature, user involvement strategy and public documents.

Access to services

Publicising the service

- Service providers should develop and implement communication and promotional strategies to publicise the service to users, health service staff and local communities.[10]

- Potential clients should have a direct route of access to advocates, and the service should be regularly publicised at clinics, health centres and surgeries and within minority ethnic communities.[11]

- Publicity information should be in an appropriate format, taking account of the needs of the partially sighted and people with loss of hearing and the range of local community languages spoken. For example, materials should be available in different languages and in Braille; should use symbols and printed text that is accessible to partially sighted people; should be available in audio and/or video formats; and should make use of new technology.

- Publicity materials should show a wide variety of people in the illustrations and give details of the different backgrounds and experiences of advocates working for the service.

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[10] Marsha Sanders, 2000

[11] Baxter, C., Baylav, A., Fuller, J., Marr, A. and Sanders, M. *The case for the provision of bilingual services within the NHS*, Department of Health, 1996

- Information on different health and social care issues should take account of the values and beliefs of BME communities.

- Jargon and acronyms should be avoided and plain English used.

Reaching communities

- Information should be disseminated widely using a range of media such as videos, plays, written information, audio formats and community radio programmes.

- Services should undertake outreach work to build links with the community, identify needs, provide information and promote the use and aims of the service.

- Services should link to communities through their networks. Important access points include community organisations, statutory services with specialist minority ethnic responsibilities and community media. Where communities are concentrated in a specific geographic area, use focal points such as shops, schools and religious and community representatives.

- Services should use diverse approaches to increase the number of people reached. For example, make use of proactive direct contact, social and religious festivals and events.

Location

- The service should operate at hours and in places that are convenient and safe for local resident communities.

- If the location of service(s) makes them inaccessible to BME communities, providers should explore the possibility of providing satellite surgeries at BME community centres.

- All offices open to users should be accessible by wheelchair, and interpreters and signers should be available when required.

Availability

- The advocacy service or information about referral to another advocacy service should be available on a 24-hour, seven-day-a-week, service-wide basis.

Accessing the service

- Users should be able to approach the service themselves, for example through contact cards, freephone numbers, mobile centres and visiting advocates.

- Where, for whatever reason, vulnerable users are unable get access to the service, arrangements should be made for advocates to visit regularly.

Personnel

Recruitment of staff and advocates

- The service should have a written equal opportunities or anti-discrimination policy which covers staff recruitment.

- A standard recruitment procedure should be followed.

- Recruitment procedures should include police checks and other checks (for example, the use of consultancies or follow-ups with previous employers, colleagues or users with whom the candidate has had dealings) to make sure that the candidate does not pose any sort of risk to service users.

- Recruitment procedures should test advocates on their potential advocacy skills and their attitudes to diversity their commitment to user's rights.

- All advocates should display good interpersonal skills, tact and sensitivity; have knowledge of public service agencies, specifically health and local government; understand the client group and its culture; be aware of patient and client rights and equal opportunities; be able to take notes and keep records when appropriate; and be able to manage a caseload competently.

- Users should be invited to participate in the recruitment of staff for jobs which involve face-to-face work.

- The service should try to recruit advocates from a range of personal and professional experiences and backgrounds, bearing in mind the diversity of people who might use the service.

- Recruitment criteria should be in place for employing trained bilingual staff.

- All bilingual advocates should be fluent in English and target languages, and able to apply standard interpreting techniques in a range of settings.

- In recruiting advocates, work should also be undertaken with employers, to ensure that job specifications are developed to similar standards in order to promote and establish a stable occupational structure with clear opportunities for skill development and promotion.

Support and supervision of advocates

- The service should provide advocates with continuous support and supervision. It should appraise their progress regularly (at least annually). Users and carers should be encouraged to contribute feedback to assist these appraisals.

- Services should encourage individual advocates to establish and/or join local and national support networks.

- Services should consider whether advocates require additional or external consultancy or support.

Training

- The training and development needs of the advocates should be assessed through regular feedback/supervision sessions.

- The service should obtain appropriate training for advocates who need it.

- The service should provide new advocates with basic training on their role and responsibilities, including these standards.

- Any volunteers should be invited to undertake training offered by the organisation that is relevant and useful in their role.

- Users and carers should be involved in this training wherever possible and appropriate.

- The service should act as a training resource on relevant topics for service-providing staff and community organisations.

- Core workers should have basic accredited advocacy training.

- Non-core workers should receive induction training.

- Advocacy schemes should have provisions for induction training and in-service training.

- Arrangements should also be made for local health and social care staff and community organisations to have access to training courses, to enable them to understand the roles of advocates and how to work with them effectively.[12]

Confidentiality

- Confidential information may be shared with the line manager or other members of the organisation when necessary.

- Confidentiality may be broken under the Child Protection Act, or by court order, in cases where external agencies request information about the client. Where the advocate knows or has good reason to believe that the safety of the client and the people around him or her are at risk, he/she should consult with the line manager as soon as possible about breaking confidentiality. In such cases the user should be informed at the earliest opportunity, and given opportunities to discuss other alternatives and to plan for likely outcomes. Reasons for breaching confidence must be recorded in writing. Where there is insufficient time for such consultation, the advocate should directly inform the GP or other health professional responsible for the medical care of the user/client.

- Where the advocate keeps records of the client/user's case, this should be made known to the client; the client should also be aware that this information

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[12] Levenson and Gillam, 1998

may be shared with colleagues within the organisation, where this is appropriate.

Accountability to clients

- The provider should have systems/mechanisms for accountability to users.

Continuity

- Information on different local advocacy services should be co-ordinated centrally, monitoring needs assessment and client-based activities to support contracting and inter-service collaboration. The service should be up to date with NHS-wide strategic developments in policy, management and technology.[13]

Empowerment of service users

The service will empower service users by:

- seeking all available avenues to raise users' awareness of the opportunities they have to affect their own treatment and conditions;

- ensuring that the client has control over the process at all stages;

- working with people towards developing their self-confidence, aspirations, opinions, and skills to stand up for themselves in the long term;

- informing the patient that it is their right to make a complaint, comment or suggestion about the service they receive;

- encouraging people to speak up for themselves and helping people to become more confident about dealing with organisations and staff;

- giving people the information they need to make their choices;

- helping people to ask for services that suit them and which respond to their needs;

- striking a balance between giving enough help and giving too much: i.e. not smothering or overprotecting the user/client/partner and recognising that learning and developing requires certain risks – this requires support rather than an over-protective reaction.

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[13] Marsha Sanders, *As good as your word: a guide to community interpreting and translation in public services,* The Maternity Alliance, 2000

Choice of advocate and appropriate matching of advocate to the service user

- Individuals have a right to the advocate of their choice.

- Funders and advocacy schemes must recognise and accommodate the diversity of people requiring advocacy. Wherever possible gender, dialect, culture and political sensibilities should be taken into account when matching bilingual advocates and interpreters with clients. If such matching is not possible, acceptability should be checked with the client.

- Where it is not possible to provide an advocacy worker from the client's own background, the advocate will make every effort to understand cultural and religious differences, in particular where these may impact on the quality of service a person receives. Specialist schemes and workers, and awareness training for all advocacy workers, should also be considered.

- The advocate should only accept the assignment if he/she is competent to communicate in the client's language and dialect.

- The advocate should always check whether the gender of the advocate is important to the user. While the preference cannot always be met, the provider should make every effort to meet the request. The advocate may find that a client of the opposite sex will not wish to share information with him or her, but will not say so openly; the advocate should be aware of this possibility and encourage the user to express his or her feelings.

Advocacy boundaries

- Advocates must make their role clear to clients, using any means of publicity available.

- Advocates must explain clearly and concisely their reasons for not acting in certain situations.

- The advocate must understand that advocacy work often involves complex issues and problems, which may not have a 'right' answer. Strategies are needed to deal with such problems.

- Advocates must be independent. There should be no conflicting interests which limit the action of the advocates and the project.

- When a friendship develops with the user, the advocate must clarify his/her professional boundaries with the user. Where a conflict arises, the advocate should discuss the possibility of relocating the case with his or her line manager.

Referrals to appropriate agencies

- The service should have an up-to-date and comprehensive referral list. It should take active steps to identify who is likely to provide a good service, and be able to make personal referrals.

- The service should seek to work collaboratively with others with similar concerns and objectives.

Internal systems and processes for managing and running a service

- The service will have a personnel and anti-discriminatory policy, systems for accounting, good physical access, and policies on confidentiality and dealing with conflicts of interest.

Monitoring and evaluation

- Provision of advocacy services should be based upon regular assessment of need, with arrangements in place to monitor the use of, and demand for, advocates and bilingual advocates. This information should be analysed in order to obtain data on:
  - ethnic group, language and dialect and different cultural, political and religious needs;
  - specific care group , disability and clinical speciality issues;
  - patterns of demand and activity;
  - frequency of use by departments, professionals, localities and external services.

- Mechanisms should be established for consulting with users about the quality, effectiveness and availability of the service, and to gather feedback from staff regarding user/client needs and staff support and development requirements. This information should be used to:
  - evaluate the work of the service and of individual advocates;
  - encourage feedback, comments and criticisms from users, carers and families, both on their advocate and on the service generally (opportunities should be provided for users to give verbal feedback, as well as having a supply of written feedback forms);
  - confirm that the advocacy is effective and consistent with the wishes of users and carers;
  - evaluate the health and social care outcomes of advocacy within the target communities;[14]
  - review bilingual advocacy needs;
  - recruit appropriate advocates;

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[14] Healthwork, Standards for Specialist Practice in Public Health, Prime R&D, Jan 2001, www.healthwork.co.uk/pdf/PH_consultation_standards.pdf

- record unmet need;
- improve existing internal systems for recording and collecting information and data;
- improve practice and standards.

- Quarterly monitoring meetings should be held to oversee take-up, quality and level of provision.

- Any initiative to target a particular audience should be monitored for effectiveness and to inform future initiatives.

Stimulating changes to health and social care services

The advocacy service should:

- campaign for changes that need to be made to other health and social care services;

- provide feedback about changes which need to be made to other health and social care services;

- encourage communities to express their needs, and work with groups of people, in formal and informal settings, to identify their health concerns and to take appropriate action;

- influence policy and practice in service-providing agencies to make them more user-friendly to vulnerable groups.

Providing support to a specific care group

You may want to design and tailor your standards to take into account the specific needs of your care group. In order to determine whether you need to do this, you need to consider:

- whether there are any relevant care group issues not covered by the standards;

- any specific legislation and government guidance for your care group for which unique standards are needed;

- key areas your standards should cover.

Once you have identified particular standards for a specific care group, you will need to discuss them with a local group of representative users and professionals to consider their relevance and any changes required before adopting them.

Appendix 3 identifies some existing standards for mental health service users and children, which have been developed through a process of consultation.

The standards for advocacy providers could form the basis of:

- quality assurance systems

- contracts

- service level agreements

- job descriptions and person specifications

- training policies

- engagement protocols/working agreements with health care providers.

What standards should commissioners work to when funding advocacy?

The standards for commissioners are separated into core and aspirational standards. The core standards identify standards which commissioners should be using on a day-to-day basis. Commissioners undertaking joint commissioning in particular should be working towards the aspirational standards.

When developing advocacy services, commissioners should base their actions on a systematic identification of the local need for the service, and should put in place mechanisms for monitoring and evaluation of the development and delivery of the service. The possibility of widening service provision across primary and community settings should be considered, and efforts made to ensure that a seamless service is provided across primary/community and secondary care settings.

Given the complex nature of user needs and the likelihood that advocates will need to operate across service boundaries, collaborative commissioning and joint funding options are useful strategies to reduce the financial burden on a single agency. Contractual agreements and service specifications for the service should reflect an overall framework for equal opportunities for minority populations.[15]

The ideal vision which commissioners or funders should be trying to achieve in a locality or borough is set out below.

- The commissioning and funding of advocacy for BME groups is brought into the mainstream, so that all commissioning of general services considers whether advocacy is required.

- A strategy is in place for commissioning advocacy.

- A flexible person-centred approach is used, which empowers individuals and care groups to have greater influence over the way their needs are met.

- Education packages on advocacy are included in joint training programmes for NHS and local authority staff.

- A comprehensive range of advocacy is offered, to reflect the differing and changing needs of vulnerable people.

- A partnership approach is used, addressing any cross-boundary issues.

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[15] Marsha Sanders, 2000

- The service builds on the strengths of existing jointly funded independent advocacy projects, and recognises and supports the wider provision of advocacy services.

- There is a managed network of advocacy services, which builds on existing structures and encourages shared training, recruitment and resources.

- All commissioners work to the core standards for commissioners when commissioning and funding advocacy services.

- All commissioners encourage the recording of unmet need.

Core standards

All funders and commissioners should:

- support and fund user consultation and feedback;

- seek to support and develop continuity of funding with other partnership bodies;

- assess costs and allow time and resources for organisations to carry out training, monitoring and evaluation;

- encourage and recognise the value of the wider campaigning role of advocacy organisations;

- recognise that advocacy can be very time consuming and each case is unique, so time limits for 'advocacy interventions' are unhelpful;

- recognise legal requirements,[16] assess their implications for funding and development of advocacy, and allocate funding to fulfil the statutory and legal obligations (for health authorities, primary care trusts and SCSDs);

- assess the impact of asylum and immigration on local services and support mechanisms and recognise that local organisations supporting these groups may be undertaking a higher volume of work;

- develop clear criteria/specifications for funding advocacy services, in order to provide a seamless service [regarding the scope (e.g. information giving, one-to-one support and practical assistance, campaigning activities, encouraging user feedback on services) and the intra-agency boundaries (e.g. health, housing, benefits, social services) of advocacy activities].[17]

[16] *Valuing People: A new strategy for Learning Disabilities for the 21st Century;* Section 12 (5) of the Health and Social Care Act (2001); Reforming the Mental Health Act White Paper (2001); Asylum Bill; Race Relations Amendment Act; Human Rights Act.

[17] Our research showed that most users want a seamless service and some services may not have a similar advocate to whom a client/user can be transferred.

Aspirational standards

Funders and commissioners should seek to:

- support the infrastructure development of organisations;

- support wider advocacy developments, such as the need to make accredited training more accessible to local communities and to develop career pathways for advocates within local health economies;

- influence advocacy policy and practice developments.

These standards could form the basis of:

- departmental contracting guidelines for commissioning any advocacy service

- contracts

- service level agreements

Stage 6: Monitoring and evaluating advocacy

Effective monitoring and evaluation should inform all service development and commissioning processes and decisions. This section offers tried and tested approaches that services currently use and brings together the ideas of advocacy providers and commissioners on how they would like to see this area developed. The approaches covered are:

- user evaluation

- peer evaluation

- stakeholder evaluation

- independent/external evaluation

- commissioner monitoring and evaluation
    - static monitoring and evaluation
    - dynamic monitoring and evaluation

User monitoring and evaluation is often seen as difficult: it is argued that many users may not know or be able to express what they want, or have any concept of what a good service might be. However, having user feedback is an important principle, which should be integral to all monitoring and evaluation.

Our research and fieldwork highlighted a number of ways in which user experiences have been used to monitor and evaluate services: for instance, by inviting funders to an afternoon of 'story telling' by users; attending specific focus group sessions to listen to users; attending organised user group meetings; using real 'case study' examples in reports to illustrate issues; and conducting user satisfaction/feedback surveys.

Many providers were enthusiastic about **peer evaluations,** as they offer a way for voluntary organisations to be monitored and reviewed by people who have a good understanding of the issues they face. Henderson and Pochin[18] comment that peer evaluations are increasingly being piloted within the field of advocacy.

Stakeholder evaluation can be integrated into any evaluation methodology and ensures that the views of all key individuals involved in the service are taken on board, such as the views of health professionals.

Independent monitoring and evaluation is also viewed as the way forward by a number of projects; they see the benefits in terms of good practice, equity,

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[18] Henderson, R. and Pochin, M. *A right result? advocacy, justice and empowerment,* Policy Press, 2001

fairness and as a safeguard against malpractice, such as unjustified funding cuts. For example, Advocacy 2000, in its *Guide for Commissioners,* recommends that all commissioners and groups invest in regular independent evaluation. It recommends that external evaluation should only begin once a project has been running for 3 years and that thereafter at least £2,500–£4,000 should be set aside for this purpose on a three-year cycle.

Static monitoring and evaluation presents a snapshot of what an advocacy project is doing and offers insights into both the *process* and the *outcomes* of advocacy interventions. This picture is usually built up in terms of quantitative (measurable) and qualitative (things which can't be measured, like feelings, attitudes and opinions) information, which a project collects. This could include such information as: who uses the service; which parts of the service people are using; where people are referred from; the amount of time it has taken to work with one client; what people like and don't like about the service; and what action the project takes.

It provides answers to questions such as the following.

- Which group of clients is not using the service?
- Which services are used most?
- Do we have enough staff to undertake different activities?
- Which advocacy activity do our clients find most helpful?
- What don't clients like about the service we provide?
- What are the information needs of our clients?

Dynamic monitoring and evaluation happens when evaluators and funders/commissioners analyse the information which has been collected and use it to try to bring about change. This process again offers insights into both the *process* and the *outcomes* of advocacy interventions.

An example of this approach would involve a funder working with an organisation to solve problems that are being experienced or that have been brought to their attention.

Below are some examples of questions which users, providers and commissioners could ask, whatever process of monitoring and evaluation is used.

	User	**Provider**	**Commissioner or funder**
Assessing the need for a service	Who can help me find out how the system works? Is there a service locally where I can get help with a complaint or filling in my benefits form? Do staff providing the local service understand my religion, culture and needs as a woman?	What types of information do our users/clients want? What types of advocacy activity do users need?	What is the size and composition of my local BME population? What do we know about the health and social care needs of our local BME population? Do we feel confident that the access needs of our local BME population are being met?
Impact of service	Do staff listen to me and understand my needs? Do staff help me to solve my problem?	Which aspects of our services do users like? Which don't they like? Do users feel that they have more knowledge about and understand their rights? Do users feel more able to approach and use services for themselves?	What are the health and social care outcomes for users? How many people use the service and which parts of the service do they use? What are the levels of unmet need and in which areas?
Organisational capacity to deliver a service	Can I get the service when I need it? Can I get a female Somali-speaking advocate when I want one? If the service can't help me, do they tell me where I can get help?	Do we have enough staff and volunteers to deliver our service? Who is using our service and who is not using it? What types of advocacy activity do we spend most of our time on? What would we like to do that we can't?	How does the organisation record what it does? Does the organisation have an equal opportunities policy or statement and how does it use it?

Appendix 1: Health and social care advocacy

The role of the advocate (who provides health and social care advocacy) is to inform, empower and represent the interests of the service user to improve access to health and social care services, and to improve health and social care outcomes.[19] Advocates help patients and their families make decisions about care and work with health and social care professionals to develop more appropriate and sensitive services. Advocacy sees things from the service user's perspective and recognises that the user or patient is often in an unequal power relationship with the service provider.

The role of the interpreter is recognisably different from that of an advocate, as an interpreter is paid to be impartial and communicate a message between professionals and users.[20]

Advocacy can take place in many settings: in day centres, hostels, hospitals, GP surgeries, community health services, community agencies, advice centres and other voluntary organisations.

Advocates who work in these settings may be **paid** or **unpaid. Health and social care advocacy** includes some of the following activities:

- helping people to say what their needs and problems are;

- helping people to obtain their rights to health and social care from GPs, hospitals, hospices, mental health services, social services, housing offices, dentists, health visitors, community nursing services and so on;

- representing a person's interests to any agency or individual in the health and social care system;

- ensuring that people obtain the services and practical support they need to ensure they or their dependants receive the services they need.

As an organisation, you may facilitate or provide one or more of the following advocacy models:

- Self-advocacy: speaking up for oneself and making one's views or wishes clear

- Group advocacy: a group with similar experiences meets together to put forward shared views

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[19] Silkap, *Making advocacy work in Westminster: a resource pack for service providers and commissioners*, May 2001

[20] In practice, however, interpreters often act as unofficial advocates.

- Peer advocacy: support from someone with experience of using a particular service

- Formal, professional or paid advocacy: advocates are trained and paid. The focus tends to be on short-term or crisis work

- Citizen advocacy: matches people with partners who are members of their local community, with a view to building long-term, supportive relationships

- Legal advocacy: people with specialist knowledge and training, such as lawyers and advice workers, represent people in formal settings such as courts, tribunals or complaints processes

- Best interests (non-instructed) advocacy: the advocate represents what he or she feels the person's wishes would be if they were able to express them.[21]

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[21] Nancy Kelley, *The Mind Guide to Advocacy*, Mind Publications, 2000

Appendix 2: Implications of the NHS Plan for BMEC

The NHS Plan[22] aims to redesign services 'around the needs of the patient,' a policy that will require service delivery to recognise diverse needs and respond to specific individual requirements. The Plan explicitly recognises that ethnicity can be a key factor in health inequalities and commits the NHS to tackling health inequalities for minority ethnic groups. A report from the National Ethnic Health Projects Coordinator identifies the implications of some of the key tenets of the Plan.[23]

Partnership: To develop relevant and appropriate service responses it is essential to work with community groups and voluntary organisations representing the interests of BME groups. The NHS and social care services need to learn from the many local service responses and projects initiated by BME communities to meet their needs.

Performance: All service delivery should be monitored for fairness in service uptake. This should include mandatory ethnic monitoring in primary care, integrated with the development of electronic patient and health records. Basic service standards should include standards for cultural competence.

Professions: The Vital Connection establishes an equalities framework for the NHS workforce and should be implemented alongside measures to tackle racial harassment. Access to all professions should be monitored and measures taken where recruitment is skewed (e.g. the therapy professions). Initiatives need to be taken to improve fairness in recruitment, promotion and reward.

Patient care – access: Services must be delivered in a culturally appropriate way. This includes paying attention to religious practices and festivals (e.g. fasting times and death customs); the implications of dietary customs (e.g. in drug delivery mechanisms); and proper nutrition for in-patients. Specific issues around access to services may include: access at a primary care level and timely and appropriate referral to secondary care; recognising that assessment procedures may be Eurocentric, resulting in misdiagnosis and inappropriate care; and recognising that staff may not have the appropriate skills, knowledge and expertise to provide culturally sensitive services. There should be equity of access to differing care packages in accordance with identified need, appropriate to specific cultural, linguistic and religious circumstances. Resource decisions should take into account issues such as the availability of trained bilingual

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[22] Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, Stationary Office, July 2000
http://www.nhs.uk/nationalplan/contentspdf.htm
[23] Su Kingsley, The NHS Plan: addressing equalities in the patient centred NHS, September 2000

support staff. Inadequate ethnic monitoring may result in problems tracking patients' care pathways, including the outcomes and clinical effectiveness of assessments and care packages.

Patient care – empowerment: Properly trained health interpreters and advocates should be available for all consultations where English is not the patient's preferred language, and other health staff should be trained to work with advocates.

Prevention: Black and minority ethnic groups have different levels of morbidity and mortality for various conditions, and may also be subject to effects due to the impact of wider socio-economic factors. Health and social care services, in their efforts to tackle health inequalities, must develop appropriate interventions for health promotion and prevention that are designed to be acceptable to, and supportive of, people with diverse lifestyles.

The NHS Plan identifies ten core principles, and states that these principles must be read as applying to the whole of the population. Su Kingsley suggests that if the principles are enacted with an equalities perspective then the NHS may be expected to:

- Provide a universal service for all based on clinical need, giving equal status to minority groups in the design and delivery of services.

- Provide a comprehensive range of services, taking into account specific conditions such as high demand for sickle cell services among ethnic minority patients.

- Shape its services around the needs and preferences of individual patients, families and their carers, meeting cultural competence standards to address fully the needs of minority ethnic groups. The NHS needs to involve these groups actively in the critical review and re-design of services to ensure their needs are met.

- Respond to different needs of different populations, e.g. providing appropriate maternity services as part of routine service design.

- Work continuously to improve quality services and to minimise errors. Services for BME groups will respect and address cultural and religious requirements within assessment procedures and care pathways and provide support for communication – interpretation, translation and advocacy – where needed.

- Support and value staff, demonstrating zero tolerance for racial and other harassment of staff. Procedures for recruitment, development and promotion should be demonstrably fair and encourage BME staff to develop their careers within the NHS.

- Devote public funds for healthcare exclusively to NHS patients.

- Work together with others to ensure a seamless service for patients.

- Give greater recognition of the role of the BME voluntary sector in service provision.

- Develop health promotion and address health inequalities, including targeted and appropriate interventions which meet minority ethnic needs in culturally sensitive ways.

- Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance through appropriate media and language. Interpreting services should establish standards for patients' confidentiality.

The Plan's objective of refocusing services with the patient at the centre requires respect for every patient's ethnic, cultural and religious background. In this light:

- Advice to enable people to take care of themselves and their families will need to respect cultural and religious differences and preferences.

- Electronic patient records which include ethnicity will provide a single point for recording important patient profiling information, enabling better care and access to culturally appropriate services.

- Health interpreters and advocates based in GP practices will be able to support the whole team working from the same base.

- Intermediate care services will need to provide for the needs of all patients, including those from minority ethnic groups, respecting the full range of cultural and religious practices.

- NHS standards should include sections on cultural competence, with a common means of assessing this, including patient and user surveys.

Some specific opportunities to ensure that black and minority ethnic populations' needs are addressed include:

- NHS facilities – improvement to primary care premises should be targeted towards inner-city and deprived areas where there are often high minority ethnic populations. New standards for diet and nutrition must pay attention to cultural and religious requirements; the national franchise and local delivery contracts need to ensure that the local population needs are included in specifications.

- Availability of NHS staff – minority ethnic applicants need to be encouraged to enter training in clinical professions, and anti-discrimination and harassment policies must be in place and be observed.

- Information and patient involvement – ethnic monitoring data collection needs to be improved to facilitate monitoring of waiting times by ethnicity, to measure access. PALS, while not replacing the need for culturally sensitive health advocates, should demonstrate cultural competence, and should recognise

and respond appropriately to language, cultural and religious needs in patients. Patient surveys should be available in formats appropriate to the local community, taking into account literacy levels and relevant languages, and allowing interviewers to gather information from patients who are not literate. Patient forums and local advisory forums should include BMEC membership, with the possibility of local capacity building in voluntary and community organisations to enable engagement where necessary. Local government scrutiny could bring the NHS more into contact with good practice in local government regarding the application of equal opportunities frameworks in employment and service delivery.

- External relations – the 'concordat' with the independent sector will require capacity building in the BME voluntary sector to enable BME organisations and providers to participate on an equal footing.

- Equalities – national targets will need to be interpreted locally with regard to inequalities experienced by BME groups; specific targets should be set and monitored. NHS Direct will provide a national translation and interpretation service. Hospital nutrition policies need to address cultural and religious needs.

- Clinical priorities – investment in coronary heart disease and mental health should recognise and benefit black and minority ethnic groups at higher risk of disease, with proper monitoring and prevention efforts. Particular problems of access for older BME populations must be addressed.[24]

- Systems – PCG/Ts should have an understanding of the needs of their whole local population, including BME groups. Ethnic monitoring needs to be improved in both primary and secondary care to deliver 'fair access'. Protocols and guidelines should include attention to their application to BME groups especially where patterns of health/illness differ, while the Performance Assessment Framework should include cultural competence as a baseline requirement. The Vital Connection diversity aims could be used to inform the criteria for pilots to test the feasibility of 'team bonus' systems in NHS Trusts. The Modernisation Board should reflect diversity in membership and include equality in its remit, as should all task forces, while the appointments commission should have diversity targets. Criteria for joint inspection between health and social services should include a quality and diversity dimension.

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[24] Su Kingsley, National Ethnic Health Projects Co-ordinator, September 2000

Appendix 3

Advocacy standards for mental health service users[25]

- Listen to the individual client and their perceptions of the underlying problems and solutions to their particular situation.

- Ensure that alternative treatments are known about, respected and made available, recognising that for many Black people these therapies are 'mainstream'.

- Learn which practitioners are aware of the issues and the full range of relevant therapies to ensure people's needs are met more effectively. Ensure that the needs of women and their dependents are catered for, and where fostering is necessary, this should be cultivated from within the community, rather than placing children in care.

- Develop holistic individual care plans, recognising the need to address not only people's psychological needs, but also spiritual, general health and social needs.

Advocacy standards for children[26]

- The service should assist children and young people in identifying and claiming their legal rights (including referring them on to appropriate experts). It should promote the human rights of children and young people as upheld by the UN Convention on the Rights of the Child and other international treaties, rules and standards.

- The advocacy service and all those working for it should be explicitly committed to implementing the rights of all children.

- Those providing direct advocacy should have sufficient understanding of children's legal rights to able to identify when the child might be able to claim a right.

- The service should seek to contribute to improving laws, policies and services for children collectively.

- The service should ensure that 'best interest' is defined by the child and not mediated by any other party.

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[25] MIND Standards
[26] Standards agreed by all providers in the Children's advocacy Consortium

Appendix 4: Where to get support and help

Citizen Advocacy Information and Training

162 Lee Valley Technopark

Ashley Road

London N17 9LN

Tel / Minicom: 020 8880 4545

Fax 020 8880 4113

Email: cait@teleregion.co.uk

Website: www.leevalley.co.uk/cait

CAIT is not a local agency but it is a useful resource to know about. It provides training on a range of advocacy tropics relevant to practitioners in the health and social care sector, as well as useful publications. CAIT also hosts a network of advocacy groups which work within the learning disabilities field.

Advocacy Across London

PO Box 31856

Lorrimore Square

London Se17 3XR

Tel / Minicom: 020 7820 7868

Fax 020 7820 9947

Email: karen.aal@btopenworld.com

Website: http://www.btinternet.com/~advocacyacrosslondon/index2.html

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