Equalities Screening Record Form

Date of Screening: January 2016	**Directorate:** **ADULT SOCIAL CARE, HEALTH & HOUSING**	**Section:** **Adults and Joint Commissioning**
1. Activity to be assessed	Updating the Advocacy Joint Commissioning Strategy for Bracknell Forest	
2. What is the activity?	☒ Policy/strategy ☐ Function/procedure ☐ Project ☐ Review ☐ Service ☐ Organisational change	
3. Is it a new or existing activity?	☐ New ☒ Existing	
4. Officer responsible for the screening	TBC	
5. Who are the members of the EIA team?	Hannah Doherty, Head of Learning Disabilities Lynne Lidster, Head of Joint Commissioning Reuben Colton, Joint Commissioning Officer	
6. What is the purpose of the activity?	The Advocacy Joint Commissioning Strategy is being updated to reflect recent legislative changes that affect the commissioning and provision of statutory advocacy, as well as taking into account changes in policy, practice and the needs of local residents. It will cover the strategic direction and local priorities for commissioning advocacy services in Bracknell Forest from 2016-2021.	
7. Who is the activity designed to benefit/target?	People who are eligible for advocacy services, including statutory advocacy defined in legislation such as: • Local Government and Public Involvement in Health Act 2007 as amended by section 185 of the Health and Social Care Act 2012 • Part 10 of the Mental Health Act 1983 as amended by section 30 of the Mental Health Act 2007 and section 43 of the Health and Social Care Act 2012 • Sections 35 and 36 of The Mental Capacity Act 2005 • Sections 67 and 68 of the Care Act 2014 This will include, for example: • People who access local health services	

	• People with care and support needs, which includes people with a range of disabilities and health conditions • People with mental health needs • People who don't have the mental capacity to make some decisions

<table>
<tr><th>Protected Characteristics</th><th colspan="2">Please tick
yes or no</th><th>Is there an impact?</th><th>What evidence do you have to support this?
E.g equality monitoring data, consultation results, customer satisfaction information etc. Please add a narrative to justify your claims around impacts and describe the analysis and interpretation of evidence to support your conclusion as this will inform members' decision making, include consultation results/satisfaction information/equality monitoring data.</th></tr>
<tr><td>8. Disability Equality</td><td>Y
☑</td><td>N</td><td>Yes.
The impact is expected to be positive.</td><td>The estimated number of people with particular health conditions and disabilities in the local area is:
<table>
<tr><th>Disability or health condition</th><th>Number of people</th></tr>
<tr><td>Learning disability</td><td>2176</td></tr>
<tr><td>Autism</td><td>911</td></tr>
<tr><td>Common mental disorder (18-64)</td><td>12088</td></tr>
<tr><td>Psychotic disorder (18-64)</td><td>300</td></tr>
<tr><td>Dual sensory need</td><td>596</td></tr>
<tr><td>Hearing support needs (moderate or severe)</td><td>9922</td></tr>
<tr><td>Visual support needs (some level of sight loss/VI)</td><td>1950</td></tr>
<tr><td>Limiting long-term illness (65+)</td><td>7369</td></tr>
<tr><td>Dementia</td><td>1188</td></tr>
<tr><td>Physical disability (moderate or severe, aged 18-64)</td><td>7574</td></tr>
<tr><td>Older people (65+)</td><td>17000</td></tr>
</table></td></tr>
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				As some types of advocacy are only available for people in specific situations or with particular needs, these people are more likely to use and benefit from advocacy services. This includes people with mental ill health, learning disabilities, dementia, care and support needs, and a range of other disabilities or health conditions. For example, Independent Mental Health Advocacy (IMHA) is for people with mental health needs detained under the Mental Health Act and in select other situations. Similarly, Independent Mental Capacity Advocacy (IMCA) is for people who don't have the mental capacity to make specific decisions. People with learning disabilities, dementia and mental ill health are most likely to use IMCA services Additionally, combined data from two separate surveys estimated how many advocacy providers supported particular groups as: • 55% provided advocacy for people with mental health conditions • 55% provided advocacy for people with learning disabilities • 47% provided advocacy for older people • 43% provided advocacy for people with dementia The other most commonly supported groups included people with physical or sensory impairments, people from a Black or Minority Ethnic (BME) background, carers and young people. The strategy has been developed in response to national and local policy as well as feedback from people who have used advocacy services, or may need to use them in the future. The primary aims of advocacy include helping people to understand and secure their rights, representing their interests and helping them access the support they need. For some time, advocacy has been recognised as promoting equality, social inclusion and social justice. Consequently, the development of the advocacy joint commissioning strategy will have a positive equality impact on people who are most likely to access advocacy, including people with a range of disabilities.
9. Racial equality	Y ☑	N	Yes. The impact is	The 2011 Census shows that the majority of the population in Bracknell Forest describes themselves as White British/English/Welsh/Scottish/ Northern Irish (84.9%) followed by Asian/Asian British (5%), then other white

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			expected to be positive.	(4.8%), mixed (2%), Black African/Caribbean/Black British (1.9%), white Irish (0.9%) and finally other ethnic group (0.4)%. Equalities monitoring data from the local independent advocacy service for the first 9 months of 2015 showed that the demographic profile of referrals broadly matches the profile of Bracknell Forest. Although, there are slightly lower referral levels for the Asian British/Indian/Bangladeshi and the Black British or Black Caribbean/African populations that would be expected, and slightly higher levels of some other groups, such as White British. It should be noted that this is a single 9 month sample, and there is not sufficient data from other services to draw conclusions. National data also shows lower than expected referrals from the Asian/Asian British population to another type of advocacy, Independent Mental Capacity Advocacy. It has been suggested that there may be cultural reasons for this. Some evidence also suggests that the prevalence of learning disabilities among people of South Asian background is up to three times higher than in majority communities in the UK, indicating that they may benefit from advocacy. Local research highlighted communication as one of three priorities to be addressed to improve access to all services for the local Nepalese community and advocacy could enable the overcoming of cultural barriers and bring about earlier intervention and prevention by involving these people in the determination of their support needs. There is also some emerging data from NHS Complaints advocacy services to suggest that people in travelling communities benefit from advocacy support and there are no reasons to suggest that this would not be applicable to all areas of advocacy provision. CQC's annual report into use of the Mental Health Act in 2014-15 notes that it has been widely known for many years that people from certain backgrounds are more likely to be detained under the Mental Health Act, and therefore also need IMHA. Nationally, compulsory admission rates for black people are almost three times greater than those for white patients. The MHA annual report explains that the reasons for this are still unknown. All local advocacy services are available to anyone who is eligible, regardless of race, ethnicity or background. The development of the advocacy joint commissioning strategy aims to ensure high quality advocacy is available to people based on need and eligibility. This will help people from the groups above to speak up about their views, needs and choices and thus help eliminate discrimination and promote equality of opportunity for people with this

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				protected characteristic.
10. Gender equality	Y ☑	N	Yes. The impact is expected to be positive.	The prevalence of different disabilities, illnesses or circumstances that might make someone more likely to need advocacy varies by gender. For example, men are more likely to have a learning disability or autism than women. In contrast, women are more likely to have dementia. Research published in the journal *Psychological Medicine* in 2014 found that being female was one of the factors that made it more likely for someone to be detained under the Mental Health Act, meaning females are more likely to need IMHA. This gender balance is mirrored in equalities monitoring data for the local IMHA service. However, the gender balance is roughly equal when the different types of advocacy are considered together. The 2013/14 national report on IMCA noted equal numbers of males and females accessing this type of advocacy. Results from the consultation around the development of the strategy showed that both genders have similar views, with few exceptions, about the importance of different types of advocacy, where advocacy should be available, and what makes a good service. All local advocacy services are available to anyone who is eligible, regardless of gender. The development of the advocacy joint commissioning strategy aims to ensure high quality advocacy is available to people based on need and eligibility. This will help both genders to speak up about their views, needs and choices and thus help eliminate discrimination and promote equality of opportunity for people with this protected characteristic.
11. Sexual orientation equality	Y ☑	N	Yes. The impact is expected to be positive.	No evidence could be found that people are more or less likely to need advocacy based on sexual orientation alone. However, nationally it is recognised that LGB&T people sometimes face discrimination and poor service, and may therefore benefit particularly from access to advocacy if they are eligible. Local monitoring data shows there is hesitancy and difficulty in recording data on sexual orientation. A report from the Equality and Human Rights Commission noted that low proportions of advocacy services record sexual orientation. Priorities in the strategy will include improved monitoring by service providers. Providers are expected to monitor demographic information for everyone who uses their service, including sexual orientation in line with recommendations in the LGB&T Partnership ASCOF companion.

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				All local advocacy services are available to anyone who is eligible, regardless of sexual orientation. The development of the advocacy joint commissioning strategy aims to ensure high quality advocacy is available to people based on need and eligibility. This will help people of all sexual orientations to speak up about their views, needs and choices and thus help eliminate discrimination and promote equality of opportunity for people with this protected characteristic.
12. Gender re-assignment	Y ☑	N	Yes. The impact is expected to be positive.	No evidence could be found that people are more or less likely to need advocacy based on gender re-assignment alone. However, nationally it is recognised that people undertaking, or who have been through, gender reassignment sometimes face discrimination and poor service. They may therefore benefit particularly from access to advocacy if they are eligible. Attitudes are changing, however, and recent (2015) research by the Tavistock and Portman Clinic in London says that NHS referrals of support for transgendered people has increased four fold to nearly 450 people in 2013/14 from 2009/2010. This is a complex clinical and psychological area and an increase in numbers requiring advocacy should be expected over time. There are no local equalities monitoring data from advocacy services about gender re-assignment. The Equality and Human Rights Commission noted that low proportions of advocacy services record whether people accessing their services are transgender. Priorities in the strategy will include improved monitoring by service providers. Providers are expected to monitor demographic information for everyone who uses their service, taking into account the recommendations in the LGB&T Partnership ASCOF companion. All local advocacy services are available to anyone who is eligible, regardless of gender re-assignment. The development of the advocacy joint commissioning strategy aims to ensure high quality advocacy is available to people based on need and eligibility. This will help transgender people to speak up about their views, needs and choices and thus help eliminate discrimination and promote equality of opportunity for people with this protected characteristic.
13. Age equality	Y ☑	N	Yes. The impact is expected to	Age is the most significant risk factor for dementia, and dementia is one of the main reasons people need IMCA. It is also a common reason why people may need most other types of advocacy except for IMHA. Eligibility for some types of advocacy is also restrictive based on age. For example, Independent Mental Capacity Advocacy (IMCA) is only available to people aged 16 and over who lack mental capacity. The most recent IMCA national

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			be positive.	report in 2013/14 People from a wide range of ages responded to the advocacy strategy consultation, from 18-34 up to age 80+. Notably, the 80+ age group had the lowest number of people who said they had used advocacy in the past. It was also the only group in which more people reported not having used advocacy than had used it. However, monitoring data indicates that older people are accessing some local advocacy services, so improved monitoring is required. For example, data from NHS complaints advocacy showed that 43% of people accessing the service were aged 65 or over. IMHA was not considered as age is not a determining factor in Mental Health Act detentions, and data was not available for the other two types of statutory advocacy. Other than specific eligibility requirements that are defined in legislation or national guidance, all local advocacy services are available to anyone, regardless of age. The development of the advocacy joint commissioning strategy aims to ensure high quality advocacy is available to people based on need and eligibility. This will help people of all ages to speak up about their views, needs and choices and thus help eliminate discrimination and promote equality of opportunity for people with this protected characteristic.
14. Religion and belief equality	Y	N	Neutral impact is expected.	No evidence could be found to suggest an adverse or positive impact based on religion or belief alone.
15. Pregnancy and maternity equality	Y	N	Neutral impact is expected.	No evidence could be found to suggest an adverse or positive impact based on pregnancy or maternity alone.
16. Marriage and civil partnership equality	Y	N	Neutral impacted is expected.	No evidence could be found to suggest an adverse or positive impact based on marriage or civil partnership alone.
17. Please give details of any other potential impacts on any other group (e.g. those on lower incomes/carer's/ex-offenders) and on				**Drug and alcohol mis-users** Yes. The impact is expected to be positive. There is a close link between drug or alcohol mis-use and mental

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promoting good community relations.			illness, and these people are therefore more likely to benefit from advocacy. **Carers** Yes, the impact is expected to be positive because carers now have a statutory right to advocacy under the Care Act. The strategy has been updated to reflect this change in legislative context, and services will be commissioned in line with this. The 2011 census showed that there were approximately 9600 carers in the local area. **People on lower incomes** Neutral impact is expected. No evidence could be found to suggest an adverse or positive impact based on low income alone.
18. If an adverse/negative impact has been identified can it be justified on grounds of promoting equality of opportunity for one group or for any other reason?			No adverse impacts have been identified.
19. If there is any difference in the impact of the activity when considered for each of the equality groups listed in 8 – 14 above; how significant is the difference in terms of its nature and the number of people likely to be affected?			Some types of advocacy are available to anyone, such as NHS complaints advocacy. Anyone who is eligible for the other types of advocacy can benefit from it, irrespective of any protected characteristics. People with a range of different disabilities, health conditions and specific circumstances will be positively affected. Please see above for the numbers of people potentially positively affected.
20. Could the impact constitute unlawful discrimination in relation to any of the Equality Duties?		No.	No adverse impacts have been identified.

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21. What further information or data is required to better understand the impact? Where and how can that information be obtained?			The strategy defines several priorities and a detailed action plan will be drawn up from these priorities. Actions will include developments around the measurement, monitoring, and analysis of service performance, to help improve understanding of the need for and impact of advocacy and any potential inequities. Improvements to the recording of equalities monitoring information will be an integral part of this.
22. On the basis of sections 7 – 17 above is a full impact assessment required?	Y	N X	

23. If a full impact assessment is not required; what actions will you take to reduce or remove any potential differential/adverse impact, to further promote equality of opportunity through this activity or to obtain further information or data? Please complete the action plan in full, adding more rows as needed.

Action	Timescale	Person Responsible	Milestone/Success Criteria
Key Performance Indicators (KPIs) will include equalities monitoring information to help measure and monitor for any potential inequalities across groups with protected characteristics.	Quarterly	JCOs/Contracts Team	Comprehensive equalities monitoring information will be included in regular monitoring reports for all advocacy services.
Services will follow recognised standards, such as the advocacy Quality Performance Mark (QPM), to ensure they are accessible and tailored to the needs of disabled and older people, and other groups with protected characteristics.	2016	JCOs/Contracts Team	The requirement will have been included in service specifications and/or service providers will provide evidence to commissioning organisations that they meet the agreed standard(s).
24. Which service, business or work plan will these actions be included in?	• The action plan that will be developed based on the strategy • Service specifications		
25. Please list the current actions undertaken to advance	Redefining service specifications		

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equality or examples of good practice identified as part of the screening?			Improvements to monitoring information about protected characteristics from advocacy providers. Consultation included a range of ways to give feedback including a questionnaire online, on paper, in large print, in easy-read, and with the support of staff from local services such as advocacy and learning disability services.
26. Chief Officer's signature			Signature: **Zoe to complete** Date:
27. Which PMR will this screening be reported in?			**Zoe to complete?**

When complete please send to abby.thomas@bracknell-forest.gov.uk for publication on the Council's website.