

Newcastle Advocacy Centre A Project Of NCVS



Black and Minority Ethnic Case Advocacy Pilot Project

An Evaluation Report Executive Summary

Jill Remnant
April 2008



This report is an independent evaluation of the Black and Minority Ethnic (BME) Case Advocacy project based in Newcastle Advocacy Centre, Newcastle Council for Voluntary Service (NCVS).

The project was established as a pilot in June 2005 and was funded by the BIG Lottery Foundation for three years. The current funding ends in June 2008. The evaluation will help us develop the project in the future.

The current project provides case advocacy around health and social care issues to four BME communities.

Jill Remnant (an independent consultant, previously employed by the North East Strategic Health Authority) undertook an external evaluation of the project from September 2007 to January 2008. Jill can be contacted by email on: jillremnant@googlemail.com

We very much appreciate the effort, time (over and above our original requirements!) enthusiasm and energy that Jill Remnant brought to this evaluation – thank you Jill.

We have produced both a full report and an executive summary of this report, you can download copies of the report from our website www.csvnewcastle.org.uk/projects/advocacy/advocacy.htm

Or you can contact the project for printed copies.

1 Executive Summary

The evaluation was commissioned in August 2007 and was required to cover

- An analysis of user and other stakeholder views;
- A review of how this project fits with other services for this group in the city;
- An analysis of the project model;
- Recommendations about improvements to service.

Stakeholders (17) were identified and semi structured interviews conducted. Work was done with the advisory group to develop an outcome logic model and identify future development opportunities. Three other projects providing health and social care advocacy to BME clients were contacted. Five project clients were interviewed using interpreters to gain insight into their experience of the project and the outcomes they felt had been achieved for them. A variety of resources relating to the provision of health and social care advocacy to BME communities were examined.

A number of strengths of this project were identified including:

1 Extensive preparatory work (see section 6)

- undertaken prior to producing a bid for funding, including seeking community views, establishing what services existed, exploring different operational models and engaging with stakeholders about which model would best fit the circumstances in Newcastle.

2 Existence of diverse and engaged advisory group (see section 7.2)

- membership includes some of the most knowledgeable people in the city about the needs of BME communities in general and asylum seekers and refugees in particular.

3 An effective operational model (see section 7.3)

- that works in practice, particularly the relationship with the Newcastle Interpreting Service. It has been continuously developing and now has the effective relationships, capacity with bilingual advocates and support from the advisory group to really make an impact.

4 Delivery of the outcomes agreed with its funding body (see section 8)

- it has made a difference to the lives of the project clients and has in my view, significant potential to really influence practice within health and social care services.

The stakeholders were very consistent in believing the need for the project remains high, and there is not another organisation providing similar services. This is an effective and well run project highly valued by local stakeholders and clients of the service. However it is inadequately funded and operates under great pressure, the pace at which the project is currently running is not sustainable in the long term. In my view it has great potential to significantly influence practice within health and social care services as well as improve the lives of individuals. To do this effectively it requires the security of mainstream funding and additional resources. The available evidence shows that health and social care organisations are still not providing equitable services to all members of the community. This project can make a significant contribution to reducing these inequalities if it is adequately funded and resourced to do so.

2 Acknowledgements - I am grateful for the generous contribution of all of those individuals who agreed to speak to me, particularly the five clients of the project.

3 Terminology used - Terms used are generally widely understood but I recognise that other people may have different understandings and preferred terminology.

4 Background - Newcastle Council for Voluntary Service, through its Advocacy Centre, is the host organisation for the Newcastle Black and Minority Ethnic (BME) communities' case advocacy pilot project. They wished to undertake an evaluation of the pilot project to include:

- An analysis of user and other stakeholder views;
- A review of how this project fits with other services for this group in the city;
- An analysis of the project model;
- Recommendations about improvements to service.

The Newcastle BME case advocacy pilot project is coming to the end of a three year funding arrangement with the Big Lottery in June 2008. The evaluation is intended to inform decision making about possible futures for the pilot project as well as providing information to all the relevant stakeholders about how the project is perceived, what improvements can be made in how it is run and how it might be developed in the future.

5 Methodology - Stakeholders were identified by the project and semi structured interviews conducted. The advisory group worked to develop an outcome logic model describing the project and identify future development opportunities. Three other projects providing health and social care advocacy to BME clients were contacted. Five project clients were interviewed using interpreters and a variety of resources relating to the provision of health and social care advocacy to BME communities were examined.

6 Context

The BME community in Newcastle upon Tyne

Newcastle upon Tyne has a relatively small but diverse Black and Minority Ethnic (BME) population. Newcastle City Council's mid year population estimates for 2006 (the latest available) record a total population of 270,500, of which 18,664 (6.9%) are from BME communities. Newcastle Interpreting Service currently provides interpreters in more than forty languages. There were 1498 asylum seekers in Newcastle in November 2007, (the latest available figures). The figure for refugees is unknown but estimated to be between 4,500 and 5,000. Neither of these figures reflects those people who failed their asylum application and choose to remain in Newcastle supporting themselves in the "informal or underground" economy. There is also a significant migrant population in Newcastle that is increasing.

The early development of the project

The origins of the project are the Newcastle Health Action Zone (HAZ) Advocacy and Interpreting subgroup. Over two years activities were undertaken in order to better understand the advocacy needs of local BME communities and existing provision. In 2003 a stakeholder workshop considered possible models and there was overwhelming support for advocacy provided by the existing advocacy service working closely together with the interpreting service.

A proposal application was produced for the Community Fund, (subsequently Big Lottery Fund) but the project had to be scaled back because the funder could not fund at the level of the original costing. This meant a significant reduction in management support; reduction in beneficiaries supported and piloting the service with four communities (two established i.e. Chinese and Bangladeshi and two refugee i.e. Iranian and French speaking Africans).

The need for the project had been established prior to starting. Part of the evaluation was to check whether the needs remained. Without exception all of the local stakeholders interviewed felt that the need for a service in Newcastle that provided BME case advocacy in health and social care remained high, e.g. ***“there are no other resources so the needs are still there. Some communities are not very large but have very high needs and no community workers.”*** My conclusion therefore, is that there is still a high level of need for this project in Newcastle.

7 Implementation

7.1 Breakdown of project beneficiaries

Since the project became operational in June 2005, one hundred and seventeen cases (64 % female) have been managed by the project. The following breakdowns are taken from the monitoring return up to 19th December 2007.

1 Community

Chinese clients 40 (34%); Congolese 28 (24%); Iranian 26 (22%); Bangladeshi 10 (9%) and other 13 (11%). Of these 72 (62 %) required an interpreter, which suggests that these clients might experience particular difficulty in accessing health and social care services.

2 Age

The age profile of clients ranges from 18 years to over 65 years with just over half being between the ages of 26 and 50 years old.

3 Status background

Thirty five of the clients (30%) fall into the category of “failed asylum seekers” placing them amongst the most vulnerable and disadvantaged individuals in Newcastle. They also represent a heavy demand on advocacy time because of the range and extent of their needs. Over 50% of the clients of the project are from the broader group of asylum seekers or refugees.

7.2 The Advisory Group

The Advisory group membership has relevant individuals who are well informed about the needs of the BME community in Newcastle and collectively have a vast experience of providing services to the more vulnerable and disadvantaged. There is a mix of community organisation and health and social care representatives. Many of the stakeholders see this as a key strength of the project: e.g. ***“When a gap in services is identified they proactively follow up on issues and feed them into the advisory group. It is a good advisory group with lots of relevant people involved who use the information in their work.”*** In my opinion the advisory group is an asset to the project in terms of the expertise and intelligence about the particular communities available within it. The members are committed to the project and use information gleaned from it to influence service provision.

7.3 The project operational model

The evaluation considered whether the model used in this project is the most appropriate and made comparisons with other projects elsewhere. Three other projects were contacted and provided information about their services and the way they work. Although the other projects contacted shared some of the strengths of the Newcastle Project, they did not in my view have a model of delivery that is superior to the Newcastle Project.

The Newcastle model has a very clear separation of advocacy and interpreting activities, coupled with a very close working relationship with the Newcastle Interpreting Service. This results in joint training, the sharing of information and protocols and allows each service to promote the other to statutory service providers who do not always understand the distinction. The role of the advisory group described above is another element that makes the Newcastle model so successful.

The project recruits and trains as advocates (accredited by the Open College Network) bilingual members of the target communities. This increases advocacy capacity within those communities and provides some employment opportunities, although this is necessarily limited. The bilingual sessional advocates all receive individual supervision and support managing their case load, e.g. ***“The model is good – advocates have training and supervision; there is confidentiality and trust and the service is respectable. Separation from the community is a strength.”***

7.4 Administration of the project

The project adopted operational policies and procedures of the Advocacy Centre. The coordinator developed a questionnaire evaluation method but experience showed an extremely low response rate. An alternative produced a report for each client listing ten possible outcomes. Some forms examined had insufficient detail to see what the outcomes were. This method does not allow anyone else examining the documents to determine whether or not the goals have been achieved. The Advocacy manager should have an independent monitoring role in project evaluation recognising this has implications for the capacity of the project and particularly the management time available.

It may be timely to conduct a review of the project administrative processes, particularly the recording of cases signposted on to other bodies. Only those taking a considerable time are recorded and this is an understatement of activity.

7.5 The BME project in the context of wider advocacy services.

The Newcastle Advocacy service provides citizen and mental health case advocacy as well as supporting a network. There have been referrals from the BME case advocacy project to the mental health case advocacy project and these are perceived to be more complex because of the very high levels of need of the individuals and the language difficulties. Being part of a wider team of skilled advocates also gives the coordinator access not just to management support and supervision but also peer support from colleagues.

8 Outcomes

8.1 Project Outputs and Outcomes Agreed with the Big Lottery Fund

The following is a list of outputs and outcomes agreed with the funder:

Outputs

- Provide at least 20 advocacy cases in year 1 and 40 in years 2 and 3
- During advocacy cases at least 100 people will be supported in gaining information about their circumstances and learn how to use this.
- Training and awareness raising sessions will be provided – these were about advocacy and to be provided to both BME communities and health and social care professionals.

Outcomes

- Individuals from BME communities will have better access to health and social care services.
- Individuals from BME communities will improve their self confidence and gain increased knowledge about their rights.
- Health and social care professionals will gain a better understanding of non English speaker's needs.

The evaluation found evidence to demonstrate that all of these have been delivered by the pilot project.

8.2 Outcomes for individuals

Evidence about outcomes for individuals is from clients and feedback to local stakeholders from clients of the project.

The five clients of the advocacy project interviewed (2 Chinese, 2 Iranian, 1 French speaking West African; 4 females, 1 male), described some of the outcomes achieved for them:

- Four had been accompanied to hospital appointments
- Two were registered with GPs
- Two received help applying for disability status and/or benefits
- Two received help applying for additional income (one in relation to a child; the other because they were destitute)

- Two received help enrolling to study English
- Two had been helped to get accommodation
- Other areas of help referred to included: booking interpreters for health appointments; finding and communicating with a solicitor; linking to social services;

There may have been other outcomes for these individuals but these were the ones they mentioned. A number of the local stakeholders were able from their own experience to validate outcomes for individuals from the project: e.g. ***“I have had positive feedback from mutual clients e.g. help getting accommodation sorted out and help in accessing Section 4 support.”***

8.3 Outcomes in terms of influencing statutory services:

Some stakeholders have referred to awareness sessions run for health and social care staff by the project that have resulted in referrals. The project has also been successful in influencing on a wider stage and the specific example referred to below demonstrates this. A failed asylum seeker was admitted to mental health services under the Mental Health Act and although provided with an interpreter, she was not provided with the relevant written information in her own language. The advocacy project raised the issue and it was picked up regionally by the “delivering race equality project” and raised nationally. It has resulted in the Department of Health acknowledging that information available in different languages is not currently adequate and the situation is being reviewed.

8.4 Other project outcomes – strategic use of cases studies

Two stakeholders referred positively to the use of anonymised case studies with the advisory group to draw attention to strategic issues arising from case experience. This provides the opportunity for all the advisory group members via their networks to use the case study material in seeking to influence statutory services, e.g. ***“Very effective use of case studies in various forums e.g. issue of not using interpreting support appropriately and a child was removed from an appropriate cultural and language environment.”***

8.5 Other project outcomes - Partnership working

A number of the stakeholders interviewed, referred very positively to the nature of the relationship they had with the BME Advocacy project. This is clearly something that the project invests time and effort to sustain, e.g. ***“We refer in both directions. Yvonne is really good and her referrals are always appropriate, unlike some GP referrals.”***

8.6 Perceived quality of the project

Stakeholders have a real sense of the quality of service the BME case advocacy service provides and many refer to the personal qualities of staff in achieving that. Comments provide evidence of the high esteem in which the staff and the project is held, e.g. ***“One of the success factors of the project is the commitment of Jacqui and Yvonne.”***; ***“I have recommended this service to friends and they have used it.”***; ***“The fact that it is a professional and can keep confidentiality is important.”***

No one had anything negative to say about the project either from personal experience or through comments from their networks, colleagues or clients.

9 Discussion

9.1 Understanding of the concept of advocacy

An issue in the literature is the understanding of the concept of advocacy, as well as the distinction between the role of the advocate and the interpreter. Five stakeholders referred particularly to a lack of understanding by health care professionals: e.g. ***“Most health professionals do not understand advocacy and cannot see the difference between advocacy and interpreting.”*** Three of the stakeholders referred to a lack of understanding about advocacy among community members and/or a lack of capacity to self advocate: ***“Some English speaking partners simply do not have the confidence to speak to professionals.”***

The project could further extend its work promoting advocacy by helping health and social care staff understand advocacy and its distinction from interpreting and make appropriate referrals for support. Community support groups also need to understand the nature of advocacy and its availability in Newcastle.

9.2 Advocacy provided within the same cultural context

Another issue in the literature is the desirability of advocates sharing a cultural background with the client. Whilst this might be an ideal, stakeholders felt it was not always possible because of the diversity within communities as well as between them. For some clients there are people within their own communities that they would not feel comfortable with as an advocate because of political, religious or ethnic origin differences.

In order to get a sense of how important this issue is to the clients of the service the clients were asked their views in answer to the question – ***“is the advocate speaking your language important?”***. The responses suggest it is less important than other factors, e.g. ***“It doesn’t matter that she doesn’t speak the same language.”***; ***“Sometimes we use telephone interpreting. The qualities of the person are more important than the language.”***

9.3 Management resource available to the project

The original estimate of management time needed to support and develop the project was set at one day a week but the project was asked to cut the bid. So the funded management time was reduced to half a day a week but ***“this has caused difficulties because it actually takes up a lot of time.”***

This project has benefited throughout its life from a greater level of management time than has been paid for. It has been necessary for the Advocacy Manager to commit about two days a week. Other advocacy services and Newcastle CVS are subsidising the BME case advocacy project. Funding available for interpreting costs was over budget this year and Newcastle CVS provided £7, 000 to allow the work to continue.

The need for additional management time comes from a number of sources; the co-ordinators relative inexperience of this type of work; the inclusion of failed asylum seekers among the targeted communities resulting extremely complex, demanding and emotional cases where she is often the only means of support between a client and destitution and the need to provide the coordinator with appropriate supervision and support; the necessity for the manager to attend meetings and forums where the opportunity to influence arises. More recently there have also been support tasks around the recruitment, selection, training and supervision of bilingual sessional workers.

9.4 Issues facing the project raised by local stakeholders:

Stakeholders identified a number of issues the project faced. Some of these were strategic issues about the survival of the project recognising the risks relating to sustainability of funding and the stretched capacity of the project, and others were operational issues relating to how the project runs. A full list is included in the full report.

10 Conclusions and recommendations

Conclusions:

This is an effective and well run project that delivers the outcomes agreed with its funding body. It has developed during its three year pilot phase and is valued by local stakeholders and clients of the service. It is inadequately funded and operates under great pressure. This is not just related the level of demand and the intensity of some of the cases but to the pressure on the whole advocacy centre because of the time the manager has to commit to the support and development of this project at the expense of the other projects. The pressure forces the project to react to circumstances rather than be proactive. Having said that, there have been benefits to the advocacy centre as a whole in having the BME project along side the other services. ***“The project has affected the other advocacy services in terms of increased cultural awareness and sensitivity to BME issues.*”**

One of the real strengths of this project is the extensive preparatory work that was undertaken prior to producing a bid for funding. This included seeking the views of community members, seeking to establish what services were already provided in Newcastle for BME communities and specifically which related to access to health and social care; exploring different models of provision and engaging with stakeholders about which model would best fit the circumstances in Newcastle. These activities may have taken a considerable time but they provided an excellent foundation for establishing the project once funding was secured. It provides a good model of the bottom up type of needs identification and assessment and positive engagement with relevant stakeholders that is more likely to produce a project that genuinely meets the needs of disadvantaged communities.

Another real strength of the project is the existence of a diverse and engaged “advisory group”. Its membership includes some of the most knowledgeable people in the city about the needs of BME communities in general and asylum seekers and refugees in particular. There are one or two key individuals who

have been involved from the beginning and they provide both continuity and experience of the whole development process of the project.

Because of the expertise available within its membership, the advisory group is thus both a resource to the project staff and a resource of the project in that members promote the use of BME advocacy and use case studies gleaned from the project to influence improvement in health and social care provision.

The project has managed to establish and maintain excellent working relationships with both voluntary and community sector organisations that work with vulnerable communities and health and social care professionals who work directly with the most disadvantaged members of society. These relationships are valued highly by those interviewed and in my view contribute to the projects reputation and standing.

Another example of good practice by the project is the inclusion of a substantial budget for interpreting costs as a core part of the projects expenditure. Any project, public or voluntary and community sector, working with BME communities should include adequate funding for interpretation ensuring independent, accurate information is available to both the client and any other parties providing services to them.

A number of stakeholders have commented on both Jacqui and Yvonne's qualities and they are highly regarded amongst their peers working in this field. To quote one of the stakeholders ***"The project is very lucky in both Jacqui and Yvonne – it is so dependent on these key roles."***

The single greatest risk to the project is the insecure and inadequate funding the project currently receives. There are insufficient resources going into the project to cover the current actual level of work undertaken, let alone to maximise its potential impact. This situation is not untypical and the trend of funding to the voluntary sector which is almost always short term and frequently inadequate to cover the actual costs of the work that goes into the project has caused the Government to seek to develop strategies to try to rectify the matter in terms of the statutory sector commissioning work from the voluntary and community sector at real cost.

A significant number of stakeholders are very concerned about the lack of awareness and knowledge about advocacy and interpreting and the difference between them, particularly among health care staff.

Time and resource constraints force choices on the project about what activities to prioritise. There is considerable evidence that the project is delivering positive outcomes to the individuals it provides advocacy for. It has however not had the resources available to maximise its impact on influencing health and social care services to improve their practice to make services more accessible to BME communities.

In terms of the strategic impact of the project, the old proverb comes to mind, ***"Give a man a fish and you feed him for a day. Teach a man to fish and you***

feed him for life.” Whilst the project is very successful at improving quality of life for individuals from BME communities, especially failed asylum seekers, by enabling their access to relevant health and social care services (*feed for a day*), it is not having the same opportunity to enable those services to be far more responsive to those BME community members’ needs in the first place (*feed for life*).

The responsibility for reducing inequalities in health and social care provision rests firmly with the commissioners and providers of those services, with a particular responsibility resting with Primary Care Trusts as commissioning bodies and leaders within the health economy. They should be actively working to reduce those inequalities not just by improving their own policies, systems and practices but also by supporting the organisations working to reduce the impact of those inequalities on people. The “**Delivering race equality in mental health strategy**” recommends that primary care trusts (PCTs) and service providers ensure adequate investment in and provision of culturally appropriate independent advocacy. It can be argued that this is no less important in primary care, where GPs act as the gatekeepers to other services.

If the project were to receive additional resources to both recruit an additional worker and be supported with appropriate management time, it should be able to have the same impact on influencing the statutory sector that it has on improving individual’s lives by facilitating their access to health and social care services.

In the longer term it is influencing change within the statutory service practice that will reduce the needs of the BME community members not the assistance of individuals from that community. The current level of funding and resource does not permit these two priorities to have equal energy and commitment put into them. The project does what it can and indeed is very successful at identifying strategic issues from individual experiences. There is however in my opinion great potential to dramatically increase the impact in this aspect of the work with additional resources.

An additional risk consequent on the insecure funding is that the project worker will look for another job before the funding runs out in June 2008. Two of the advisory group referred to this as a particular issue and two others referred to the isolation of the role and the dependency of the project on an effective lone full time worker. This is a significant risk and the consequences would be severe if the worker were to leave the project before funding was secured. The cost and time lag involved in having to recruit and train another worker would totally disrupt the delivery of this service. If the wider pressure on the Advocacy Centre is not reduced there may also be a risk that other advocacy staff may leave.

This is why the first two recommendations are the substantive ones of the securing of long term sustainable funding for the project from the statutory sector and gaining additional capacity in the project to focus on making as

much difference to the cultural competence of health and social care services as it is currently making to the lives of project clients.

The remainder of the recommendations are operational suggestions to improve the working of the project.

Recommendations

- 1 Commissioners of health and social care services should recognise the need to secure mainstream sustainable funding for the service – recognising that alternative funding may be necessary in the interim.
- 2 The level of resources within the project should be increased to fund appropriate management time for support and development and an additional worker to enable an equal concentration on influencing change within health and social care practice to make services more culturally sensitive and appropriate for all members of Newcastle’s community.
- 3 Further targeted activity be undertaken to increase client numbers from the Bangladeshi community.
- 4 The project keeps a record of all the cases signposted to other agencies, organisations or groups in order to more accurately reflect the project activity.
- 5 Consideration should be given to undertaking work with project staff to clarify the boundaries of what is meant by “health and social care” in terms of the activities of the project, this should then be discussed with relevant stakeholders.
- 6 A review should be undertaken of the ways achievement of outcomes for individuals are monitored by the project. The Advocacy manager should have a role in independent monitoring, perhaps by selecting a sample of clients from the project for evaluation and interviewing them to understand their perception of the outcomes achieved and the quality of the service.
- 7 A review of project documentation should be undertaken to reduce it to the minimum consistent with running an efficient and effective project including the flexibility of the computer system
- 8 Further work to be undertaken on refining the outcome logic model so that the outcomes listed are within the projects capacity and capability to deliver.
- 9 Further work is undertaken by the advisory group to consider future development of the project, dependent on the outcome of recommendations 1 and 2.

Newcastle Advocacy Centre provides:

- * Citizen advocacy for vulnerable adults in Newcastle.
- * Case advocacy for people with mental health problems.
- * Case advocacy for people from Black & Minority Ethnic Communities.
- * Support to Advocacy Network Newcastle (ANN) which is open to individuals and groups with an interest in advocacy.

We are often looking for volunteer advocates.

**Newcastle Advocacy Centre
NCVS, MEA House
Ellison Place,
Newcastle upon Tyne
NE1 8XS
Tel: 0191-2327445
Fax: 0191-2305640
E-mail: advocacy@cvsnewcastle.org.uk
Website: www.cvsnewcastle.org.uk**